IN THE SUPREME COURT OF THE NORTHWEST TERRITORIES

IN THE MATTER OF:

HER MAJESTY THE QUEEN

- v -

ROBERT WALTER BONNETROUGE

Transcript of the Reasons for Sentence (Dangerous Offender application) delivered by The Honourable Justice L. A. Charbonneau, sitting in Yellowknife, in the Northwest Territories, on the 18th day of November, A.D. 2013.

APPEARANCES:

Mr. M. Lecorre:	Counsel for the Crown
Mr. J. Bran:	Counsel for the Accused

(Charges under s. 271 x2 and 279(2) x2 of the Criminal Code of Canada)

BY COURT ORDER, INFORMATION THAT MAY IDENTIFY THE COMPLAINANTS REFERRED TO IN THE PROCEEDINGS AND IN THE EXHIBITS FILED MAY NOT BE PUBLISHED, BROADCAST OR TRANSMITTED IN ANY MANNER, PURSUANT TO SECTION 486.4 OF THE CRIMINAL CODE

THE COURT: I want to remind everyone that there is a publication ban in effect with respect to these proceedings which prohibits the publication and broadcast of any information that could identify not only the two complainants in the matters that led to this hearing but also with respect to any other victims of any other offences that were referred to in the evidence. There is extensive documentary evidence that has been filed in this case and marked as an exhibit. The publication or broadcast of any information that could identify any of those earlier victims is also prohibited.

I was not able to find specific notes about whether the issue of ancillary orders was addressed during submissions. By this I mean DNA, firearms prohibition, and SOIRA order. Could be just my notes are incomplete on that. They all seem to be mandatory orders with these type of offences. I did not see anything in Part XXIV that would remove these orders from being mandatory. So my understanding of things is that they should be made, but I just could not find specific notes. There were a lot of things that were addressed in submissions and everyone was focused on, obviously, the larger part of the decision. But do you have any recollection of

those issues being addressed, Mr. Bran?

MR. BRAN: I don't recall specifically addressing those issues. My understanding is the same as Your Honour's comments. And I'm not sure that they were in any of the written submissions either.

THE COURT: No, I thought it was -- I thought somehow I neglected to make a note of it, but I looked and couldn't find any reference to it. So, in fact, what you are saying reassures me. I cannot think of why the orders would not be made in a case like this. Mr. Lecorre, you were not at the hearing, but you are in agreement, essentially?

MR. LECORRE: Yes, I am. And just for the record, Ms. Boucher sends her apologies. She's ill today and has asked me to attend to receive the decision. If the Crown for some reason did not ask that you make the ancillary orders, the Crown asks that Your Honour do so now.

THE COURT: I will first deal with ancillary orders. Given the types of offences for which Mr. Bonnetrouge was convicted of, it is appropriate that there be a firearm prohibition order that would commence today and expire ten years from his release. Any firearms in his possession will be surrendered forthwith.

Knowing how long he has been on remand, I know that is not an issue. There will also be a DNA order as the offences of sexual assault are primary designated offences. Finally, there will be an order that he comply with the requirements of the Sexual Offender Identification Registration Act for a period of 20 years.

I want to reiterate my thanks to counsel for the manner in which this hearing was conducted, for the quality of materials and quality of submissions that were presented, all of which were of great assistance to the Court in reaching what was a difficult decision.

This is an application by the Crown to have Robert Bonnetrouge declared a dangerous offender and sentenced to an indeterminate term of imprisonment.

The application was made after Mr. Bonnetrouge was found guilty by a jury on two counts of sexual assault and two counts of unlawful confinement.

The hearing proceeded in April 2013. The predicate offences date back to 2009. There has been considerable delay in bringing this matter to its conclusion, and there were many reasons for this. I want to refer to those reasons briefly, for the record.

First, there were significant delays in the trial process. The first attempt to hold a jury trial was in May 2010 in Fort Providence and it resulted in a mistrial because of difficulties in empaneling the jury. A second attempt was made to hold a trial, this time in Yellowknife, in January of 2011. The trial proceeded at that time, but after several hours of deliberations, the jury reported that they were at an impasse and the presiding judge declared a mistrial. The trial was set for the third time to proceed in September 2011 in Yellowknife. It was at the conclusion of that trial that Mr. Bonnetrouge was found guilty by the jury.

The process of the Crown bringing the dangerous offender application involved delays as well. In November 2011, the Crown applied for an assessment order, pursuant to Section 752.1 of the Criminal Code, and the order was granted. The assessment period was extended twice to permit its completion. The report was finally received in June 2012. By that point, defence indicated that it was attempting to make arrangements to have a second assessment completed and, understandably, that took some time to arrange. That second assessment was eventually completed and, in the meantime, a

hearing date was set aside for April of 2013. The hearing proceeded at that time and there was a further adjournment to allow for the preparation of transcripts of the evidence and for counsel to prepare written submissions. Final oral submissions were made to the Court on August 28th, 2013.

In finding Mr. Bonnetrouge guilty of the four charges that he was facing at trial, the jury necessarily had to have accepted the testimony of the two complainants. This is not a verdict that left any ambiguity as to what facts were found such that as I, as the trial judge, would be required to make findings of fact.

