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1. Introduction

[1] Mr. Mumford pleaded guilty to two counts of aggravated sexual assault and two counts of choking to commit the offence of aggravated sexual assault with respect to two victims. These will be referred to as the "predicate offences". This is an application by the Crown for a declaration that Mr. Mumford be declared a dangerous offender or a long term offender.

2. The hearing of the Dangerous Offender Application

[2] Mr. Mumford pleaded guilty to the predicate offences on April 10, 2006. On August 10, 2006, I made an order for an assessment to be done by Dr. Lisa Ramshaw. In reasons dated September 12, 2006, I extended the time for the assessment but declined to make an order requested by the Crown to transport Mr. Mumford so that phallometric testing could be undertaken. Dr. Ramshaw's report is dated November 10, 2006.

[3] Counsel agreed that the trial would begin in May for approximately 2 weeks.

[4] Dr. Lisa Ramshaw was the only witness the Crown intended to call. As a result of her personal circumstances, the Crown sought an adjournment. Ms. Rochman agreed. The trial was set for June 19, 2007 for approximately 2 weeks.

[5] Dr. Ramshaw attended on Monday June 19th. At the conclusion of the first day of her evidence it became clear that she did not expect to return and her schedule did not permit her to attend the next day. In order to accommodate her schedule, her evidence was continued on June 21, and June 27-28. It was known that the Crown intended to call only one witness. Ms. Rochman had several witnesses but as the end of June neared, their schedules became compromised. On June 28th, I established this timetable. Evidence of the defence would begin on Monday July 30th and occupy that week and the week of Tuesday August 7th. The final witness for the defence would be called on Monday September 10th with submissions on Thursday, September 13 and Friday, September 14.

[6] On August 10, 2007, at the conclusion of Dr. Gojer's evidence Ms. Sweeney said that she was contemplating calling a witness to talk about whether what Dr. Gojer recommended would be available. Ms. Rochman did not concede that that would be proper reply evidence. At my request, Ms. Sweeney agreed to advise Ms. Rochman by September 7th what her expectations were with respect to reply evidence.

[7] On Monday, September 10, Dr. Pollock gave evidence and Ms. Rochman closed her case. Ms. Sweeney reported that she had informed Ms. Rochman on September 7th that she wanted to call reply evidence from Dr. Jan Looman as to what types of programs are available in the penitentiary system for sex offenders and what was made available to Mr. Mumford. She argued that that evidence was in response to Dr. Gojer and Dr. Pollock saying that if Mr. Mumford had the individualized assistance he required, it increased the prospects of treatability. She advised that Dr. Looman was not available that week and with her own scheduling complications, she proposed to call that evidence in the middle of October.

[8] Ms. Rochman objected to an adjournment of the trial for that purpose. She argued that it was not proper reply. Ms. Sweeney had spoken to Dr. Looman but she had not interviewed him and consequently, Ms. Rochman did not have a witness statement. Ms. Rochman reported that during the pre-trial, the issue of a witness from Correctional Service Canada had been discussed and the Crown had obviously made a strategic decision not to call that evidence in chief. She

argued that it would be very unfair to allow that evidence in reply. She noted that all the experts had given evidence based on the institutional records and that by allowing such supplementary evidence in reply, all of the evidence might have to be revisited. She observed that Dr. Ramshaw and others had given evidence about what was or was not available in prison.

[9] On September 10th, at the conclusion of the evidence called on behalf of Mr. Mumford, I ruled that I would not grant the adjournment requested by the Crown.

3 Criteria for a finding of dangerous offender or long-term offender

[10] According to s. 753(1)(b), the criteria that must be satisfied before a declaration is made that Mr. Mumford is a *dangerous offender* are these: the offender has been convicted of a serious personal injury offence; his conduct in any sexual matter (including the predicate offences) has shown a failure to control his sexual impulses; and there is a likelihood of causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses.

[11] According to s. 753.1(1), the criteria for a *long-term offender* are these: it must be appropriate to impose a sentence of imprisonment of two or more years in respect of the predicate offence; there must be a substantial risk that the offender will re-offend; and there must be a reasonable possibility of eventual control of the risk in the community.

[12] Ms. Sweeney's position is that the court should find Mr. Mumford to be a dangerous offender. However, she asks for long-term offender status as an alternative.

[13] Ms. Rochman conceded that the evidence demonstrated the following: Mr. Mumford has been convicted of a serious personal injury offence; his conduct has shown a failure to control his sexual impulses; there is a likelihood of causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses; a sentence of imprisonment of more than two years in respect of the predicate offences is appropriate; and there is a substantial risk that the offender will re-offend. Ms. Rochman conceded that Mr. Mumford meets the criteria of a long term offender.

[14] The issue is whether there is a reasonable possibility of eventual control of the risk in the community.

[15] For the reasons that follow, I find that there is a reasonable possibility of eventual control of the risk in the community. I find that Mr. Mumford fits the criteria for a long-term offender.

[16] Although all but one of the factors has been established, I must nonetheless consider Mr. Mumford's background in detail to explain my conclusion.

4. Family History

[17] Mr. Mumford was born on January 11, 1976 in Vancouver. His mother is of aboriginal descent. He has no biological siblings. His biological parents separated shortly after they married. Mr. Mumford described his parents as chronic alcoholics. By the time he was 3 years old, his mother was unable to care for him and she asked her sister to take care of him. From that point on, Mr. Mumford became a member of the family of his maternal aunt and her husband. He considers them and his three cousins to be his family. Since he referred to his aunt and uncle as his mother and father, I will do the same.

[18] After Mr. Mumford was incarcerated in 1995, his parents were interviewed. They said that his biological mother "liked to drink".

[19] Mr. Mumford continued to have a relationship with his biological father and visited with him from time to time. However, his father sexually abused him during weekend visits. The abuse may have started as early as age 6 or 7 and ended when he was 11 or 12. Mr. Mumford's cousin was also abused. When his mother learned of the abuse, she contacted the police. His father was convicted and sentence to jail.

[20] By his self-report, Mr. Mumford was a poor student. He had difficulties reading and writing. He attended special education classes but did not think he had been diagnosed with a learning disability. He said that he had been expelled from school in grade 10 for throwing a chair at a teacher. He has also said that he quit in grade 11 after he was expelled. He was frequently in trouble for fighting, stealing, joyriding, vandalism and alcohol use. He was involved with a gang in his early teens.

[21] In his evidence during this hearing he said that he had a relationship with a young woman and they had a daughter who was born on December 26, 1994. She moved into the home he shared with his mother and father. He dropped out of the gang when she became pregnant.

[22] His biological mother died of cancer at age 39 in 1997. He was in the penitentiary but he was permitted to attend her funeral. There were some visits with his mother and father while he was in the penitentiaries in the west but they were not feasible whenever he was in prison in Ontario or Quebec.

5. Prior Convictions

[23] In December 1994, Mr. Mumford and his 31-year-old cousin had been partying and consuming alcohol during the evening. They returned to her residence and he began to make sexual advances towards her. She refused to have sex with him. He began to punch her in the head and face. He armed himself with a beer bottle and struck her in the face with it several times causing the bottle to break. In trying to fend off the blows, the victim suffered cuts around

the left side of her face and to her hands. Mr. Mumford obtained a carving knife from a kitchen drawer. He held it to her throat and said, "pull down your pants or I'll kill ya". The victim complied, as she feared for her life. He had intercourse with her on the couch in the living room. When he got off of her, she left the residence and the police were notified. Mr. Mumford was arrested at her residence. In addition to the cuts to her face and hands, the victim's upper lip was bruised and swollen, as was her left cheek. Her left eye was swollen shut. She sustained a fractured zygomatic bone on the right side of her skull. Mr. Mumford gave a statement to the police in which he admitted to the offence. He said he had a bet with another man who had been at the victim's apartment earlier as to whether Mr. Mumford could have sex with the victim. In his statement he also said the following:

Before he took off he made a bet with me that I can't get her in bed and I decided to force her, I guess. Well, I started to force her and she said, No. So I kept on forcing her and forcing her and I got sick and tired of it and I hit her. And then she told me to stop and I didn't, so I kept on hitting her and hitting her and forced her to have sex with me. And after I was done I went into the bedroom and I kind of passed out.

[24] While he was awaiting trial¹ on charges including aggravated sexual assault, he was arrested for events that had occurred in late 1994. He had been asked to baby-sit his 7 year-old cousin. He fondled her vaginal area over top of her clothes and he pulled down her clothing to expose her private parts. He exposed his own penis. He instructed the victim to place her mouth on his penis. He moved up and down. During this assault, as he fondled her, he also inserted his finger into the victim's vagina. There was digital penetration. When he was arrested in February 1995, he admitted to the fondling, the digital penetration and the fellatio.²

[25] In May 1995, Mr. Mumford pleaded guilty to aggravated sexual assault involving his adult cousin and sexual assault involving his child cousin. He was convicted.

[26] At the time the offences were committed in late 1994, Mr. Mumford was 18 years old. By the time he pleaded guilty in May 1995, he was 19 years old. He was a first offender. The court had a pre-sentence report that indicated that Mr. Mumford "knew in each instance that his behavior was wrong but each offence was planned and purposeful. The subject obviously considers his needs first while empathy for his victims is rudimentary at best". The report included a recommendation for long term and intensive sexual offender treatment. Mr. Mumford had been in custody for 3.5 months at the time he was sentenced. He received a sentence of 3.5 years for the sexual assault on the child and 4.5 years consecutive on the aggravated assault for a total sentence of eight years. The trial judge observed that Mr. Mumford would receive counseling while incarcerated and should look forward to being

¹ It was suggested that the offences involving this child occurred while he was on bail. While Mr. Mumford agreed with Ms. Sweeney, the documentation indicates that he had been released on bail when he was arrested for the offences that had occurred earlier. This is an example of being easily led and being an unreliable historian.

In the institutional records referred to below, there is an indication that this assault involved penile penetration. It was not in the facts agreed to at the time of his conviction and Mr. Mumford has consistently denied that aspect.

rehabilitated. He directed that Mr. Mumford serve at least half his sentence prior to parole eligibility.

[27] In May 1998, he pleaded guilty and was convicted of assault. The victim was a staff member at the Saskatchewan institution. She was using the staff washroom. She opened the door to leave and found Mr. Mumford in the hallway. He tried to get in. She tried to push him out. She kept yelling and tried to lock the door. She couldn't get it locked. Help arrived. She was not hurt in the incident but said that based on his history, she felt considerable fear. Mr. Mumford was sentenced to 6 months consecutive to the time he was then serving.

[28] Mr. Mumford was moved to Kingston. In August 2002 he was charged with forcible confinement and assaulting a Peace Officer engaged in the execution of her duties. In November 2002, he pleaded guilty to both charges stemming from the same occurrence. According to the facts when he pleaded, the female Corrections Officer attempted to open the washroom door. She thought the door was jammed, as it would not open. As she put pressure on the door from the outside, Mr. Mumford opened it, grabbed the victim around the neck with one hand and forced her into the washroom, covering her mouth with the other hand. He told her to shut up. The victim screamed. Mr. Mumford released her and he ran out of the washroom. He was observed by other officers and he was apprehended. The victim was not injured, but she too expressed concern for her safety as a result of Mr. Mumford's history. Mr. Mumford was sentenced to 12 months concurrent on both offences but consecutive to the sentence he was serving.

6. The Predicate Offences

[29] Mr. Mumford was arrested in December 1994 and released. He was re-arrested in early 1995. He was in custody (pre-trial and sentence) effectively from December 1994 to November 2004, a period of almost 10 years. He served the full term on all offences. He was released at warrant expiry on November 17, 2004.

[30] On April 10, 2006, when Mr. Mumford pleaded guilty to the predicate offences, he admitted the following facts. On June 13th, 2005 at about 5:00 a.m. the victim ST (who is a sex trade worker) was walking in the area of King St. W. and Dowling Avenue in Toronto. Mr. Mumford approached her and asked if she was working. The victim asked what Mr. Mumford was looking for. He said a "blow job". The victim said that she was finished for the night but that she would take him to another girl provided he gave the victim a \$20.00 delivery fee. He paid the fee. The victim told him to follow her. As they walked through the back yard of a residence, Mr. Mumford produced a green cloth belt and from behind the victim he wrapped the belt around her neck and began violently choking her. She fought him and bit him on the hand. Mr. Mumford choked the victim so hard that she began losing consciousness. He demanded that she perform oral and vaginal intercourse. The victim was forced to the ground on her knees. He controlled her during the assault by choking her with the belt. Fearing that he would kill her, the victim had oral and vaginal intercourse with Mr. Mumford. When he had finished sexually

assaulting her, Mr. Mumford fled, leaving the belt. The victim grabbed the belt and ran to safety. The next day the victim reported the assault and provided the belt and her own clothing that had Mr. Mumford's blood on it.

[31] On June 22nd, 2005, at about 4:00 a.m., Mr. Mumford approached another woman and asked if she was working the streets. The victim MV said that she no longer did. She asked Mr. Mumford what he was looking for. He said he wanted a "blow job". She said she wasn't in the business and she was just out to get a coffee. Mr. Mumford said he would join her. As they walked up a lane, Mr. Mumford came from behind the victim and punched her in the face with such force that it caused her to stagger backwards. Her nose started to bleed and she was completely dazed. The trauma also caused her to urinate in her pants. Before she could recover, Mr. Mumford wrapped a blue bandana around her neck and began violently choking her. She struggled and tried to get her finger under the bandana but Mr. Mumford kept pulling the bandana tighter. The victim tried to scream but Mr. Murnford yelled at her to shut up. She was losing the ability to breathe and felt as if she was going to pass out. Fearing that he would strangle her to death, the victim pretended to be dead. Mr. Mumford loosened the grip of the bandana and the victim reacted as quickly as she could and grabbed the bandana and pulled it from her neck. She clutched the bandana close to her stomach so that he wouldn't use it as a weapon to choke her. He jumped in front of the victim, put his hand on his back pocket and said to the victim "you don't want to go there". Fearing what he had in his back pocket, the victim pleaded for her life. She asked him what he wanted and he said sex. The victim said he could have sex with her, fearing that if she didn't agree, he would kill her. She asked if he would use a condom. He told her he wasn't using a condom and he pushed her up against a vehicle and forced vaginal intercourse from behind her. When he was done, he pulled up his pants and demanded the bandana. She gave it to him. He walked away. When the victim was safely out of the laneway, she found a police car and reported the attack. Mr. Mumford was arrested two days later.

7. Institutional Records

[32] The school records obtained by the Crown are not comprehensive. Based on those records and information from Mr. Mumford while he was incarcerated, he did not complete high school. While in high school, he was associated with a gang and was using drugs and alcohol. He may have been involved in some property offences but he had no record as a young offender.

[33] Ms. Rochrnan prepared a list of the dates of transfers between penitentiaries. Ms. Sweeney accepted the accuracy of the list that reflects the following:

Date	Institution	Offences committed
May 18,1995	Stony Mountain Institution	
October 10,1995	Drumheller	
December 9, 1996	Bowden	
January 8,1998	RPC	
May 27,1998	Saskatchewan Penitentiary	Transferred after pleading guilty on May 26, 1998 to assault corrections officer on May 20,1998
June 11,1998	Bowden	
July 30, 1998	Edmonton	
March 18, 1999	SHU	
August 3,2000	Kingston Penitentiary	
February 6,2002	RTC (Ontario)	
August 4,2002	Millhaven	Transferred after assaulting corrections officer on August 4,2002
December 12,2002	Special Handling Unit	
March 31,2004	Saskatchewan Penitentiary	

[34] I note that the longest time he spent in any institution was about 18 months.

[35] In a Front-end Assessment Screening Report dated June 8, 1995 at Stony Mountain, it was noted that he showed no deficits in concentration or memory and abstract reasoning abilities were detected. Psychological testing was not available at the time. His specialized program needs included substance abuse, sexual offender assessment, anger management, suitable for RPC programming, cognitive living skills program, education and vocational training. He was observed to be very cooperative, anxious and remorseful. The psychologist noted that he was anxious, depressed and fearful. He blamed alcohol for the offence. The details of the offense suggested sadistic features. The overall impression was that he was burdened by tenuous personality organization and that he might become suicidal. It was recommended that he transfer to the Regional Psychiatric Centre in Saskatoon.

[36] A Community Assessment was done in June 1995. His mother and father were interviewed and provided **considerable** background information including the explanation for them having custody of him was that his biological mother "liked to drink" and she and his biological father "liked their freedom". His mother and father were supportive of him and indicated that they would visit at Stony Mountain and in Saskatchewan.

[37] In his self-report he said that *he slept 15 hours a day*. He identified his own needs as follows: help to improve his relationship with his wife; help to stop or control his drinking; help for drug and alcohol abuse problems; education; job skills; learning how to handle money. [Emphasis added.]

[38] The first MMPI-2 Basic Service Profile Report dated July 27, 1995 was prefaced by a concern as to its validity because of "**faking bad, inadequate reading ability, psychotic thought processes, or a cry for help**". [Emphasis added.] In a later psychological report it was observed that he had invalidated his MMPI-2 results by attaining the maximum score on one of the "lie scales" which was said to be indicative of "feigning symptoms: people who produce profiles with such an extreme elevation on this particular scale tend to want to project the image that they are not in control of their own behaviour".

[39] The Intake Assessment completed August 30, 1995 indicated that Mr. Mumford had been cooperative with authorities following his arrest and had provided written and verbal statements. It was reported that he took responsibility for the offences. The GSIR was not done because he is a native offender. It was noted that he would need significant assistance in personal and emotional orientation and that he would need to address his sexual offending. The author observed that "the victimization at the hands of his natural father has had a serious effect on many areas of his life". He was however well motivated for sexual offender programming. It was noted that:

Due to the subjects previous victimization, however, it is likely a milestone that the subject actually believes he has done something wrong. Despite his inability

to show any other insight he will likely develop this over time through programming.

The subject quite obviously is considered a sex offender, however, the offending behaviour is believed to be a form of acting out due to anger. The subject's programming should therefore have a high degree of focus on his violent potential and his pent up anger.

[40] It was considered that he had a problem with alcohol and should be referred to an awareness program but not that it was a serious addiction.

[41] The recommended programming was the following: transfer to the Regional Psychiatric Centre for the sex offender program; anger management; referral to the psychology department for regular counseling including dealing with victimization by his biological father; substance abuse counseling.

[42] I conclude from these records that, at the beginning of his incarceration, other than the invalidated MMPI for which several explanations were possible, there was some degree of optimism that Mr. Mumford was treatable. He expressed remorse. He said he wanted treatment. He had a supportive family.

[43] He was transferred to **Drumheller** Institution in October, 1995. A memo from the Chief of Psychological Services shortly after his arrival indicated that his level of education was "very poor" and upgrading was recommended. She also thought he had a "significant substance abuse problem" and that both the education and substance abuse problems had to be addressed before any sex offender treatment began.

[44] In January 1996 the Preliminary Sex Offender Program – Referral **Form** indicated that he admitted responsibility for his offences, he believed he needed treatment, he wanted treatment, and while he had problems with reading and writing that could interfere with his ability to comprehend material and complete assignments, he worked hard.

[45] Mr. Mumford's Correctional Plan was updated in March 1996 at Drumheller. In addition to the sex offender program, it was recommended that he take programs to address cognitive living skills, anger and emotions management, self-esteem, living without violence, substance abuse, and relapse prevention.

[46] At Drumheller, Mr. Mumford had problems with other inmates that precipitated several unit changes. In September, 1996 he asked to be placed in segregation until a transfer to another institution could be arranged. The Psychologist noted that "given his presentation and size", **Bowden** might be the only institution in which he would integrate well.

[47] In the Correctional Plan updated in late October 1996, it was noted that he had not completed any courses to date. He had been enrolled in the Living Without Violence Program but he had withdrawn. He had been employed in the kitchen but had quit shortly after he started. In January 1996 he had become a cleaner for the Native Brotherhood. It was observed

that he "must put more effort into following his Correction Plan and into the programs assigned to him". However, on the same page it was recorded that he had completed two programs: Interpersonal Communication and Relapse Prevention. On the next page it was noted that he had been enrolled in 4 programs: ABE School Level 1, Stress Management, Native Culture and Kitchen but he had been suspended for poor attendance. He said he "*liked to sleep in during the morning* and that was why he did not go". The writer concluded that he showed a "real lack of motivation for addressing his criminogenic factors". [Emphasis added.] He had received 7 minor institutional charges including being late 3 times.

[48] In a Program Performance Report dated November 1996, the Correctional Officer indicated that Mr. Mumford had attended 11 of the 14 sessions of the Letting Go treatment program before he was transferred to the Dissociation Unit and was therefore unable to attend. This was described as a new abuse recovery group for inmates who had experienced abuse in childhood. Mr. Mumford did participate by sharing when asked directly. He was trying to communicate more openly but had *difficulties finding the words to express his feelings and thoughts*. [Emphasis added.]

[49] Mr. Mumford was moved to **Bowden** on or about December 9, 1996. Later in December a Lifestyle Assessment Report was prepared. Based on self-report data, it indicated a serious problem with drugs and alcohol. He reported needing help to stop committing crimes, upgrade his education and learn how to save and handle money.

[50] A Psychological Report was prepared in April 1997. He told the psychologist that when he was three years old "his alcoholic mother gave him to her sister to raise". The psychologist considered that the invalidated MMPI-2 was the result of **feigning**.³ Dr. H. Elise Reeh reported that Mr. Mumford showed no remorse for his victims, he had firmly entrenched antisocial values and he admitted that it would be very hard to quit offending. She observed that he had shown poor institutional adjustment demonstrated by stealing tobacco at **Drumheller**, 2 counts within 9 days at **Bowden** for refusing to stand for afternoon count and "*slept in* to such an extent that he was expelled from three programs and the institution's school twice". [Emphasis added.] She assessed his risk to **reoffend** as high. She recommended that he complete the high intensity sex offender programming at the Regional Psychiatric Centre.

[51] In June 1997, the 90 Day Review noted that he had tried the Offenders Substance Abuse Program (OSAP) but *due to his lack of education, he was removed and would be slotted into a program for lower functioning inmates*. [Emphasis added.]

[52] A Community Assessment was completed in August 1997 that included information from Mr. Mumford's parents that they had maintained regular contact with him since he had been incarcerated and were wanting to help **him**. The author noted that because of the nature of the offences and the fact that the victims were family members, caution was needed in considering a private family visit.

³ See para. 38 above

[53] A Psychological Report was completed in October, 1997. The psychologist reported that Mr. Mumford's mother and father would be visiting and that they were not aware of Mr. Mumford's offence against their niece. That was relevant because Mr. Mumford's parents have a severely handicapped then 27 year old daughter who might be visiting and there was a concern for her safety. That information was wrong. It is clear from earlier records that Mr. Mumford's mother and father were aware of the offence against their niece. Unfortunately this wrong information led the psychologists to recommend that Mr. Mumford not be allowed private family visits.

[54] In November 1997, Mr. Mumford signed an application requesting a transfer to the Regional Psychiatric Centre so that he could "get some help not sexually abusing any more people".

[55] A Progress **Summary** prepared in November 1997 to consider that request included the following:

The subject appears to be well motivated for sexual offender programming. He does not attempt to minimize his actions, despite his lack of ability to recognize the **harm** that he has caused his victims. The subject, has verbalized motivation to change and he is willing to address his criminogenic factors, through recommended treatment routing, at this time.

. . . Since arriving at **Bowden** Institution Mumford has participated in two programs which were assigned to him and completed them with a moderate amount of success. . .

The subject does not have an exemplary work record, with examples of being fired or quitting, scattered throughout his employment record. . .

Mumford has completed his grade 11 but still has problems with the language and further schooling is something he should pursue while incarcerated or when he is released to the street. He has no other official training on record at this time. . .

The subject has been willing to address all of his **criminogenic** factors and any programs which have been assigned to him. Program involvement to date is as follows:

97-11-07 Family Life Improvement Program: completed with no evaluation report available as yet.

97-07-27 Alternatives To Violence: Positive evaluation.

97-04-22 OSAP: removed from program due to inability to comprehend material.

96-05-17 Relapse Prevention: Drumheller Institution/Successful completion.

95-12-06 Interpersonal Communication: Positive.

96-09-22 Letting Go: Unsuccessful

[56] In a Program Performance Report after he completed the Family Life Improvement Program, it was recorded as follows:

Mumford had a positive attitude entering FLIP and maintained it during the six week program. He was conscientious of time throughout the sessions and coffee breaks. He was late a few times, however, most times he would notify me prior to coming late. He was often early for the morning session and volunteered to help with set up for the day. Mumford was very helpful in assisting with the weekly sweats and was willing to help prepare the sacred grounds.

[57] It was observed that he had participated and shared his experiences and he had expressed interest and respect for native culture and spirituality.

[58] In an Interim Performance Report dated February 19, 1998, Mr. Mumford's suitability for the Clearwater Sex Offender Program was assessed. In April, 1998, another Interim Performance Report was prepared that contained the following:

Mr. Mumford does not present as a highly motivated patient. It took him over 4 weeks to come up with just 5 pages of autobiography, of which, the contents were lacking in sufficient detail. He was seen openly masturbating in his cell during a female security officer's hourly bed check. He apologized for this behaviour and, to the writer's knowledge, this has not reoccurred. . . .

Wayne attended 9 of 12 sessions of the Family Violence Group. He had to be called and reminded to attend group. *He had a great deal of difficulty comprehending some of the material.* The instructor felt that Wayne participated as best as he could and respected both his peers and facilitator. He remained sincere and with a positive attitude throughout the groups; however, he was unable to meet group objectives. . .

Wayne was discussed at ward rounds on Thursday April 16, 1998. It was decided that he will no longer attend afternoon teaching groups, but rather attend school. A program to meet his needs will be developed in the school. Testing done with the Psychology department indicates that Wayne has very poor educational skills. *It was suggested that Wayne may be FAS or perhaps FAE, thus he would be unable to get the maximum benefits from the teaching groups.* He is expected to meet with his primary nurse/therapist on a regular basis to work on his crime cycle, as well as other treatment issues. Wayne's participation will be monitored and reviewed in two weeks. [Emphasis added.]

[59] At this point, Mr. Mumford had been incarcerated almost 3 years. This is the first reference to the possibility that he might have FASD.

[60] As a result of the concerns about his intellectual functioning, Mr. Mumford was referred for a psychological assessment that was conducted on April 28, 1998. His performance on the WAIS-R indicated as follows:

Overall, Mr. Mumford's cognitive ability falls within the borderline range. His performance in the verbal area indicates that he has poor verbal ability, including a limited ability in language comprehension and expression, knowledge of words, and ability to reason with words. Similarly, Mr. Mumford appears to have some difficulty with non-verbal tasks which involve perceptual organization and processing visual material efficiently. He does possess a relative strength, however, in short-term auditory memory ability.

Recommendation

Given the above findings, it is recommended that treatment for Mr. Murnford be carried out in a concrete and simple manner. This implies that communication or instructions should be provided with simple wording and concrete examples. Assistance should be given for activities requiring processing of verbal information, whether it be in verbal or written form. In carrying out activities, repetition of instructions would be helpful, as well as checking for understanding and providing Mr. Mumford with an opportunity to practice each task. Provision of the above recommendations should ensure that Mr. Mumford obtains maximum benefits offered from the sex offender program.

[61] In anticipation of his transfer to the Saskatchewan Penitentiary, a Student Termination Form was completed. The teacher indicated that Mr. Mumford had had difficulty focusing and had made very little progress and that:

Learning Disability screening indicated possibility of FAE. Security concern: stalking behaviors. [Emphasis added.]

[62] This is the second and last reference to the possibility of FASD.

[63] On May 20, 1998, he assaulted a staff member. A staff member was in the staff washroom. When she opened the washroom door, Mr. Mumford confronted her. He attempted to push her back into the washroom. She escaped and closed and locked the washroom door. Her calls for help were answered by other staff. Mr. Mumford was arrested and charged. On May 25, 1998 he pleaded guilty and was sentenced to 6 months consecutive to his existing sentence. This behaviour caused him to be discharged from the Clearwater Sex Offender program. On May 27, he was transferred to the Saskatchewan Penitentiary. On June 11, 1998 he was transferred back to Bowden and then on July 30, 1998, he was transferred to Edmonton all apparently because of the assault.

[64] In August, 1998, a Psychological Assessment was prepared at Edmonton that included these observations:

Mr. Mumford spoke with an occasional stutter. His informal speech was effortful, soft and poorly articulated, although he performed well on formal tests of articulation. He frequently misheard the questions posed to him. He showed weak reading and reading comprehension skills. He responded very openly to interview questions but delivered minimal spontaneous speech. At times he seemed almost compelled to respond to my questions, even though he appeared reluctant to provide certain kinds of information.

. . . it is likely that Mr. Mumford's intellectual capacity falls within the low average range. . .

Mr. Mumford . . . was transferred to the Edmonton Institution after a sexual assault against a female staff. Mr. Mumford told me that this assault was impulsive and he knew it was wrong. He recalled thinking that he had been "in for a while and wanted to get lucky". Mr. Mumford attended **RPC** for four months and would like to return. He has been told he may do so after one year. Although uncomfortable for him to discuss, he acknowledged a problem with his sexual behavior and is aware that he needs further treatment.

OVERALL PROBLEM SEVERITY: SEVERE

[65] A Follow-Up Psychological Assessment Report was prepared in late 1998. He continued to express a request for sex offender treatment. He had started up-grading classes in English and Mathematics. He was interested in becoming involved in aboriginal programs and had requested to see an elder. His overall problem severity was then mild.

[66] A lengthy Progress Summary ~~was~~ prepared in late 1998 to assess his voluntary transfer to Kingston Penitentiary. This contains considerable detail as to Mr. Mumford's progress and behaviour since his original incarceration. The recommendation was that he transfer to Kingston where he could participate in intensive sex offender programming in a maximum security setting.

[67] In May 1999, a Correctional Plan Progress Report was prepared at the Regional Reception Centre in Quebec after his transfer there in March. It contains great detail as to his progress and behaviour. The Psychologist reported that Mr. Mumford had refused to participate in an assessment.

[68] The Psychological Activity Notes prepared in December 1999 and January 2000 reflect considerable progress having been made in the Violence Prevention Program although difficulties doing homework were again noted. But his attitude was described as "overall open and constructive". In the Correction Plan Progress Report in late January 2000, it was noted that Mr. Mumford had returned to school on a regular basis now that he had completed the Violence Prevention Program. He continued to meet with the Native counselor and Elder. The Elder was reported as trying to get funding from Ottawa to offer a program for Native Sex Offenders.

[69] The Psychological Activity Notes in February, 2000 reported that he had written to his (biological) father asking why he had abused him. He was anxious and confused about the prospects of re-establishing contact with him. In March, 2000, the psychologist noted that Mr. Mumford had spoken to his father on the telephone.

[70] The Correctional Plan Progress Report prepared in March 2000 contained the following:

Mumford's attitude has improved since his admission to the SHU. His regular participation in counseling with the psychologist and the completion of the Violence Prevention program seem to have had a positive impact on him. Mumford's self confidence has improved which leads to him being able to speak more openly about himself, his behaviour, and his crimes.

He expresses some understanding of the harm he inflicted on his victims. Mumford also seems to have a basic understanding that his actions were wrong. However at this stage there still is not a great deal of insight into his behaviour. Nor does he have at this point, the social skills and techniques to say that these situations would never happen again.