The two complainants, M.E. and A.L., were 16 years old at the time of the events, July 4th, 2009. That night they went to Mr. Bonnetrouge's house with another male person. They all consumed alcohol, and the other man passed out at some point. They testified that when they decided to leave, Mr. Bonnetrouge would not let them leave. He dragged them to one of the rooms in the house and closed the door. He attempted to remove M.E.'s pants but was not able to because she was wearing a belt. He was, however, able to take A.L.'s pants down and had forcible sexual intercourse with her.

The evidence at trial was that both girls tried to resist him. M.E. said he struck them while in the room and that A.L. had bruises after this. M.E. testified that as Mr. Bonnetrouge was raping A.L., he was also preventing M.E. from leaving by holding on to her sweater.

That is a summary of the facts as they came out in the evidence of the complainants at the trial.

A considerable amount of evidence was adduced at the April hearing. A lot of documentary evidence was filed by consent. This evidence included documents setting out the details of the criminal offences that Mr. Bonnetrouge has been convicted of prior to the 2009 offences as well as the sentences that he received for those earlier convictions. There were also documents retracing his correctional history, setting out where he has been incarcerated over the years; programs he has taken during his various jail terms; how he performed; his behaviour and attitudes towards programming during those sentences; assessments that he has undergone. The documents also include general information about Mr. Bonnetrouge's conduct while he was in custody and some of the attitudes he displayed with

respect to the victims of his past offences.

Witnesses were also called at the hearing, including the two experts who assessed Mr. Bonnetrouge. Dr. Scott Woodside, a psychiatrist, was called by the Crown. Dr. Mark Nesca, a psychologist, was called by Defence. Generally speaking, their evidence pertained to Mr. Bonnetrouge's diagnoses, the assessment of his risk, their opinions about whether that risk could be managed in the future and, if so, how.

The Crown also called Cindy Sparvier and Bruce Anderson. These witnesses testified about intake and classification procedures for federal inmates, the programs that are available in the federal correctional system and, once offenders are on parole, the level of supervision that is available in the community, as well as some of the processes that are in place for the supervision of offenders who are on long-term supervision orders.

This application is governed by Part XXIV of the Criminal Code. There are certain procedural requirements that must be complied with in order for an application like this one to be entertained by the Court. In this case, all these requirements have been met.

There are really two broad issues that a

court has to examine in an application like this one. The first is whether the offender meets the criteria to be declared a dangerous offender as defined in Section 753(1)(a) or paragraph (b) of the Criminal Code. The second issue only arises if the Court is satisfied that the offender does meet the criteria and should be declared a dangerous offender. If that is the case, the Court has to determine what sentence should be imposed, and paragraph 753(4) gives the Court three options. The first is a sentence of detention in the penitentiary for an indeterminate period of time; the second is a sentence that must be at least two years and is followed by a period of long-term supervision order, which can be for a maximum of ten years; the third is to sentence the offender under the usual sentencing regime.

Paragraph 753(4.1) states that the Court shall impose an indeterminate sentence unless it is satisfied that there is a reasonable expectation that one of the other two sentencing options will adequately protect the public.

A number of cases were filed by counsel. Those cases address various elements of the statutory framework and they were very helpful to me. I will not be referring to all of them in

these reasons, but I have reviewed them all.

With respect to the first issue: Whether the criteria for a dangerous offender designation have been met, based on the written and oral submissions presented at the conclusion of the hearing, I understand the issue between these parties is not whether Mr. Bonnetrouge meets the criteria to be declared a dangerous offender. Rather, the issue is what sentence should be imposed on him. Still, for the record, I do want to outline why the evidence satisfies me beyond a reasonable doubt that Mr. Bonnetrouge meets the criteria to be designated a dangerous offender.

The Criminal Code outlines various sets of criteria that can lead to such a designation. In my view, the evidence establishes that Mr. Bonnetrouge meets the criteria for a dangerous offender designation under a few different headings. More specifically, he meets the criteria under Section 753(1)(a)(i) and 753(1)(a)(ii) as well as 753(1)(b).

Section 753 says that "the court shall find the offender to be a dangerous offender if it is satisfied", under the first heading:

> that the offence for which the offender has been convicted is a serious personal injury offence ... and the offender constitutes a threat to life, safety or physical or mental well-being of other

persons on the basis of evidence establishing a pattern of repetitive behaviour by the offender, of which the offence for which he or she has been convicted forms a part, showing a failure to restrain his or her behaviour and a likelihood of causing death or injury to other persons, or inflicting severe psychological damage on the persons, through failure in the future to restrain his or her behaviour.

The designation can also be justified if the evidence establishes:

> a pattern of persistent aggressive behaviour by the offender, of which the offence for which he or she has been convicted forms a part, showing a substantial degree of indifference on the part of the offender respecting the reasonably foreseeable consequences to other persons of his or her behaviour.