Mumford has shown definite progress since the last incident in December 1999. It seems that this incident has been a catalyst to help him move on and has lit his motivation to work on his weaknesses and to change his ways. He still has a great deal of work to do, however his motivation for programs is still strong and is believed to be authentic.

. . . Mumford is asking to be transferred to Kingston Penitentiary. He has requested such a transfer as he feels that this would provide him with the opportunity to be closer to his father who is incarcerated in a medium security facility in the Ontario region. More importantly, Mumford says he would have access to programs which could help him prepare for his release. He is interested in participating in the Sex Offender program at RTC (Ontario) and realizes he needs help dealing with his weaknesses and criminogenic factors.

[71] An Assessment dated April 2000 was prepared for the National Parole Board. The recommendation was that full parole be denied based on the following:

As Mumford has not participated in any sex offender programming geared to reduce the risks he represents, has re-offended while incarcerated, and is presently housed in the SHU where there have been three incidents of a sexual nature towards female staff members between August 1999 and December 1999, there is every belief that he in fact continues to be an undue risk for the community at this time.

. . . At this point there is no indication that Mumford's release will help him continue to reduce the risks he represents. He presently is evaluated as requiring a maximum security classification, has not successfully completed any programs

for sexual offenders, and has only shown recent improvement and progress with respect to having a better understanding of his criminogenic factors and expressing his emotions and needs in a socially acceptable manner.

[72] In April 2000, the Psychological Assessment Report prepared at the Special Handling Unit in Quebec contained the following:

Our psychological examination of the subject identified a mixed sexual disorder, including pedophilia and mixed hebephilia (sexual interest in prepubescent children and adolescents of both sexes), as well as an interest in the rape of adult females. . .

In terms of personality, our primary diagnosis was antisocial personality disorder. . . .

Mr. Mumford's sexual criminality is highly active and varied, *i.e.* directed against both children and women. The persistence and severity of the sexual disorder, despite the interventions of the justice system, have caused us to conclude that the risk of recidivism in a similar offence remains more than likely since he has not yet managed to take the necessary steps to control his deviant urges. In addition, since the risk pertains to both children (boys and girls) and women, the pool of potential victims is very large. We thus recommend that the subject not be granted any form of release into the community until he has completed a high intensity treatment program for sex offenders. In addition, he will more than likely need to take such a program when he is in the community. Mr. Mumford will need to be well supervised in the institution and in the community and, above all, he must never be left alone in the presence of a female staff member.

[73] In early August, 2000 Mr. Murnford was transferred to the Kingston Penitentiary. At the end of August another detailed report was prepared that concluded that *he be referred to a specialized treatment program for sex offenders for individuals with learning disabilities.* [Emphasis added.]

[74] A Progress Assessment Report in April 2001 contained the following:

Mumford has been actively participating in individual counseling with staff from the Kingston Penitentiary Sex Offender Program to develop coping mechanisms for his sexual behaviour and in preparation for the high-intensity sex offender treatment program at RTC(O). This participation is commendable and is suggestive of a willingness to address his identified dynamic risk factors through recommended treatment. However, since he has not yet participated in a full sex offender treatment program, any discussion of his level of insight into his sexual behaviour and offending is premature.

[75] In August 2001, the Psychological Activity Notes included the following:

Overall, Mr. Mumford continues to engage in numerous justifications for not engaging in activities (e.g. yard, gym, etc.) that get him off the range despite the self-reported benefits of doing so. He also expressed little motivation to engage in these activities in the future, especially since he anticipates being transferred to the RTC in the next two weeks.

[76] In February, 2002, he was transferred to the Regional Treatment Centre (Ontario). A Cognitive Assessment Report was prepared in April 2002. It concluded as follows:

Mr. Mumford's cognitive profile indicates that he would have a great deal of difficulty with the verbal comprehension, reasoning, and memory required for core correctional programming. This is consistent with Ms. B's feeling that he may be unable to benefit from Cognitive Skills. *The suggestion is that he should be considered for "special needs" version of programming.* Mr. Mumford will eventually require Sex Offender programming, and the present observations suggest that strong consideration should be given to exempting him from the group portion of that program. [Emphasis added.]

[77] On August 4, 2002, Mr. Mumford assaulted a staff member.

[78] In a Psychological Report prepared in July and August 2002, Dr. Jan Looman reported that the High Intensity Sexual Offender Programme had begun on July 10, 2002 and would have ended in February of 2003. Mr. Mumford was admitted early to prepare for the program. After 8 sessions, he was discharged on August 4, 2002 after attempting to take a female staff member hostage in a staff washroom. Dr. Looman noted that Mr. Mumford's explanation at the time was that he was under stress and attacking the staff member was his way of getting off the unit. Dr. Looman was not optimistic about Sex Offender Treatment for Mr. Mumford. He concluded as follows:

Given the two incidents of re-offending while in treatment it is difficult to foresee future treatment opportunity being provided to Mr. Mumford. One possibility would be to offer him anti-androgenic treatment. Mr. Mumford reports great difficulty managing sexually inappropriate urges; perhaps sex drive reduction would assist in this regard, affording him the opportunity to participate in treatment at some point in the future. Individual treatment, as opposed to group, would also be an appropriate course of action.

[79] Mr. Mumford was immediately transferred to Millhaven. On November 6, 2002, he pleaded guilty to assault and was given a sentence of 12 months concurrent. In December, 2002, he was transferred back to the Special Handling Unit in Quebec.

[80] Mr. Mumford did start another program. However, in January 2003, he wrote to the psychologist a note that indicated that he was withdrawing because he had "too much problems" on his mind. The Psychologist interviewed him and reported that Mr. Mumford felt that he was not ready and he had other family problems that he had to deal with first. He said that he would like to try again the next time the program became available.

[81] It appears from other records and the Psychological Activity Notes that he withdrew because he was experiencing an unusually high level of stress caused by a number of factors including receiving additional time of 12 months for the assault in August. He was observed and he admitted to masturbating more often as a way of relieving stress.

[82] In September 2003, a Program Performance Report indicated that he had attended all the sessions of a substance abuse program and had put a lot of effort into the exercises. Based on pre and post program scoring, his level of performance was considered as above average. He continued to be willing to attend programs.

[83] Mr. Mumford was treated with a sex drive reducing medication (Androcur) twice a day from November 28, 2003 until May 2004. He stopped on May 11, 2004 because of weakness, fatigue and lethargy. During the assessments by Dr. Ramshaw and Dr. Gojer, Mr. Mumford said he had stopped because he was growing breasts.

[84] In late March, 2004, he was transferred back to the Saskatchewan Penitentiary where he stayed until warrant expiry in November, 2004.

[85] In the months leading up to his release, Corrections Officers communicated with the Toronto Parole Office to alert them that he would be released in November and that he had not addressed the high intensity program needs he required. Consequently, he would be released "as an untreated sex offender, who has anger and violence management issues".

[86] There are hundreds of pages of institutional records. Some were collected by Ms. Rochman in Exhibit 5 while others were assembled in the application record as those upon which Dr. Ramshaw had specifically relied. The foregoing reflects only a portion of the records created over 9.5 years. These conclusions can be drawn:

- (a) the possibility that Mr. Mumford had FAS was raised twice but was never investigated;
- (b) the records are replete with indications of FAS as were described by Dr. Stanley such as attention deficits, cognitive impairment, lack of understanding and impulsivity;
- (c) as a result of not being diagnosed, programs designed to respond to what we now know is the diagnosis of partial FAS were not offered;
- (d) in most of the records, Mr. Mumford is shown as motivated to take programs and to change his behaviour. That motivation was never suspect although his ability to carry through because of his cognitive impairment was noted;
- (e) Mr. Mumford did have some successes;
- (f) Mr. Mumford did not complete Sex Offender Treatment for various reasons: he assaulted a corrections officer twice and was removed from the program and the

institution; he felt highly stressed and he dropped out; he was unable to use the written materials that were part of the program; he did not respond in group therapy;

- (g) he frequently displayed inappropriate sexual behaviour under conditions where his behaviour would have been closely controlled, suggesting that he was not amenable to such controls;
- (h) he asked for access to Elders and to programming available for Aboriginal offenders. His requests were met but the extent to which he was engaged in the Aboriginal culture and programming is not apparent from the records;
- (i) Mr. Mumford voluntarily took **Androcur** for over 5 months and stopped because of side effects;
- (j) at the outset and from time to time depending on where he was incarcerated, the relationship with his mother and father continued. He did have some family supports albeit often unavailable because of geography.

8. Events Between November 17, 2004 and June 2005

[87] After almost 10 years in pre-trial custody and in prison, Mr. Mumford was released from the Saskatchewan Penitentiary. He was almost 29 years old. Prior to his release, there was some attention paid to arrangements for him. He heard on the grapevine that if he returned to Winnipeg, relatives of the adult cousin whom he had attacked would retaliate. He understood it was a death threat. He asked to go to Toronto where his father resided. When he arrived in Toronto on November 18th, the only arrangement made for him was that his father knew he was arriving and met him at the airport.

[88] As mentioned earlier, Mr. Mumford's father had been convicted of sexually assaulting him. It is an indication that there were no other options available to him that Mr. Mumford asked to live with the person who had victimized him, who he had not seen for about 15 years and with whom he had had only sparse contact by letter or by phone in the latter years of his incarceration.

[89] Donald Mumford was living in rented accommodation with a female companion. Because of his criminal record, Donald Mumford had been involved with the Circles of Support and Accountability. The people who had been working with him were very concerned about the effect on Donald Mumford of resuming a relationship with one of his victims and indeed, living with him. Because of those concerns, a member of Donald Mumford's Circle also went to the airport and monitored the relationship.

[90] On November 24, 2004, Mr. Mumford voluntarily entered into a s. 810.2 recognizance for 12 months. The predicate offences occurred in June 2005 while he was subject to that recognizance.

9. Evidence of Dr. Lisa Ramshaw

[91] Dr. Ramshaw provided a 42 page report and gave evidence over 4 days. Her diagnoses are similar in some respects to that of Dr. Gojer. They have different views as to whether Mr. Murnford is treatable and whether there is a reasonable prospect that the risk can be controlled in the community.

[92] Dr. Ramshaw quoted at length from the institutional records, some of which I have referred to as well as others that she considered particularly relevant and on which she relied in forming her opinion.

[93] By all accounts, Mr. Mumford is not considered a good historian although there are different theories as to the reason for inconsistencies. One example is his explanation to Dr. Ramshaw about employment just before he was arrested:⁴

After his release in 2004, while residing in Toronto, he worked at Barrymore Furniture for three to four months. He worked six days a week for \$11 an hour, packing and helping to build the furniture. A few weeks prior to his arrest he suddenly left work and never returned. He had become upset when he was questioned about why he was late. He had been working "long days and ended up having a good time on weekends and was sleeping in." He liked going out with friends on Fridays and Saturday nights, and he had started drinking and was using drugs, including crack cocaine. He stated that he "had lots of money" and "had trouble handling money". He stated that he had thought he would have kept his job, "but it didn't work out". He had no thoughts of returning to work after he quit, though he now regrets his behaviour. He stated if he could do it again he would have asked for a five day instead of a six day week.

[94] Dr. Ramshaw incorporated the results of tests done by Dr. P. Wright. Mr. Mumford was reading at the grade 5 level which was above what had been reported in earlier tests but not quite sufficient for the testing questionnaires, particularly when combined with his intellectual functioning. His approach to the Rey Complex Figure Test was surprisingly organized and the results did not suggest gross neuropsychological impairment.

[95] CSC staff assessed Mr. Mumford as having borderline intellectual functioning, as assessed by the WAIS-III with strength in matrix reasoning. Despite this area of strength, Dr. Ramshaw reported that he had struggled with the WCST. He appeared to struggle to utilize feedback and perseverated a great deal. She noted that his inability to change his approach after feedback was marked, as was his pull toward incorrect strategies by stimulus characteristics. She opined that this tendency to respond impulsively based on the pull of what is in front of him and perseverate will be a challenge in his learning to control his behaviour.

⁴ See para. 186 below in the evidence of MB for what is likely a more accurate version of his employment. This is another example of Mr. Mumford being an unreliable historian.

[96] Mr. Mumford generated an MMPI-2 profile containing consistent responding, indicating that he was able to comprehend the item content using the audio taped format. Validity scales suggested a profile of marginal validity due to symptom over-reporting. The resulting profile is in keeping with an individual who has high levels of impulsive energy and internal tension. Dr. Ramshaw concluded that the chronic nature of their difficulties, render a poor prognosis for change.

[97] Mr. Mumford's PAI profile was similar to his MMPI-2 results. The most unusual aspects of the profile were the elevations in the violence potential index, suicide potential index and the treatment process index. She observed that any form of treatment would be complicated by periods of defensiveness, believing he is being mistreated, trouble trusting authority figures and over-reacting to perceived slights.

[98] Dr. Ramshaw noted that Mr. Mumford's Anger Disorder Scale (ADS) profile was "quite concerning". He endorsed severe and prolonged revenge ideation. His overall vengeance score was very high.

[99] On the treatment preference survey, Dr. Ramshaw noted that Mr. Murnford expressed an interest in a narrow range of treatment programs, but they did include sex drive reducing medication and individual and group therapy targeted at sexual behaviour control and anger management. On the Sexual History Questionnaire he indicated sexual involvement with only 2 to 5 women and denied all other forms of sexual contact or paraphilias, save adult homosexual contact both while incarcerated and after release as well as 31 to 100 exhibitionism events while incarcerated. He denied all aberrant sexual fantasies, except for exhibitionism.

[100] On the MAST he endorsed items indicating an alcohol abuse problem, losing jobs, fighting, attending AA, losing a girlfriend etc., due to alcohol. He also endorsed items indicating that he has had a severe substance abuse problem involving heroin, cocaine and LSD.

[101] Dr. Ramshaw administered the usual instruments designed to provide a statistical appraisal of risk. As she noted, these are static tests that provide a fixed estimate of risk at a particular point in time. Mr. Murnford received a score of 26.7 out of a possible 40 points on the Psychopathy Checklist – Revised (PCL-R). She reported that scores over 20 are considered significant for sex offenders. While his score is lower than 30 (the threshold for psychopathy), Dr. Ramshaw noted that it was high and his score is particularly concerning in the context of his versatile sexual offending behaviour.

[102] Dr. Ramshaw explained that the PCL-R is an important component of the Sex Offender Risk Appraisal (SORAG). He ranked in the 98 percentile. Research indicates that 89% of individuals re-offended violently (including sexual violence) within 10 years of opportunity.

[103] The STATIC-99 is an instrument that was developed as a screening tool to identify individuals at risk for future sexual re-offense. It takes into account a limited number of historical events. His score was 7, falling within the high risk category.

[104] Dr. Ramshaw also considered the dynamic factors that contribute to the assessment of risk including employment problems, relationship and residential instability, association with pro-criminal peers, antisocial values, and a lack of any significant depth of understanding of his underlying problems and need to change. Other areas of concern included versatile sexually deviant behaviour, high sex drive, emotional dysregulation, anger, poor impulse control and short survival time in the community. Dr. Ramshaw noted that Mr. Mumford can present as more stable and endearing at times, and can be quite likable. But he **has** offended during apparent times of stability.

[105] Dr. Ramshaw's diagnosis was as follows:

Mr. Mumford's history and presentation was in keeping with a paraphilic disorder (sexual Sadism, Exhibitionism and possibly Pedophilia), antisocial Personality disorder and Borderline Traits, and a Substance Abuse Disorder (polysubstances, including alcohol, cocaine, as well as heroin and LSD). He evidenced borderline intellectual functioning through intelligence testing, and presented clinically as low average. *Fetal Alcohol Spectrum disorder could not be ruled out.* There was no evidence of a major mental illness such as a psychotic disorder or mood disorder. . .

There is no doubt that **Mr.** Murnford's chaotic early experiences *including parental alcohol abuse with possible fetal alcohol effects*, poor modeling and the pre-pubescent sexual abuse he endured, have had an impact on **his** life and his behaviour. . . [Emphasis added.]

[106] Dr. Ramshaw explained each of the diagnoses as follows:

Paraphilias describe a sexual preference for an inappropriate sexual object or activity. Sexual sadism, denotes a primary sexual preference for sexually arousing fantasies, urges or behaviours involving acts (real, not simulated), in which the physiological or physical suffering (including humiliation) of the victim is sexually exciting to the person. . . .

There is general agreement that sexual sadism is one of the most difficult to treat of all the sexual paraphilias. When present in combination with an antisocial personality disorder or psychopathy, the prospects for successful treatment are extremely poor. Further, Mr. Mumford has offended while undergoing sex offender treatment, indicating that such treatment is a risk-enhancing factor.

Personality traits are characteristic ways of interacting with one's environment. . . . Psychological treatment of personality disorders tends to involve a protracted period of time and requires considerable motivation and commitment on the part of the individuals so treated. . .

The diagnosis of antisocial personality disorder requires that there be evidence of conduct disorder, with onset of conduct disorder symptoms before the age of 15 years. Mr. Mumford meets all the criteria for antisocial personality disorder.

Individuals with borderline personality pathology have a pattern of emotional and interpersonal instability, with impulsivity, anger and suicidal gestures and ambivalent attachments. While Mr. Mumford has some affiliative needs, he has significant interpersonal and emotional instability, which impact his coping strategies.

Substance Abuse is defined as the use of substances in a maladaptive fashion leading to clinically significant impairment or distress as manifested by one or more recurrent substance abuses resulting in a failure to fulfill major role obligations, recurrent substance use in situations in which it is physically hazardous, recurrent substance related legal problems or continued substance abuse by having a persistent or recurrent social or interpersonal [sic] caused or exacerbated by the effects of substances.

[107] Dr. Ramshaw concluded that Mr. Mumford was at a very high risk to re-offend sexually and violently, both in the short term and the long term. She observed that his risk is not only very high, but he remains young with a lengthy window of opportunity for recidivism.

[108] On the subject of risk management/treatment, Dr. Ramshaw said the following:

While Mr. Mumford is motivated to obtain his freedom, he is not motivated to change, and lacks any depth of insight into his own difficulties. . .

The only known significant intervention that could decrease his risk in the community is high potency sex drive reducing medication . . . resulting in castration levels of testosterone, in the context of supervision. However, this is unlikely going to result in an assumable risk, as an ability to commit to this treatment over the long term would be doubtful due to his frequent shifts in attitude, his impulsivity and his intolerance for side effects. Further his self-report is unreliable and he has not been forthcoming regarding his problems prior to offending in the past.

Sex offender programs would not be recommended, due to his heightened risk and sexual dyscontrol while taking such programs, though he might do better if he were treated with appropriate sex drive reducing medication. Further, while anger management would be indicated, his limited intellectual functioning would impact his ability to understand and learn from the strategies necessary to make a paradigm shift. Substance rehabilitation treatment would not be expected to impact risk significantly, though he may benefit personally from further treatment in this area. Previous attempts at intervention have not been successful.

Mr. Mumford has been offered and has tried various treatments while incarcerated. Even in this structured setting he has done poorly and has offended while undergoing treatment. He would be a poor treatment and supervision candidate based upon his history, his psychopathy, behavioural dyscontrol with anger, antisocial values including problems with authority, his need for control, his substance abuse and his impulsivity.

[109] While not recommending it, Dr. Ramshaw then anticipated that the issue of eventual community re-integration might be considered and she proposed conditions to which I will refer below.

[110] Dr. Ramshaw concluded that from a limited psychiatric perspective, Mr. Murnford meets the criteria for a dangerous offender status:

He has exhibited a pattern of repetitive behaviour with a failure to restrain his behaviour and sexual impulses. His offending behaviour involved sexual violence causing injury and likely severe psychological damage upon the victims, and there is a high probability that he will re-offend in the future. While there are possible risk-reducing strategies, there are no clear treatment interventions that would render his risk assumable in the community, or result in eventual control with a period of up to ten years of supervision.

[111] In her report, Dr. Ramshaw reviewed the diagnoses of Mr. Mumford that are found in the institutional records. They included Antisocial Personality Disorder, Pedophilia, Substance Abuse, Borderline Intellectual Functioning, and possible Exhibitionism and *Fetal Alcohol Spectrum Disorder*. Later in her report she noted that Mr. Mumford is of native heritage on his maternal side and *he was born of alcohol parents*. As indicated above, in her own diagnosis, she indicated that *Fetal Alcohol Spectrum Disorder could not be ruled out*. [Emphasis added.]

[112] In cross-examination, Dr. Ramshaw said she thought Mr. Mumford did not have the facial features indicative of FAS but she acknowledged that it was a possibility. She did not dispute the validity of the diagnosis by Dr. Stade. She agreed that the criteria to diagnose FAS is not complex and that specialized clinics exist to make this diagnosis.

10. Evidence of Dr. Barry Stanley

[113] Dr. Stanley graduated from medical school in England in 1964. He qualified in Canada and had a practice as a General Surgeon from 1971 to 1997. He and his wife had adopted a child who posed many challenges. In his late teens, the child was diagnosed with a form of FASD. He left surgery and committed himself to training in the diagnosis and treatment of patients with FASD. He did not see Mr. Mumford. Ms. Rochman called him as a witness to contextualize FASD. In effect, he delivered a lecture on the subject. Ms. Sweeney did not challenge his qualifications. He was accepted as an expert in FASD.

[114] Dr. Stanley talked about historical awareness that pregnant women who drank alcohol put the foetus at risk. The first scientific study was conducted in 1899 of 120 chronic alcoholic women prisoners where those who carried the child to delivery while incarcerated had healthier babies than those who were not in jail. In the 1970's Dr. Ann Streissguth was engaged in research of malformations in offspring of chronic alcoholic mothers. In the last 40 years, considerable research has been conducted.

[115] Those children with facial features are diagnosed with Fetal Alcohol Syndrome while those without facial features are categorized as Fetal Alcohol Effects. Fetal Alcohol Spectrum Disorder (FASD) includes about 20% of persons with FAS and about 80% who are categorized as Alcohol Related Neuro Development Disorder (ARND). Partial FAS is diagnosed when the individual has some but not all of the facial features. It does not mean that the individual is only partially affected.

[116] Dr. Stanley opined that FASD is grossly under diagnosed and misdiagnosed.

[117] As a result of research, tools have been created to diagnose FASD. The FAS Diagnostic Clinic at St. Michael's Hospital in Toronto uses a system based on the 4-Digit Diagnostic Code, 1997 that was developed at the University of Washington, Seattle and is widely used throughout North America.

[118] Dr. Stanley referred to national statistics that indicate that 10% of Canadians have mental health problems. If 1% of Canadians have FASD, then he reasoned that 95% of those with FASD have mental problems. Yet FASD is rarely diagnosed.

[119] FASD is a neuro-psychiatric condition and attention disorder. Primary disabilities are inherent in FASD individuals and are a consequence of the neurological damage and impaired neurological function. Individuals with FAS/FAE develop a range of secondary disabilities which could be ameliorated with appropriate interventions including mental health problems, disrupted school experience, trouble with the law, confinement/incarceration, inappropriate sexual behaviour, alcohol and drug problems, dependent living and problems with employment.

[120] According to Dr. Stanley, 40% to 50% of juvenile and adult offenders are FASD. Recidivism, probation and parole violations are inevitable.

[121] Typically an individual with FASD perseverates and has difficulty in concrete thinking: s/he only understands what is literally said. Often they present with disorganized narration. Dr. Stanley noted that those with FASD are not able to process accurately every word said to them and sometimes compensate by filling in gaps with similar sounding or meaning words. They sometimes make up what they cannot remember. This often leads to misunderstandings and accusations of lying.

[122] The average IQ for those with FAS is 79-72 and with FAE it's 90. Of those afflicted with FASD only 10% have an IQ below 70. 90% have an average or higher than average IQ. However, all have a significantly lower AQ (Adaptive Abilities) than would be

expected. Adaptive abilities are those needed to perform the daily activities required for personal and social sufficiency.

[123] Dr. Stanley used a diagram to illustrate the developmental stages of an 18 year old child with FASD: actual and physical age of 18; expressive language may be at the age of 20 and reading ability might be at the age of 16; however living skills might be at 11 years, money and time concepts at 8 years, social skills at 7 years and comprehension and emotional maturity at 6 years of age.

[124] FASD cannot be cured. However, cognitive therapy and drugs are used to respond to symptoms: Ritalin and other drugs are used for the attention deficit issues; SSRI's are used for mood issues; and anti-psychotics are used for mood and cognitive stabilization. Trials of individual drugs and combinations must be done under supervision and methodically to achieve optimum results.

[125] FASD is caused by a pregnant mother drinking alcohol. Dr. Stanley reported that the official position of the Canadian government is that no amount of alcohol is safe. Research does indicate that severity of FASD is related to quantity, frequency, time and manner in which alcohol is taken during pregnancy. An individual with FASD has a brain injury.

II. Evidence of Dr. Nathan Pollock

[126] Dr. Pollock has a Ph.D from the University of Toronto. He has had an independent practice in clinical psychology since 1992. For three years he was director of the Sex Treatment Program at the Clarke. His principal interests include psychological assessments for criminal and civil proceedings and assessment and treatment of adult behaviour problems. He has acted as a consultant for CSC for treatment and for risk evaluation for parole purposes. He is a member of the Ontario Review Board. Ms. Sweeney conceded that he is an expert with respect to the administration and interpretation of neuro-psychological tests.

[127] Dr. Pollock administered various tests with respect to Mr. Mumford's cognitive functioning and three tests on psychosocial adjustment. In addition, he had access to the results of 2 tests done at the request of Dr. Ramshaw. He too took a detailed history from Mr. Mumford.

[128] The results of the TOMM (Test of Memory & Malingering) led Dr. Pollock to conclude that Mr. Mumford was putting forth an earnest effort and that the findings are likely an accurate reflection of his current level of functioning. On the WAIS-III (Wechsler Adult Intelligence Scale – 111), Mr. Mumford's FSIQ (Full Scale Intelligence Quotient) falls at the 12th percentile, at the low end of the Low Average Range.

[129] The WAIS-III yields separate measures of verbal and nonverbal intelligence. The VIQ (Verbal IQ) is a measure of verbal abilities including language comprehension and expression, long-term memory for verbal information, and the ability to reason with words. The PIQ (Performance IQ) is a measure of the capacity for visual analysis and synthesis, spatial judgment, attentiveness to detail, and the ability to process visual material efficiently. Mr.

Mumford's VIQ falls at the 5th percentile, in the Borderline range. His PIQ falls at the 30th percentile, at the low end of the Average range.

[130] Dr. Pollock referred to the discrepancy between Mr. Mumford's VIQ and PIQ. He noted that Mr. Mumford's scores indicate a particularly limited vocabulary, difficulties handling verbal abstractions and categorizing things or ideas into logical groups, and a limited ability to attend to, process, and respond to verbal information.

[131] The WMS-III (Wechsler Memory Scale – III) is a test designed to assess key domains of memory and learning. Mr. Mumford scored below average on nearly all Index scores suggesting limitations in nearly all areas of memory functioning, but particularly with verbal learning and recall.

[132] The WRAT-4 (Wide Range Achievement Test – Revision 4) indicate that Mr. Mumford is functioning at a grade 6 level in sentence comprehension, at a grade 5 level in word reading and math computation, and at a grade 4 level in spelling.

[133] Results of the HVOT (Hooper Visual Organization Test) suggest mild impairment in visual analysis and recognition.

[134] The TMT (Trail Making Test: A& B) is a test of visual search speed, attention and concentration, mental flexibility and motor function. Mr. Mumford scored at the 30th percentile, indicating slowed response speed and difficulty alternating between cognitive sets.

[135] The SCN (Stroop Colour Naming Test) is a measure of cognitive flexibility. His performance showed serious impairment.

[136] Dr. Pollock concluded that cognitive testing indicates that Mr. Mumford has very modest intellectual abilities, problems with attention, difficulties with immediate and delayed memory and a tendency to become cognitively distracted and disorganized under stress. His findings of substantial cognitive impairment are consistent with the cognitive limitations reported with those with FASD. He noted that FASD is associated with intellectual limitations, attention deficit, learning and memory problems and impairment in language and motor abilities. As well, those with FASD tend to show slower processing speed and inefficiently, particularly when cognitive tasks involve working memory. Impaired executive functioning, characterized by perseveration, cognitive inflexibility, distractibility and impulsivity, are also commonly associated with FASD.

[137] Dr. Pollock reported on the 5 tests for psychosocial adjustment. The MCMI-III (Millon Clinical Multiaxial Inventory – III) is a personality inventory designed to assess patterns of personality and emotional disorders. It is widely used for diagnostic screening and assessment of clinical populations, with a primary focus on the presence of personality disturbance and disorder. The MMPI-2 (Minnesota Multiphasic Personality Inventory – Version 2) is a test designed to assess major patterns of personality and psychological disorders. The PAI (Personality Assessment Inventory) is designed to provide information relevant to clinical diagnosis, treatment planning, and screening for psychopathology.

[138] The validity indicators for the MCMI-III suggest consistent and valid responding. The results showed an uncommon willingness to be frank and self-revealing regarding behavioural and emotional difficulties and might be construed as a deliberate overstatement of psychological difficulties. Dr. Pollock noted that most offenders are inclined to minimize the severity of their psychological difficulties in order to create a favourable impression.

[139] Results of the MCMI-III, consistent with the results of the MMPI-2 and PAI administered at the request of Dr. Ramshaw, point to a basic personality pattern characterized by antisocial, avoidant, passive-aggressive, and depressive features. Schizotypal and Borderline traits are also evident as was an elevation on the Alcohol Dependency Scale.

[140] The ADS (Anger Disorders Scale) is an instrument designed to evaluate the intensity of his subjective anger and patterns of anger expression. His score indicated that his level of anger is unlikely to interfere with his functioning on a regular basis. There are indications of feelings of suspiciousness, resentment, and brooding which may escalate into pathological anger reaction. As well, features of vengefulness, indirect aggression, and impulsivity suggest a tendency to ruminate and stay angry for long periods of time.

[141] The PCL-R (Hare Psychopathy checklist – Revised) is designed to evaluate the degree to which personality features characteristic of a diagnosis of psychopathy are present. Individuals scoring at or above criterion on the PCL-R pose a significantly higher risk of violence than those scoring below. Mr. Mumford's PCL-R score of 26.7 places him at the 70th percentile, a fairly high score although below the cutoff level of 30 considered indicative of psychopathy.

[142] I note that the test results to which reference was made by Dr. Ramshaw were not fundamentally different.

[143] Dr. Pollock said that he had seen the written materials used in prison programs and he estimated that they would typically be at the grade 10 level. Such materials would be over Mr. Mumford's head.

[144] Dr. Pollock was familiar with the resources available in the community. He said that the programs that Mr. Mumford needed were available.

[145] Dr. Pollock was asked about Mr. Mumford's expressions of remorse. He said that based on the test results, his expression of remorse might be limited by his intellectual ability; his inability to express such thoughts in words might undermine the sincerity of the expression of remorse.

[146] Dr. Pollock was referred to Mr. Mumford's evidence that he desired treatment yet his track record indicated some failures. Dr. Pollock said that the information had to be communicated in simple terms and Mr. Mumford would need to be asked for feedback to ensure that what was being conveyed was being absorbed and processed. Concrete examples and no abstractions would be necessary. Treatment would have to be intensive and lengthy.

12. Evidence of Dr. Brenda Stade

[147] Dr. Stade graduated with a diploma in Nursing in 1978. Since then, she obtained a Bachelor of Science and Masters of Science in Nursing. Her Masters thesis was on the subject of raising a child with FAE. In 2003, she completed a PhD in Medical Science at the University of Toronto. Her dissertation was entitled: The Burden of Prenatal Exposure to Alcohol: Measurement of Quality of Life and Cost. At the University of Toronto, she is an Associate Member of the School of Graduate Studies and Lecturer in Nursing. Since 2002, she has led the Fetal Alcohol Spectrum Disorder Clinic at St. Michael's Hospital.

[148] Dr. Stade's qualifications to diagnose FAS and FAE was not challenged by the Crown.

[149] Part of Dr. Stade's assessment is the extent of prenatal alcohol exposure. Mr. Mumford's mother died many years ago. Mr. Mumford reports his understanding that his mother drank heavily. The institutional records reflect many such references. While the quantity, frequency, time and manner in which his mother consumed alcohol is not known, it is apparent that her alcoholism largely contributed to her inability to care for him by age 3. On the basis of information available to her, Dr. Stade concluded that Mr. Mumford had a history of significant prenatal exposure to alcohol.

[150] Dr. Stade also reported that he was apparently of normal size at birth and had no growth restriction on the parameters of weight, height or head circumference. She reported that he is in good health although a carrier for Hepatitis C.

[151] Dr. Stade had reviewed Dr. Pollock's draft report because she needed the results of the psychological testing to complete her diagnosis. She specifically referred to the results of his testing on the TOMM, WAIS-III, WMS-III, WRAT-4, HVOT, and the TMT as indicative of Mr. Mumford's cognitive impairments. She said that he demonstrated significant cognitive problems that are well beyond what is needed for a diagnosis. He has the neuro-psychological profile of a person with FASD.

[152] There are three facial features that are indicative of FAS and Mr. Mumford has two of them. The space or groove between the upper lip and the nose is called the pilltrum. The first feature is the measurement of the lip and pilltrum. His lip and pilltrum measured 4 and 4, 2 standard deviations below the mean. The second facial feature is the palprebral fissure length, that is the distance between the outer edge of the eye and the inner edge of the eye. His mean palprebral fissure length was below the 50th percentile, and above the 25th percentile. She diagnosed him as having partial Fetal Alcohol Syndrome (PFAS) and she noted that while an individual with PFAS does not have all the characteristic facial features and growth restrictions seen in the full FAS, the neuro-toxicity resulting from prenatal exposure to alcohol can be as significant and as disabling.

[153] The measurement guide does not specifically take into account the eyes of Asians and Aboriginals. However, Dr. Stade had significant experience in adapting the guide to Aboriginals and was confident in her assessment.

[154] Dr. Stade noted that based on her experience, many individuals with FASD qualify for the Ontario Disability Support Program (ODSP) which currently provides income of almost \$1000 per month.

[155] Ms. Sweeney cross-examined Dr. Stade on several areas including the extent to which the measurements of facial features were objective or subjective. Dr. Stade insisted that they were objective but it is clear that there is a subjective element. Be that as it may, the Crown did not resist the opinion of Dr. Stade that Mr. Mumford has PFAS.

13. Evidence of Dr. Julian Gojer

[156] Dr. Gojer accepted the review of the institutional records contained in Dr. Ramshaw's report. He added a few extracts. He had reviewed the results of testing by Dr. Pollock and incorporated those conclusions into his assessment.

[157] Dr. Gojer took a detailed history from Mr. Mumford, as had Dr. Ramshaw and Dr. Pollock. There are some differences in the history given by Mr. Mumford but one example that relates to planning and deliberation and inappropriate executive functioning is relevant. This is taken from Dr. Gojer's report:

Mr. Mumford said that following his release he had told himself that he had already been convicted of two sexual assaults and he had no hope of ever having a normal sexual relationship with a woman. He told himself that his options were to purchase sexual gratification and if he had no money to deceive a prostitute or rape a woman. He had been carrying the cord with him from about January 2005 telling himself that if he had the opportunity he would use it to rape a woman. He told himself that if he raped a woman, it would be a prostitute as "they get raped anyway from time to time and are used to it and it won't affect them". He said that he had thought of strangling a prostitute from about January 2005 and this thought would get him sexually excited. He said that he does not recall masturbating to such fantasies. He would masturbate to fantasies of consensual sex only and would use pay per view pornographic videos to get himself excited.

[158] Dr. Gojer's clinical interview and his review of the test results led him to the diagnosis of personality disorder with antisocial traits. **Mr. Mumford's** history and criminal offending indicates that he has multiple paraphilias or sexual deviations. He has a problem with exhibitionism, a fetish for female buttocks, and sexual interest in coercive sexual activity. His descriptions of his sexual interests are indicative of sexual sadism. He concluded that pedophilia could not be ruled out.

[159] Relying on the work of Dr. Pollock and Dr. Stade, he came to this conclusion:

Mr. Mumford has a history of being exposed to alcohol in utero. He shows some of the facial features of the Fetal Alcohol Syndrome and some of the behavioral problems sometimes reported with what is known as the Fetal Alcohol Effects. Collectively all features of this disorder if not manifested in its complete form is

known as the Fetal Alcohol Spectrum Disorder. There is neuropsychological evidence of brain damage that likely had its origins to the exposure to alcohol prior to birth.

This brain damage has also led to him exhibiting complex problems of a neuropsychological nature that interfere with his learning ability. He presents with problems related to an Attention Deficit Disorder and its associated problems with impulsivity. He has a history of alcohol abuse and abuse of cocaine and cannabis. His use of cocaine appears to have reached a dependency level when he was in the community in 2005.

Mr. Mumford has also had difficulty controlling his anger.

He is lacking in self esteem and confidence and has limited social skills. Mr. Mumford's poor concentration and attention along with impulsive behavior is indicative of an attention Deficit Disorder, often seen in individuals who suffer from the effects of the fetal Alcohol Syndrome.

[160] Dr. Gojer's conclusion as to risk assessment was similar to that of Dr. Ramshaw:

Clinically Mr. Mumford suffers from multiple paraphilias and an antisocial personality disorder. The paraphilic component that is of greatest concern is the predilection for coercive sexual activity with adult females and this is coupled with sexualized violence or sadism. Some paraphilic disorders are more dangerous to the public. The presence of a coercive Paraphilia and Sexual Sadism is a dangerous combination not only for the psychological trauma that is inflicted on the victim but also the concomitant physical harm and possibly death. Mr. Mumford appears to have derived pleasure from choking his victims. A potentially lethal expression of underlying sadism. Mr. Mumford also offended against female guards when in custody and while receiving sex offender treatment. He also was exposing himself to female guards frequently in the penitentiary. He also refused to continue with chemical castration and refused sex offender counseling indicating that he did not understand the material that was being presented to him. He also reoffended sexually while in the community and while on an 810.2 order. The associated presence of brain damage increases disinhibition of sexual urges and the concomitant use of alcohol or drugs adds to this disinhibition. Clinical evaluation places him at a high risk for reoffending and does not negate the actuarial test findings.

[161] Dr. Gojer and Dr. Ramshaw part company on the issues of treatability and eventual control in the community. Dr. Gojer noted that Mr. Mumford was willing to consider anti-androgen therapies because he came to understand from Dr. Gojer that the side effect of breast enlargement could easily be dealt with by surgical intervention. He observed that Mr. Mumford was a candidate for stimulants like Ritalin to address his Adult Attention Deficit Disorder. He identified other drugs used to treat impulsive behaviors including an anti-psychotic

group. He noted that impulsivity and compulsive thoughts can be reduced by the use of SSRI (Specific Serotonin Reuptake Inhibitors). He said that a trial of SSRI's in combination with a stimulant or independently was worth trying. He also recommended antabuse.

[162] Dr. Gojer opined that while all the problems related to FAS cannot be treated, the attention deficit dysfunction, impulsivity and sexual acting out are all modifiable. Mr. Murnford's multiple cognitive distortions towards sexual offending against women and prostitutes as a special group⁵ would have to be dealt with in therapy. Mr. Mumford needs individual counseling for self esteem issues, help to organize himself and develop strategies to deal with his attentional problems. In addition he requires social skills training, anger management and he needs to learn to develop prosocial attitudes.

[163] In his report, Dr. Gojer concluded as follows:

Mr. Mumford will require further treatment within an institution and this should be of sufficient duration to ensure that he has truly integrated the concepts of relapse prevention and has the biologically based treatments in place.

Age is a factor in Mr. Murnford's case and his youthfulness is of concern. Sex offending against adult females is expected to diminish with advancing age and significant drop in offense rates are noted as a male enters his 50s and 60s. This should be taken into consideration when contemplating a lengthy sentence along with a ten year community supervision order as in the Long Term Offender Designation.

[164] In his evidence Dr. Gojer spoke about Mr. Mumford's age, or the "burn-out theory". There is evidence that suggests that at about the age of 45, the male's production of testosterone is significantly diminished and as a result, the rate of offending by males against adults drops dramatically as one moves from the age of 40 to 60. The risk of reoffending against adults is considerably reduced. He noted that the rate of offending against children is a gradual decline and continues to be a problem for some in their 90's. But as Dr. Gojer said, this dynamic factor of age is inevitable.

[165] Based on his assessment of Mr. Mumford, his willingness to participate in treatment including anti-androgen drugs, together with this age specific inevitability, Dr. Gojer concluded from a psychiatric perspective that there is a reasonable possibility of control in the community.

[166] Dr. Gojer said that from a therapy perspective he should receive anywhere from 4 to 5 years of treatment independent of the nature of the crime. Based on the "burn-out theory", he suggested that Mr. Mumford should be on the Long Term Offender designation to his late 40's or 50's. He suggested that his sentence be approached this way: 5 to 6 years in jail to age 37 or 38 plus 10 years as LTO would take him past the age of 45 which is the point where, whether he is on anti-androgen or not, he is more likely to be managed in the community.

⁵ See para. 157 above

[167] In cross-examination, Dr. Gojer was not confident about a diagnosis of pedophilia but reinforced his other diagnoses. He agreed that Mr. Mumford has an anti-social personality disorder but he did not agree with Dr. Ramshaw on borderline traits.

[168] In the course of his cross-examination, he explained some of the differences between his opinion and that of Dr. Ramshaw and observed that he had "more hope" that Mr. Mumford could be treated. Ms. Sweeney pointed out that if a determinate sentence were imposed as Dr. Gojer had suggested, that Mr. Mumford could refuse all treatment and be released at warrant expiry. Dr. Gojer agreed that Mr. Mumford could do nothing and would again be an untreated offender. But he observed that the preparations for his release that begin when he starts serving his sentence give Mr. Mumford hope and increase his motivation. He noted that Mr. Mumford had made positive changes in his behaviour in the 2 years he has been awaiting this hearing in that no institutional charges have been laid.

[169] Ms. Sweeney asked Dr. Gojer about the scientific opinions about the value of anti-androgen medications to reduce risk. He said that it was consistently accepted that those drugs will eliminate thoughts, urges and fantasies and will eliminate or significantly reduce the ability to have an erection and produce testosterone. He said that the problem was in compliance but that if Mr. Mumford were released on such drugs and if he participated in monitoring, then the concerns about compliance would be reduced. Since Mr. Mumford had reported that the almost 6 month treatment had been beneficial except for the breast enlargement side effects and since he now understood that that could be resolved, he was optimistic that Mr. Mumford would carry out his stated intention to take the drugs.

[170] Ms. Sweeney asked Dr. Gojer about the statistics on SSRI's and sex offenders. He said that SSRI's are used in at least a small circle of highly trained individuals and that 50% responded beneficially by treating anxiety and impulsive behaviours while having a positive effect on attention. He said that there was a "good chance" that Mr. Mumford would respond to such drugs while emphasizing that they would not be a cure because brain damage cannot be cured.

[171] Ms. Sweeney asked if it was his opinion that there is a reasonable possibility that Mr. Mumford could be treated or was he just being hopeful. His answer was as follows:

No. I'm basing it on clinical opinion. I'm not making a legal opinion. I mean, we use terminologies like "reasonable", "possibility", which have legal meaning. If I had to translate that into a clinical sense, I would say there are clinical issues that this man has that can certainly be modified, if not cured. I focus on the modification process. There are clinical issues that this man has that can be dealt with to such a degree that whatever risk he poses can be reduced to a low level. There are clinical factors like age that would continue to decrease his risk as he gets older. His risk will keep reducing, unlike the static risk assessment instruments. Clinically his risk will keep decreasing. So the additional component is the legal component, how that is combined and what kind of sentence of incarceration if he were to be released which would then take age into

account also. So sometimes it's difficult to translate clinical concepts into legal concepts.

14. Evidence of Witnesses from the Circle of Support and Accountability:

[172] EH is a Project Manager with the Circles of Support and Accountability of the Mennonite Central Committee of Ontario. The MCC began its work about 14 years ago. An offender was being released at warrant expiry and someone called a Pastor in Hamilton to alert the community that he would be arriving. The inquiry was whether there was a Mennonite farm where he might live and work. There were no Mennonite farms in the Hamilton area. Other areas were not possible because of the location of his victims. A small group was formed to help the offender "to walk with him and help him make choices".

[173] From that has grown an organization that works with offenders. The rationale for the project is that there is less risk to the community if the person is supported. "Wallung with them" is supporting them, holding them accountable for legal obligations, ensuring people are taken care of around times when at greatest risk like birthdays and Christmas, celebrating milestones and creating positive track records. As the offender is reintegrated into the community, the role of the circle diminishes. She referred to a study done by CSC that indicated that people re-offend at a much reduced rate than they are involved in the circle or are otherwise connected with the community. The MCC does not do surveillance nor does it perform custodial functions.

[174] EH said that it is becoming more common for them to see offenders released at warrant expiry where Correctional Service Canada has no accountability. She observed that release on warrant expiry was dangerous because the offender is released into the community after lengthy period of incarceration with no systems in place. Increasingly s. 810 orders are sought by the police in the community where the offender lives. The John Howard Society and the MCC do what they can to fill the void. Their objective is to build a surrogate community, predominantly from the faith community, and literally and figuratively walk with the offender through the many challenges they face including housing, employment and health care.

[175] In the usual case, the MCC gets a phone call from the institutional parole officer or chaplain about 6 months before the release date. The offender is called the core member. The MCC identifies people in the community who will walk with the core member, be engaged with him and provide encouragement. Someone goes to the institution several times to meet the offender and the psychologist and to get permission to see the institutional file. If that permission is refused, the relationship ends. Typically the MCC needs to have access to the offender's records in order to have an understanding of what is needed.

[176] If the MCC agrees, then one person is identified and meets the core member on release or at court and is included in the s. 810 order as a contact person. The Reason For Harm Report prepared by the police to obtain the s. 810 is made available to the MCC. Sometimes the core member is accompanied to the police station for regular reporting. Assistance is also

provided in obtaining accommodation (which is very challenging given the limited financial resources of the core member), finding and maintaining employment, developing a social life, keeping occupied so as to have fewer temptations to turn to drugs and alcohol. Some core members need assistance on banking issues, having never had an account or used a bank machine.

[177] EH was also involved with Long Term Offenders. She said that LTO's have a parole officer and often have access to CSC psychologists. Often there is a residence requirement and there is some housing through the CSC and through the Salvation Army Canada. Both provide safe affordable housing with structure. CSC operates a training and employment service but there is no guarantee a job will be found.

[178] EH said that CAMH has a group sex offender treatment program for offenders in the community but that there was a long waiting list and typically offenders released at warrant expiry are not required by their s. 810 orders to participate. Nor are CSC psychologists available for those on s. 810 orders.

[179] Donald Mumford was a core member. The MCC had been working with Donald Mumford for some time. They knew he had a history of abuse with his son. When they learned that Wayne would be released and would live with his father, they were concerned about the effect on Donald of living with one of his victims. They had almost no information about Wayne. EH accompanied Donald when he went to the airport to pick up Wayne.

[180] Those working with Donald soon became aware that it was not a good living situation. Consideration was given to finding **alternatie** accommodation for Wayne. His financial resources were limited to the Ontario Work s basic allocation of \$525.00 per month. Donald and his partner moved into accommodation that was not big enough to include Wayne so he had to find a place. They helped Wayne find a place to live and they encouraged Wayne to find a job and he did. Some weeks before Wayne was arrested, it was decided that they had to form a circle to provide support for him and to connect him with a local psychologist that the MCC worked with. The circle had met with Wayne a few times before he was arrested in June 2005.

[181] MB is an MCC staff person. She is responsible for organizing and developing circles for offenders at warrant expiry and for long term offenders. She usually works with sex offenders. A circle typically includes her and the core member and 5 volunteers. She is routinely in contact with about 75 offenders. She elaborated on the objective of the MCC. She too referred to the research that showed that a person is at much less risk of reoffending if he has supports in the community. The more things a person has to lose, the better. If people are bored and have low self-confidence and time on their hands, problems will occur. They need to be kept occupied. She observed that people on warrant expiry have been in jail a long time and lack basic knowledge such as how to use a cell phone or a bank machine. The circle helps the offender to comply with their s.810 conditions. They members of the circle provide a daily reminder of where the offender can go. They help with decisions around housing and jobs. The members of the circle hold the core member accountable for safe living.

[182] MB was the co-ordinator of Don's circle. Before his release, Wayne had been in contact with Donald. MB knew that Wayne had been involved in sexual offences, one involving a child and one involving an adult, both female.

[183] The members of Donald's circle had misgivings about Wayne living with him. But Donald was enthusiastic and it seemed that Wayne had no alternative except a shelter. Wayne lived with Donald 1 to 2 months before Donald moved. MB became involved in Wayne's housing needs. Wayne lived temporarily with friends until an apartment was located at Lansdowne and Queen. MB was not keen about Wayne living in that area but there was no alternative. The apartment cost about \$400 per month and Wayne had only Ontario Works income of \$520 per month.

[184] Wayne did do volunteer work at the Thrift Store (run by the MCC) and he got involved in Donald's church and did volunteer work there. He was encouraged to show up for coffee. MB said he showed up at virtually everything that they scheduled. He stopped volunteering at Donald's church because he was asked to be involved in Sunday school yet he knew that his s.810 conditions prevented him from being with children. She noted that Wayne brought this issue to her to get her help in dealing with it.

[185] As the support for Wayne became more formalized in his own circle, MB encouraged him to see a counselor and she connected him with a psychologist. Wayne met with the psychologist several times.

[186] Wayne did have a job doing construction in a factory. His employer provided the safety boots and MB helped Wayne buy them. She said he was working very hard. But the employer needed Wayne 6 days a week from 7:30 to 3:30 or 4:00 and that became a problem. Wayne felt that 6 days was too much. MB helped him negotiate a 5 day week but he continued to have trouble getting up and getting to work on time. She said that Wayne lost the job because Wayne had a big argument with his employer in front of lots of other employees and the employer had no choice but to fire him. MB said that Wayne was hurt by losing the job.

[187] Wayne then applied for welfare but the waiting period created further 'stresses because it meant he had to get cheaper accommodation. MB learned that Wayne was drinking because Wayne told the circle. They encouraged him to tell the police that he had violated his s.810 by drinking alcohol and he did. She suspected he was using drugs. She said that one of the reasons she was helping him manage his money was because alcohol and drugs were available in the area where he lived and he asked her to help him avoid them.

[188] Wayne consistently showed up when he was supposed to except the night before he was arrested.

[189] MB said she was extremely disappointed and horrified about his arrest. She visited Wayne and he admitted to the offences with the two women. She said that they both cried. She has continued to keep in contact with him while he has been in the Don Jail.

[190] MB expressed concerns about how the situation with Wayne had unfolded. As indicated above, before accepting a core member, the MCC insists on having full disclosure and co-operation. Because Donald was a core member by default, the MCC ended up doing what it could for Wayne, but without the full disclosure. MB observed that had she had the full history on Wayne, she would have approached counseling and employment differently. She knew that counseling was important but she thought that he needed to have a job so that he could afford accommodation in an area with less risks. Having read parts of his institutional records in preparation for her testimony, she said in hindsight she would have made counseling the priority over employment. She would not have supported him living in an area with addictions and high prostitution. Since Wayne was arrested in 2005, the MCC has become more informed about FASD and now understands that ODSP is an option that would provide increased funds for safer accommodation.

[191] In addition, MB reported that the MCC has had discussions with the police about circumstances such as these to ensure that whatever information is available to the police is provided to the MCC.

[192] MB said that if Wayne were in the community as a long term offender, he would be welcome as a core member. LTO's have access to parole officers who have access to group counseling. His release into the community would be gradual so there would be time for integration. Instead of "playing catch up" as they did with Wayne, they would have an opportunity to plan ahead. The more time they have, the more comprehensive the plan.

[193] In cross-examination, Ms. Sweeney pointed out how much MB didn't know about what Wayne was doing in the weeks leading up to his arrest, including the frequency and quantity of alcohol, his use of cocaine and violence with the June 13th victim. But as, MB said, the circle was just beginning to form around Wayne. I accept that had the MCC been afforded the opportunity to do the job in accordance with their usual protocol and had Wayne not lost the job at that critical time, his risk of reoffending would have been lower.

[194] EH and MB and the MCC perform a very valuable function and did the best they could under unusual circumstances. I accept their evidence about Wayne Mumford and their willingness to continue to be engaged with him should he return to the community as a long term offender.

15. Evidence of Wayne Mumford

[195] What distinguishes this case from many others is that Mr. Mumford testified. I had the opportunity to observe him in court for the 16 days of the hearing, including the 1.5 days of his testimony, together with many earlier scheduling events.

[196] His current height and weight were not given to me. He described himself as small and weighing 120 lbs when he was originally incarcerated and he was picked on because of his size and charges. I estimate his height at about 5'6" and his weight about 140 to 150 lbs. He is of slight build. Based on the institutional records, he has been victimized. It is in his interest to say what is necessary to prevent being incarcerated indefinitely and potentially for the rest of his life.

[197] The Crown challenged him on the basis of inconsistencies between his examination in chief and his cross-examination and between what he told Dr. Gojer and Dr. Ramshaw. She pointed out his lack of memory and emphasized what appeared to be his lack of remorse.

[198] Over the day and a half of his evidence, many of the manifestations of FAS described by Dr. Stanley were evident. I did not have the impression that Mr. Mumford was lying. I agree with Ms. Rochman that the weaknesses in his evidence are probably due to the normal passage of time, and the consequence of having PFAS.

[199] I conclude that Mr. Mumford was authentic and he was doing his best to tell the truth. While it is in his interest to emphasize his commitment to treatment, I do not accept that he has the intellectual ability to develop that evidence and stick to it for such a prolonged period. He did say he was sorry for what he had done to his victims and that he knew he had ruined their lives. I agree with Ms. Sweeney that it was somewhat superficial remorse particularly since he resisted being reminded of some of the details of the predicate offences. But I accept that on the intellectual level that he is capable of, he knows that what he did was wrong.

[200] The key aspect of his evidence was the extent to which he is treatable. I will deal with that in more detail below. Dr. Ramshaw concluded that Mr. Mumford was motivated to obtain his freedom but he is not motivated to change and lacks any depth of insight into his own difficulties. Dr. Gojer and Dr. Pollock arrived at different conclusions. Having had the benefit of all of the evidence, I am more optimistic about Mr. Mumford's motivation to change and understanding of his circumstances. While recognizing its frailties, I accept his evidence that he will do the best he can to seek out help, to take medications, and to follow the rules.

16. Victim Impact Statements

[201] In addition to the facts read in to the record at the time of the pleas of guilty, victim ST gave a written statement. She sees objects or shadows that aren't present. She is uneasy about going in or around dark places or alleys. She would feel secure if she could carry

protection. She has experienced memory problems. She has to leave lights on rather than sleeping in the dark. She still experiences pain in her legs and arms and neck. Her eyesight has worsened because of the attack.

[202] I accept that the attacks on ST and on MV were very severe. Based on the victim impact statement from ST and the facts read in at the time of Mr. Mumford's plea, these attacks have caused permanent consequences.

17. Positions Taken by Counsel

[203] Ms. Rochman conceded that Mr. Mumford has been convicted of serious personal injury offences, that his conduct in sexual matters has shown a failure to control his sexual impulses and that there is a likelihood of causing injury, pain or other evil to other persons through his failure in the future to control his sexual impulses. Ms. Rochman conceded that the criteria for a dangerous offender have been established.

[204] Ms. Rochman argued that I ought to exercise the discretion I have in s.753(1) and not declare Mr. Mumford to be a dangerous offender. She took the position that the criteria for a long term offender have been established.

[205] Ms. Rochman asserted that the evidence of Dr. Gojer should be accepted and that based on the recent diagnosis of PFAS, and the treatment modalities identified, Mr. Mumford was treatable (although not curable) and there is a reasonable prospect for eventual control in the community. She argued that Mr. Mumford was sufficiently cognitively impaired that he could not be clever and manipulative. Rather the inconsistencies ought to be taken for what they were: manifestations of PFAS. She urged that his commitment to treatment be relied on.

[206] Ms. Rochman argued that the range of a determinate sentence would be 10 years to 12 years. Since Mr. Mumford has served the equivalent of over 4 years, she suggested that a further period of 5 to 6 years together with supervision in the community for 10 years would be consistent with the sentencing principles and would reflect Dr. Gojer's approach to treatment.

[207] Ms. Sweeney argued that I ought not to consider a determinate sentence and long term offender designation. She relied on the evidence of Dr. Ramshaw and her diagnoses. She emphasized that one can't change a sexual preference, one can only learn to modify behaviour. With the personality disorder, Mr. Mumford presents as more difficult to treat. Ms. Sweeney reviewed the statistical measures of risk assessment and the dynamic factors. She observed that while Dr. Pollock's scores were somewhat lower, Dr. Gojer nonetheless came to the same conclusion about the risk of reoffending.

[208] Ms. Sweeney reviewed Mr. Mumford's history of treatment and observed that those with high psychopathy scores do not do well in treatment. She urged that managing Mr. Mumford in the community would be next to impossible without putting others at risk. She

agreed that risk attenuates with age but there was no assurance that that would happen in his mid 40's. Furthermore, it is only that factor that attenuates with age not the other diagnoses.

[209] Ms. Sweeney took issue with Dr. Gojer's opinion that Mr. Mumford was treatable and that there was a reasonable prospect of eventual control in the community. She argued that his opinion was no more than an expression of hope and that that would not suffice.⁶ She pointed out that the Crown does not have to show the absence of a reasonable prospect of eventual control in the community; the Crown need only establish that it is unlikely.⁷ She emphasized that my task is not rehabilitation but the safety of the public.

[210] Ms. Sweeney reviewed Mr. Mumford's evidence and some of the inconsistencies. Mr. Mumford has never held a job for longer than a few weeks. He blamed his father for his behaviours. He said he wanted to write a letter to his victims but he hasn't done that. He said he didn't want to be in group therapy because he would have to read his autobiography. He said he had assaulted the corrections staff on the second occasion to get out of treatment. But he agreed that Dr. Looman had told him he could get out of treatment if he asked. He knew he would get caught for assaulting corrections staff but he did it anyway. He agreed that if somebody pushed his buttons, he acted out. He said that there was too much pressure to go to programs and so he slept in. But he also said that he didn't really understand what went on in programs. He agreed that he had stopped taking medications 6 months before warrant expiry.

[211] Ms. Sweeney had shown Mr. Mumford photos of MV and ST but he said he couldn't recall faces and he didn't remember the details of the assaults. He didn't agree with the events involved in the assaults although they had been part of the record when he pleaded guilty. She argued that his assertions of remorse were not genuine.

[212] It was Ms. Sweeney's view that Mr. Mumford had had access to sex offender treatment programs and other programs during the 9.5 years of his sentence and that all had failed miserably. He hasn't stopped offending because he can't control himself and the only way that the public can be protected is through a dangerous offender designation.

18. Analysis

[213] There is an issue as to whether Mr. Mumford is properly classified as a pedophile. On the point of previous contact with children other than his cousin in 1994, Mr. Mumford gave different information to Dr. Gojer and to Dr. Rarnshaw. It matters primarily when I consider the "burn out theory" because the reduction in risk is more dramatic for adult victims than for child victims. The only known involvement with a child was his cousin in 1994. Ms. Sweeney appropriately conceded that we are left with an unclear diagnosis with respect to pedophilia. For purposes of this sentencing hearing, I am not persuaded that I should consider Mr. Mumford a pedophile.

⁶ *R. v Walford* February 27, 2007 J. Macdonald J. Ont. Sup. Ct.

⁷ *R. v. F.E.D.*(2007) 84 O.R. (3d) page 721 OCA

[214] I turn to the diagnosis of PFAS. In her evidence, Dr. Ramshaw said FAS could not be ruled out but she thought it unlikely, largely because she did not observe the facial features that are usually present. Dr. Stade has diagnosed PFAS. The Crown did not seriously challenge the diagnosis. I accept that Mr. Mumford has PFAS and that it was not diagnosed until 2007 during these proceedings.

[215] Key to my decision are the issues of treatability and the prospects of eventual control in the community. I begin by comparing the experience and education of Dr. Ramshaw and Dr. Gojer. Both were qualified as experts in forensic psychiatry specifically with respect to the assessment of the risk of future dangerousness and the treatment of violent sexual offenders.

[216] Dr. Gojer first qualified as a psychiatrist in London, England in 1987. He qualified in Canada in 1991 and took a Fellowship in Forensic Psychiatry at the University of Ottawa in 1993-1994. He has varied experience in forensic psychiatry in several places in Canada. From 1994 to 1999, he was Senior Forensic Clinician for The Whitby Mental Health Centre and Assistant Professor of Psychiatry at the University of Toronto. He has also worked as a Staff Psychiatrist at the Centre for Addition and Mental Health at the Clarke Site and as Senior Clinician for the Medium Secure Forensic Unit on Queen St. He has done many assessments for both Crown and defence including assessments for dangerous offender hearings, sex offenders, violent offenders, fitness to stand trial and criminal responsibility. Since 1994, he has been a Consultant Psychiatrist either in a clinic or a private practice.

[217] Dr. Ramshaw took her medical degree at McMaster and qualified as a physician in 1995. She completed training and qualified as a forensic psychiatrist in 2000. She has been a Staff Psychiatrist at CAMH since July 2000. She was regularly involved in the Toronto Mental Health Court in 2002 and 2003. She too has done many assessments for dangerous offender hearings and fitness proceedings. She makes regular visits to Nunavut where she has patients and where she is routinely dealing with the Nunavut Review Board. About 2 days each week she works in the Maximum Secure Unit at Oakridge in Penetanguishene. She works with extremely high risk men who are supervised by the Ontario Review Board. She is a lecturer at University of Toronto. She took training under Dr. Phil Klassen on risk assessment.

[218] Both Dr. Ramshaw and Dr. Gojer have been qualified as experts many times in courts. Dr. Gojer has more years of experience but Dr. Ramshaw has somewhat more experience in the federal penitentiary system.

[219] I prefer the evidence of Dr. Gojer largely because he has had the benefit of considering the effect of the diagnosis that Mr. Murnford has PFAS. Because Dr. Ramshaw thought it unlikely that he had FAS, it did not figure in her assessment of treatability and eventual control in the community. In my view, the recent diagnosis of PFAS is relevant to treatability and eventual control and therefore relevant to establishing a fit and just sentence.

[220] I turn now to the criteria in s. 753(1)(b) and s. 753.1.

A. conviction for serious personal injury offences

[221] Mr. Mumford has 4 convictions for very serious personal injury offences. Ms. Rochman conceded that this criterion has been met.

B. his conduct in sexual matters has shown a failure to control his sexual impulses

[222] The circumstances of the offences in 1994 and in 2005 indicate that Mr. Mumford has shown a failure to control his sexual impulses. According to the agreed facts, he did not use violence in the offence involving the 7 year old. But he had the advantage of age and size and consequently violence was not required. On the other hand, he used violence when dealing with his 3 adult victims. He was so insistent on sexual gratification that he did not care what means he had to use to obtain it. Indeed, he admitted in the offence involving his adult cousin that his attack was provoked by a bet, and he stopped at nothing. In June 2005, he committed two serious assaults within 10 days.

[223] In addition, Mr. Mumford was convicted in 1998 and 2002 for assault. Neither was for sexual assault. But both offences reflect his impulsivity and lack of control.

[224] Ms. Rochman conceded that this criterion has been met.

C. there is a likelihood of causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses

[225] Dr. Ramshaw and Dr. Gojer both consider Mr. Mumford is at high risk of reoffending sexually and violently. Ms. Rochman conceded that this criterion has been met.

D. preliminary conclusion as to s. 753(1)(b) dangerous offender

[226] The Crown has provided evidence, as conceded by Ms. Rochman, that all of the criteria in s. 753(1)(b)⁸ have been met.

[227] The court nonetheless has discretion whether to find that Mr. Mumford is a dangerous offender since s. 753(1) provides that the Court "may" so find.

⁸ Section 753(1)(a) is available to the Crown. However, since the predicate offences are sexual in nature, the thrust of the submissions was on s. 753(1)(b).

[228] After examining the criteria under s.753.1, I will return to the exercise of discretion.

E. imprisonment for 2 years or more is the appropriate sentence for the predicate offences

[229] Ms. Rochman took the position that the range of sentence for the predicate offences is 8 to 12 years. Given Mr. Mumford's very serious prior convictions and the viciousness of the attacks on the victims in the predicate offences, the range might be 6 to 8 years on each offence. However, given the approach suggested by Dr. Gojer, which I will adopt with modifications, I need not make a determination of the appropriate range. It is clear that it exceeds the threshold in s. 753.1(1)(a).

F. treatability

[230] The review of the institutional records indicates that Mr. Murnford has had some successes.

[231] It is the case, that he did not achieve success in some areas, most notably he did not complete the Sex Offender Treatment Program. Based on the institutional records, the barriers included: sleeping in, delay in completing his biography, not receptive to group therapy and not engaged; not reading the materials. I am not prepared to conclude that his lack of success means that he is untreatable. All of those barriers are associated with FASD. I infer that it was equally probable that the lack of achievement in these programs was related to the failure to provide programs that responded to his cognitive needs. As Dr. Gojer observed, Mr. Mumford could not be expected to work on written materials at the grade 9 level when he had grade 3 reading skills.

[232] I turn to Mr. Mumford's own evidence on the subject. In his last year of incarceration, Mr. Mumford agreed to take androgen reducing drugs. He stopped because he was developing breasts and in the institution, that created conflict and potential for victimization. Dr. Gojer told him and me that there are side effects of such drugs including osteoarthritis and developing breast enlargements. The osteoarthritis is monitored by bone scans and by calcium intake. Breast enlargement is easily treated by straightforward surgery. Mr. Mumford showed a willingness to take the drugs and he considered it beneficial in reducing his urges. He stopped for understandable reasons. I cannot impose a condition that he will take such medications. However, I accept his evidence that, now that he knows about the surgical intervention, he is willing to try such drugs again in anticipation of a release date from the penitentiary.

[233] Mr. Mumford is highly motivated to assure me that he is committed to treatment. I have accepted his evidence that he is older now, he has learned that he must be treated because

he is a danger to others, and he is committed to treatment. Whether he follows through with that commitment is a function of his abilities and the resources that are made available to him.

[234] Based on the institutional records, Mr. Mumford was never diagnosed with PFAS and consequently his needs were never properly identified nor met. The fact that sex offender treatment was not completed is not a surprise.

[235] PFAS cannot be cured. But it can be managed. The diagnoses by Dr. Ramshaw and Dr. Gojer cannot be cured. But treatment modalities exist and are available in the institution and in the community that respond to Mr. Mumford's needs. Mr. Mumford has never had the opportunity to participate in a medication regime that would respond to his symptoms. He should be given that opportunity.

[236] Dr. Stade also added new information. Based on her experience, Mr. Mumford would be eligible for ODSP. With regular income of (now) approximately \$1000 per month, the financial stresses would likely be avoided. That would allow Mr. Mumford to focus on compliance issues.

[237] Last, we know that the MCC has continued its relationship with Mr. Mumford and that he would be welcome as a core member.

[238] I am satisfied that the evidence is more than "mere speculative hope". I find that Mr. Mumford is treatable.

G. reasonable possibility of eventual control of the risk in the community

[239] *In R. v. Gary Little*, Nicholas J.⁹ declared the respondent a long-term offender and sentenced him to a ten year term of imprisonment to be followed by a ten year supervision order. The Ontario Court of Appeal¹⁰ allowed the appeal and declared that Little was a dangerous offender. The Court of Appeal said the following about risk:

37. I do not agree that the trial judge misinterpreted *Johnson* when she concluded that it confirmed a "harm reduction", rather than a "risk elimination", focus to the existing long-term offender provisions in the *Code*. However, for reasons that I will explain, in the circumstances of this case it is my opinion that the trial judge erred by imposing a determinate sentence in the absence of evidence either that Little could be meaningfully treated within a definite period of time, or that the resources needed to implement the supervision conditions that the trial judge concluded were necessary to eventually control Little's risk in the community were available, so as to bring Little's risk of future reoffending within tolerable limits.

⁹ [2004] O.J.No. 1242

¹⁰ 2007 ONCA 548

38. In *Johnson*, the Supreme Court of Canada held that if an offender's risk can be managed in the community, a sentencing judge cannot properly declare the offender a dangerous offender and sentence him or her to indeterminate detention. Justices Iacobucci and Arbour, writing for the court, stated at paras. 29 and 32:

The principles of sentencing thus dictate that a judge ought to impose an indeterminate sentence only in those instances in which there does not exist less restrictive means *by which to protect the public adequately from the threat of harm, i.e.*, where a definite sentence or long-term offender designation are insufficient. *The essential question to be determined, then, is whether the sentencing sanctions available pursuant to the long-term offender provisions are sufficient to reduce this threat to an acceptable level, despite the fact that the statutory criteria in s. 753(1) have been met. . . .*

If the public threat can be reduced to an acceptable level through either a determinate period of detention or a determinate period of detention followed by a long-term supervision order, a sentencing judge cannot properly declare an offender dangerous and sentence him or her to an indeterminate period of detention. [Emphasis added.]

Also see para. 40 of *Johnson*.

39. I agree with the trial judge that these passages address the concept of risk reduction, rather than risk elimination, as embodied in the long-term offender provisions in the *Code* and in the traditional principles of sentencing. This is consistent with the plain language of s. 753.1(1)(c) of the *Code*, which focuses on the "control" of an offender's risk in the community. The use of the word "control" connotes the containment or management of risk, as opposed to the eradication of risk. Moreover, s. 753.1(1)(c) requires that there be a "reasonable possibility", rather than a certainty, of the eventual control of the risk posed by an offender.

40. In *Johnson*, the Supreme Court also confirmed, at paras. 33-36, that prospective factors concerning an offender must be addressed on a dangerous offender application, including the possibility of eventual control of the offender's risk in the community. Necessarily, therefore, an offender's amenability to treatment and the prospects for the success of treatment in reducing or containing the offender's risk of reoffending are critical factors.

41. In *R. v. McCallum* (2005), 201 C.C.C. (3d) 541, leave to appeal to S.C.C. refused, [2006] S.C.C.A. No. 145, this court stated at para. 47:

Case law from this court and from the British Columbia Court of Appeal under the former dangerous offender legislation and the amended provisions has held that in order to achieve the goal of protection of the

public under the dangerous offender and long-term offender provisions, there must be evidence of treatability that is more than an expression of hope and that indicates that the specific offender can be treated within a definite period of time: *R. v. Poutsoungas* (1989) 48 C.C.C. (3d) 388 (Ont. C.A.); *R. v. Higginbottom* (2001), 156 C.C.C. (3d) 178 (Ont. C.A.). In *R. v. M.(S.)* (2003), 173 C.C.C. (3d) 75 (B.C.C.A.), the court stated that the basic purpose of the dangerous offender provision before the 1997 amendment was the protection of the public and that under the amended legislation, the test for achieving that goal is set out in s. 753.1(1)(c), namely, whether there is a reasonable possibility of control in the community of the risk of the offender re-offending. The court also noted that the French version of the section requires “**une** possibilite reelle”, or a “real possibility”, which may require an even higher degree of certainty in the evidence than the English version, a “reasonable possibility”.

See also *R. v. Grayer* (2007), 215 C.C.C. (3d) 505 at para.70 (Ont. C.A.); *R. v. Allen*, [2007] O.J.No. 2226 at para.28 (C.A.).

42. I do not read Johnson as displacing the principle that, to achieve the goal of protection of the public under the dangerous offender and long-term offender provisions in the Code, evidence of treatability that (i) is more than mere speculative hope, and (ii) indicates that the specific offender in question can be treated within an ascertainable time **frame**, is required. The requisite judicial inquiry on a dangerous offender application, mandated by Johnson, is concerned with whether the sentencing sanctions available under the long-term offender provisions of the Code are “sufficient to reduce [the offender’s] threat to an acceptable level”. [Emphasis added.] The determination of whether an offender’s risk can be reduced to an “acceptable” level requires consideration of all factors, including treatability, that can bring about sufficient risk reduction to ensure protection of the public. This does not require a showing that an offender will be “cured” through treatment or that his or her rehabilitation may be assured. What it does require, however, is proof that the nature and severity of an offender’s identified risk can be sufficiently contained in the community, a non-custodial setting, so as to protect the public.

[240] In Little, the Court of Appeal held that in the absence of any evidence that he could be treated, his violent recidivism was assured. Furthermore, unless other measures, i.e. adequate community supervision, were available to control Little’s risk in the community, it was an error for the trial judge to designate him as a long-term offender.

[241] Little was found to be “an intelligent pathological liar and a psychopath”. He did not give evidence. There was no evidence from him about his motivation and his commitment to treatment. The evidence with respect to his risk was considerably different.

H. *evidence of resources needed to implement supervision conditions in the community*

[242] *In Little*, the trial judge concluded that the longest available period of community supervision should be on the "strictest possible terms" including almost 24 hour monitoring by officials expert in his type of disorders, coupled with Little's residency in a controlled environment for 10 years. The Court of Appeal held that the evidence demonstrated the impossibility of giving effect to the conditions of supervision recommended by the trial judge. The Court of Appeal dealt with 3 of the conditions. Dr. Klassen had suggested and the trial judge had recommended that on his release, Little would reside in a community correctional centre for a protracted period of time. However, s. 135.1(2) of the *Corrections and Conditional Release Act* limits the period to 90 days. The evidence of Parole Board officials at the dangerous offender hearing indicated that the 90 days was renewable but only on a limited basis. Dr. Klassen had emphasized and the trial judge agreed that Mr. Little would have to be "severely consequence" for breach of conditions. The Court of Appeal noted that the evidence was that the Parole Board has no jurisdiction to reincarcerate an offender but the Parole Board is required to persuade the police to lay a breach charge and that in practical terms, it would be unlikely for parole officers to do that for minor transgressions. Last, Dr. Klassen had urged that Little be supervised by probation and parole officers who are experienced with the supervision of psychopaths and who have the resources available to "spot check" little continuously. The Court of Appeal pointed out that long-term offenders are monitored by corrections personnel who are not specialists. The Court of Appeal concluded that the evidence demonstrated that the "strictest possible terms" on which the trial judge's decision was based were not available.

[243] The Court of Appeal held as follows:

56. In determining whether a reasonable possibility of the eventual control of an offender's risk in the community exists, conflict can arise between the inadequacy or unavailability of the resources necessary to implement stringent community supervision, on the one hand, and the need to ensure that an offender is not deprived of liberty – if less restrictive sanctions are appropriate in the circumstances – on the other hand: . . . The following statement by the trial judge at para. 225 of her reasons indicates that she was acutely aware of the tension between these factors:

It is evident to me, from the evidence of [the Crown's witnesses from the CSC and the Parole Board], that the legislator did not foresee this onslaught of applications, which are, for the most part, resulting in offenders being declared long-term offenders. As a result, a question arises as to whether Little should be defaulted into Dangerous Offender status because there does not appear to be suitable resources allocated, as of now, for the management of such offenders through residential structured housing, frequent and random urinalysis, and other things of

that nature which are costly but necessary to effect adequate supervision in the community. [Emphasis added.]

57. The trial judge appears to have resolved this dilemma by proceeding on the assumption that the resources necessary to implement her recommended supervision conditions, although neither committed nor available at the time of the dangerous offender hearing, will be in place when Little is released from custody. In my view, with respect, the trial judge erred in so doing.

58. The test under s. 753.1(1)(c) of the *Code* is whether "there is a reasonable possibility of eventual control of [an offender's] risk in the community". [Emphasis added.] *Johnson* confirms, at para. 29, that, at a dangerous offender hearing, "the essential question to be determined. . . is whether the sentencing sanctions *available* pursuant to the long-term offender provisions *are* sufficient to reduce [the offender's] threat to an acceptable level". [Emphasis added.] These articulations of the relevant risk management inquiry contemplate the present, rather than the future, existence of measures sufficient to control risk.

59. In my view, both s. 753.1(1)(c) of the *Code* and *Johnson* envisage that where the determination that an offender's risk may be safely controlled in the community rests, as it did here, on adequate community supervision, rather than treatment, the availability of the resources necessary to implement such supervision effectively cannot be uncertain. To hold otherwise would be speculative, thereby preventing any reliable assurance that unreasonable risks to public safety can be avoided.

60. In this case, as I have detailed at para. 54 of these reasons, the record before the trial judge demonstrated that several of the key supervision conditions recommended by her are incapable of performance, as a result of the current law or the resourcing conditions applicable to long-term offenders. In these circumstances, in my view, the trial judge's conclusion that there is a reasonable possibility of eventual control of Little's risk in the community, after he attains the age of forty-five, cannot stand. . . .

63. . . . the issue of the impact of limited institutional resources on the criminal justice system has been considered by the courts in a number of contexts, most notably in connection with the constitutional rights enshrined in ss.7 and 11(b) of the *Charter of Rights and Freedoms*. In that context, the Supreme Court of Canada has held that while account must be taken of the difficulties in securing full adequate funding, personnel and facilities for the administration of criminal justice, this consideration cannot be used to denude of meaning the rights protected under the *Charter*. . . Similarly, in my view, resourcing limitations cannot be used to render meaningless the long-term offender regime enacted by Parliament.

[244] The Court of Appeal went on to distinguish *R. v. A.N.* and concluded at para. 70 as follows:

... the overriding purpose of the dangerous and long-term offender regimes is the protection of the public. Thus, 'real world' resourcing limitations cannot be ignored or minimized where to do so would endanger public safety. The court is required on a dangerous offender application to balance the liberty interests of an accused with the risk to public safety that will arise on the release of the accused into the community. That balancing exercise is informed by this fundamental principle: in a contest between an individual offender's interest in invoking the long-term offender provisions of the *Code* and the protection of the public, the latter must prevail. This accords, in my opinion, with the intention of Parliament as expressed in the dangerous and long-term offender provisions of the *Code*, and in the *Corrections and Conditional Release Act*.

[245] Dr. Ramshaw's opinion was that Mr. Mumford met the criteria of a dangerous offender. However, she observed that if the court considered eventual community re-integration, 6 conditions ought to be imposed including sex drive reduction medication; sex offender counseling must be done with extreme caution and with close monitoring; while incarcerated, he may benefit from treatment with an SSRI; he may benefit from intensive anger management particularly one to one; abstinence in perpetuity from drugs and alcohol and attendance in regular treatment for substance abuse along with random urine drug and alcohol screens; cognitive behaviour based counseling aimed at developing a better understanding of his personality and interpersonal relationships; close monitoring both in the penitentiary and in the community recognizing that his self-report is unreliable; reside at one address and pursue full time employment to structure his life; a weapons prohibition. Last, any potential supervisors or counselors should be made aware of his history because his combination of "information gating", his at times socially pleasant stance and understated charm has had power in the past and could be a challenge in the future.

[246] I assume that Dr. Ramshaw would not have identified those conditions unless all of the resources to fulfill them were available.

[247] The conditions suggested by Ms. Rochman are found at the conclusion of these reasons. None of the conditions suggested by Dr. Ramshaw or by Ms. Rochman are in the same category as those imposed by the trial judge in *Little*.

19. Exercise of Discretion under s. 753(1)(b) and s. 753.1(1)

[248] In addition to the forgoing, there are three factors that are relevant to the discretion I have to not declare Mr. Mumford a dangerous offender: his behaviour during the 6 months in the community; the resources that are available to those declared to be dangerous offenders; and his aboriginal status.

A. *behaviour between November 2004 and June 2005*

[249] One could say that it was less than 6 months between Mr. Mumford's release and his violent re-offending. Dr. Ramshaw noted that within that 6 months, he lived in at least 3 places, he quit his job, he turned to cocaine and alcohol and he violently and sexually offended - all while subject to a s. 810.2 order. Indeed, Mr. Mumford told Dr. Gojer that as early as January he was **carrying** a cord with him and contemplating opportunities of raping a prostitute, suggesting that he was acting impulsively within a few weeks of his release. As Dr. Gojer said, it was highly predictable that he would offend.

[250] Looked at **from** the opposite perspective, one could say that he functioned in the community for almost 6 months before the violent behaviour began. He was, for reasons discussed above, an untreated sex offender who had been incarcerated for almost 10 years. Because he had no other options, his first residence was with the biological father who had sexually abused him as a child. Not an auspicious beginning. With as much guidance as the circumstances gave to the MCC, he was generally compliant with his s.810 conditions; he self-reported his alcohol use but not his cocaine use; he obtained a job but couldn't keep it which is typical behaviour according to Dr. Stanley; he turned up at every event arranged by MB except the rendezvous the night before he was arrested; he participated in volunteer work; he turned to MB when he realized his volunteer work at the church might violate his s. 810 conditions; he asked for and received guidance on financial matters. One could marvel that he lasted as long as he did in the community. Furthermore, while he may have been carrying around a cord and contemplating raping a prostitute since January, (which might not be true given his reliability issues), the first of two attacks did not happen until June 13th, a period of more than 4 months during which he did have sufficient control that he did not act on those thoughts. And one could conjecture how much better he might have done had the MCC been afforded the opportunity to establish a circle of support and accountability for him as soon as he was released.

B. *Resources available to offenders declared to be dangerous*

[251] The Criminal Code provides in s. 761 that the National Parole Board shall, **after 7** years and at 2 year intervals thereafter, review the "condition, **history** and circumstances" of that person to determine if parole should be granted. A trial judge might take comfort that notwithstanding the very serious sentence, there might be some light at the end of the tunnel for the offender.

[252] Correctional Service Canada does not have unlimited resources. However, according to Dr. Gojer, in order to manage those resources, the priority is given to offenders with determinate sentences. Virtually no resources are allocated to those with indeterminate sentences. As Dr. Gojer said, if the court makes a declaration that an offender is dangerous, it amounts to locking up the offender and throwing away the key. He noted that only 1% of those declared to be dangerous offenders ever get out. On the other hand, a determinate sentence followed by a long term offender order will put pressure on CSC to develop and implement a

plan. It was his view that LTO orders sensitize parole and medical authorities to respond to the needs of the offender. This evidence was not challenged in cross-examination.

[253] That means that an indeterminate sentence is in reality a life sentence because, unless the offender achieves some miraculous self-realized transformation, the Parole Board will never grant parole.

C. Mr. Mumford's aboriginal status

[254] Section 718.2(e) of the Code requires the court to impose a sentence that takes into consideration "all available sanctions other than imprisonment that are reasonable in the circumstances . . . with particular attention to the circumstances of aboriginal offenders". Ms. Sweeney took the position that Mr. Mumford's aboriginal status was irrelevant and s. 718.2 did not apply.

[255] Ms. Rochman did not argue that a sentence other than imprisonment ought to be imposed or that a lesser period of incarceration was appropriate. But she did argue that the court must take Mr. Mumford's aboriginal status into consideration. In addition to *R. v Gladue*¹¹, Ms. Rochman relied on *R. v Kakekagamick*¹².

[256] In *Kakekagamick*, the accused was sentenced to five years' imprisonment on the conviction for aggravated assault. The Court of Appeal observed that neither counsel nor the trial judge had given adequate consideration to the legal requirement of s. 718.2(e). The Court re-stated the principles articulated in *Gladue*, namely that s. 718.2(e) imposes a duty on the sentencing judge to approach the sentencing of Aboriginal offenders differently. The amendment to the Code was enacted as a remedial provision, in recognition of the fact that Aboriginal people are seriously over-represented in Canada's prison population and in recognition of the reasons for why this over-representation occurs. It requires a different methodology for assessing a fit sentence for an Aboriginal offender; it does not necessarily mandate a different result. The Court must nonetheless impose a sentence that is fit for the offence and the offender. The Court reiterated that the *Gladue* analysis must be performed in all cases involving an Aboriginal offender, regardless of the seriousness of the offence. The Court also pointed out that the more violent and serious the offence, the more likely it is as a practical reality that the terms of imprisonment for aboriginals and non-aboriginals will be close to each other or the same.

[257] The Court of Appeal noted that, in order to help the court arrive at a fit and proper sentence, there is a positive duty on counsel to assist the sentencing judge in gathering information as to the Aboriginal offender's circumstances. While s. 718.2(e) does not specifically apply, the court is mandated to consider the offender's aboriginal status in all sentencing proceedings.

¹¹ [1999] 1 S.C.R.688

¹² (2006) 211 C.C.C. (3d) 289

[258] Based on the evidence and the institutional records, I have considerable information about Mr. Mumford's circumstances. His mother was Aboriginal but he was brought up by his aunt and uncle because of her alcoholism. During incarceration, he asked for and was given access to Elders and to programs for Aboriginals, to the extent that they were available. He identifies as an Aboriginal.

[259] Mr. Mumford was incarcerated between 1995 and November 2004. I have no evidence as to the extent to which Correctional Service Canada was, during that time period, alert to the incidence of FASD in general and the incidence of FASD specifically in the aboriginal population. It is now known that he has the condition.

D. Conclusion

[260] There is evidence that Mr. Mumford can be meaningfully treated within a definite period of time. There is evidence that the resources needed to supervise him in the community are available. There is evidence that the sentencing sanctions available pursuant to the long term offender provisions are sufficient to reduce the threat he poses to an acceptable level. I consider it to be a fit and just sentence that responds to the priority of public safety if I impose a determinate sentence followed by the maximum period of supervision in the community provided by s. 753.1.

20. Pre-Trial Custody

[261] The predicate offences occurred on June 13 and June 22, 2005. Mr. Mumford was arrested on June 24, 2005. As indicated above, he pleaded guilty on April 10, 2006. As of the date of the sentencing decision on November 6, 2007, he will have been in custody in the Don Jail for over 28 months.

[262] Sadly, during his incarceration, Donald Mumford was arrested and charged with sexual offences involving children. When Donald Mumford arrived at the Don Jail, Wayne Mumford was moved from protective custody to super protective custody. Because of the sexual offences involving children with which Donald Mumford was charged, there was a concern that Wayne Mumford's life was in danger. He said he spent 8 months in super protective custody where he was locked in his cell 23 hours a day.

[263] Mr. Mumford has taken advantage of the Elders who are sometimes available. But he has not had access to any programs or education.

[264] There is no request to consider a credit of other than 2:1.

21. Summary of these reasons for decision for Mr. Mumford

[265] It is agreed that Mr. Mumford has cognitive impairments due to brain injury. He will not comprehend the analysis that is contained in the preceding pages. It is my responsibility to communicate the disposition in language that he might understand. What follows is a brief summary for him. If there are nuances of difference between what follows and what has preceded, it is the foregoing legal analysis that prevails. Mr. Mumford's reading skills are limited. If he wishes, he ought to be given the opportunity over an extended period of time to review these reasons with someone who will assist him in understanding them. But he should, in any event, be given a copy of the reasons from this paragraph to the end to keep with him for future reference.

[266] Mr. Mumford, we have spent many days in **this** courtroom. It began almost a year and a half ago. In April 2006, you pleaded guilty to two very serious offences. You admitted that you had violently sexually offended against two women. You had been released from the penitentiary only a few months before you committed those very serious offences. Because of your history, the Assistant Crown Attorney asked that I declare that you are a dangerous offender.

[267] If I declared you a dangerous offender, you would be sent to the penitentiary for a long time. Indeed, it is possible that you would never get out of jail.

[268] In the last year and a half, I have heard a great deal about you. Your lawyer, Ms. Rochman, has worked very hard to bring evidence to this court so that she could urge me not to find that you are a dangerous offender.

[269] This is some of what I know about you. Your mother drank alcohol, probably while she was pregnant with you. Your mother could not look after you. Your aunt and uncle made a home for you. Your birth father abused you when you were young. You were involved with some gang members. You used alcohol and drugs at a young age. You are the father of a daughter. You have little education.

[270] In 1994, you committed two very serious offences against your young cousin and your adult cousin. You spent almost 10 years in prison.

[271] When you got out of jail in November 2004, you had not completed sex offender treatment programs. You began to live with your birth father because you had no other options. Because your father was involved with the Circle of Support and Accountability, EH and MB did what they could to help you out. But you lost your job. You used drugs and alcohol. And you violently sexually assaulted 2 women.

[272] Dr. Ramshaw was the psychiatrist that Ms. Sweeney asked you to see. You heard Dr. Ramshaw say that there is a very high risk that you will offend again and that you will attack someone violently and sexually. Dr. Gojer was the psychiatrist that Ms. Rochman sent you to. You heard Dr. Gojer say that there is a very high risk that you will offend again and that you will attack someone violently and sexually.

[273] The expert psychiatrists agree that you are a very high risk. I'm sure that you understand that my job is to do what I can to protect the public against the very high risk that you present.

[274] Dr. Ramshaw told me that she did not think that you could be treated. She said that it would be unsafe to release you into the community.

[275] Dr. Gojer told me that he thinks that you can be treated. We now know that you have Fetal Alcohol Syndrome. That was probably caused because your mother drank alcohol when she was pregnant.

[276] You cannot be cured. The evidence I have indicates that you may be managed. Because your behaviour may be managed, I am not going to declare that you are a dangerous offender. I am giving you a sentence in the penitentiary followed by supervision in the community.

[277] It is important that you gave evidence in this case. For a day and a half, you talked about your history. You told me that you want treatment. You have said that in the past and you have not followed through. But now we know that you have Fetal Alcohol Syndrome. Now the prison authorities can create programs that you can understand. I am counting on you to participate in the programs that are offered to you. In particular, I am counting on you taking the anti-androgen drugs and if necessary having surgery should you again have breast enlargement as a result of the drugs.

[278] You will be 32 years old in January. You heard Dr. Gojer talk about what happens with men's sexual urges in their mid to late 40's. To increase the prospects that you will not reoffend, Dr. Gojer said you should be under controls for many years.

[279] I am sentencing you in a way that will establish those controls. Here is the sentence.

[280] You have been in the Don Jail since June 2005. That is approximately 2 years and 4 months. You probably know that when you are in jail before a sentence is passed, we count it as double. So you have already served the equivalent of 4 years and 8 months.

[281] I sentence you to jail for a **further** period of 10 years.

[282] When you are released, you will be subject to supervision in the community for 10 years. You will be classified as a Long Term Offender. You will have to comply with conditions that the Parole Board decides. If you breach those conditions, there will be very serious consequences. I cannot now say what those conditions are. Ms. Rochman has suggested conditions. I agree with her suggestions and I will recommend those conditions to the Parole Board.

[283] You have a lot of hard work ahead of you.

22. **Order**

[284] I sentence Mr. Mumford to 14 years 8 months less pre-trial custody of 4 years 8 months to be followed by supervision in the community for 10 years.

[285] I urge the institutions to start the assessment process (founded on the diagnosis of PFAS) regardless of any appeal that might be taken.

[286] I will direct that the reports prepared by Dr. Rarnshaw, Dr. Pollock, Dr. Gojer and Dr. Stade be forwarded to CSC for their review.

[287] Mr. Mumford is prohibited from possessing weapons for life.

[288] I encourage the National Parole Board to consider imposing these conditions on Mr. Mumford:

- (b) not to have contact directly or indirectly with MV or ST;
- (c) reside for a suitable period of time when released into the community in a supervised residential facility and abide by the rules of the facility until such time as the Supervisor or designate determines that you are able to manage in a less supervised residential facility;
- (d) reside at all times at an address approved by your Supervisor or designate and not to move to a new residence until the address is approved by your Supervisor or designate;
- (e) attend at St. Michael's Hospital Fetal Alcohol spectrum Disorder Clinic or a similar type specialized Clinic and follow any recommendations for medication, treatment or counseling as determined by the personnel of the Clinic;
- (f) take by injection any sex drive reduction medication or antiandrogen medication as prescribed by a qualified psychiatrist and only to stop the medication if a qualified psychiatrist determines that the side effects are intolerable;
- (g) attend at a substance abuse and/or alcohol abuse programme as recommended by your Parole Officer;
- (h) attend at a treatment or counseling programme for sex offenders that is willing to reasonably accommodate low functioning individuals and any other counseling programme willing to accommodate low functioning individuals deemed appropriate by your Supervisor;

- (i) attend at and maintain contact with a programme within the community for Native persons;
- (j) with respect to any counseling, treatment or support programme you are attending pursuant to this Order and with respect to any medications you are receiving pursuant to this Order, to sign any documents requested by your Supervisor or designate that will allow for monitoring by your Supervisor or designate of your compliance with this Order;
- (k) abstain absolutely from the consumption of alcohol and any substance defined in the Controlled Drugs and Substance Act unless prescribed by a physician or approved by your Supervisor or designate;
- (l) abstain absolutely from the consumption and possession of any form of testosterone, or androgen drugs;
- (m) be subject to random drug or chemical testing either by serological or **urinalytical** analysis in order to confirm that
 - (i) you are not taking any drugs or alcohol not prescribed or permitted pursuant to this order;
 - (ii) you are taking all drugs that are prescribed pursuant to this Order, and
 - (iii) your hormonal and testosterone levels are at levels that a qualified **psychiatrist** deems appropriate;
- (n) take all reasonable measures to obtain lawful part-time employment or to attend educational or training development courses and to advise your Parole Officer or designate of your place of employment, education or training; and
- (o) not be alone with anyone under the age of 18 unless in the company of a person approved by your Supervisor or designate.

A handwritten signature in black ink, appearing to read "Kitelev J.", written over a horizontal line.

Kitelev J.

COURT FILE NO.: 059106

DATE: 20071106

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N :

Her Majesty the Queen

- and -

Wayne Edward Mumford

REASONS FOR JUDGMENT

Kiteley J.

Released: November 6, 2007