And the final set of criteria that I find is met here is that, in my view, the Crown has established that:

> the offence for which the offender has been convicted is a serious personal injury offence described in the Criminal Code and the offender by his or her conduct in any sexual matter, including that involved in the commission of the offence for which he or she has been convicted has shown a failure to control his or her sexual impulses and a likelihood of causing injury, pain or other evil to other persons through failure in the future to control his or her sexual impulses.

One of the factors in determining whether a person meets these criteria of course can be the

offender's history. The establishment of a pattern is specifically required under the two first headings that I have quoted. Pattern is not specifically mentioned in the other paragraph, but the provision does refer to conduct "in any sexual matter" and, in particular, to "the offender's failure to control his sexual impulses". So consideration of the offender's conduct in the past, in particular with respect to sexual offences, is relevant.

Mr. Bonnetrouge's criminal history is significant and compelling. Even considering the sexual offences on his record alone, that is a significant record.

As a youth, Mr. Bonnetrouge was convicted of five separate sexual assault offences and each time was sentenced to custody under the terms of the Young Offenders Act, which was the statute in force at the time to deal with young persons. In 1993 he received a term of one-year open custody for having tried to have forced sexual intercourse with a four-year-old. Mr. Bonnetrouge was 13 at the time.

In 1994 he was sentenced to 14 months closed custody for two charges of sexual interference. These offences were committed against children. In one case a nine-year-old woke up to

Mr. Bonnetrouge undoing her belt and digging into her pants, and he was seen with his hand under the pants of a three-year-old. Mr. Bonnetrouge was 16 at the time.

In March 1996, Mr. Bonnetrouge was sentenced to two counts of sexual assault and one count of uttering threats. These offences occurred when Mr. Bonnetrouge was 17 years old and incarcerated in two separate youth custodial facilities. He sexually assaulted another 14-year-old male inmate twice, once in each facility. After the first time, Mr. Bonnetrouge threatened to kill his victim if he reported this incident. The victim did not report anything until after the second incident. This was Mr. Bonnetrouge's last time being sentenced as a youth and he received a term of two and a half years' closed custody.

In February 2010, Mr. Bonnetrouge was sentenced to three years' imprisonment for another sexual assault committed while he was in custody. On that occasion, he had been placed in a cell with another male inmate. That prisoner was sleeping and Mr. Bonnetrouge had sexual intercourse with him.

Some of Mr. Bonnetrouge's other convictions, while not for sexual assaults, are also of concern because of their underlying facts. For

example, the mischief that he was sentenced for in July 2006 was for being found asleep in a stranger's house, sleeping in the bedroom of the son of the household. The break and enter with intent he was sentenced for in September 2009 was for being found in the bathroom of a stranger's hotel room. The tenant had a small child with her. When they found him, they ran out and he followed them. There was a mischief and assault that he was sentenced for also in September 2009. These offences occurred a few months before the predicate offence and arose when he was found outside the window of an 11-year-old child. Mr. Bonnetrouge assaulted the person who confronted him, and when that person ran into the house, Mr. Bonnetrouge kicked the door, but the residents managed to keep the door shut until he left.

This series of events, in itself, goes a long way in illustrating the risk Mr. Bonnetrouge poses for the safety of others. But in addition to that, Dr. Woodside and Dr. Nesca were essentially in agreement that Mr. Bonnetrouge presents a high risk to reoffend at this time.

I will get back to their evidence in more detail later in these Reasons, but, for now, I will say only that while they disagreed on some

things, they did not disagree on this fundamental question that is very important as far as deciding whether Mr. Bonnetrouge should be designated as a dangerous offender: they both agree that he presents a high risk of reoffending. They both agree that absent significant intervention, Mr. Bonnetrouge is likely to offend again.

Finally, I also have the benefit of the correctional records. These records suggest that with respect to many of his offences, Mr. Bonnetrouge appeared to show little empathy towards his victims and little insight into his behaviour. There are some indications that, at times, he did express some remorse. But, there are several other indications of him not showing empathy and not taking responsibility.

On the whole of the evidence, I am satisfied beyond a reasonable doubt that Mr. Bonnetrouge meets the criteria to be declared a dangerous offender under the provisions that I have referred to. I want to make it clear that I have reached this conclusion without resorting to the rebuttable presumption that is set out at Section 753(1.1) of the Criminal Code. In written submissions, defence had conceded that the presumption would be engaged in this case, and,

on the face of the record, it is. But I do not need to rely on it because I am satisfied that it has been positively established by the Crown, beyond a reasonable doubt, that Mr. Bonnetrouge should be declared a dangerous offender based on the criteria set out at the paragraphs that I referred to.

The next question is: What sentence should be imposed? As I already mentioned, three sentencing options are available to the Court once it declares someone to be a dangerous offender. Here, the defence does not suggest that a determinate sentence in the usual course would be appropriate. This leaves the two other options, namely, sentencing Mr. Bonnetrouge to an indeterminate sentence, which is what the Crown asks, or sentencing him to a determinate sentence followed by a period of long-term supervision.

As I have already stated, the Court must impose an indeterminate jail term unless it is satisfied there is a reasonable expectation that a lesser measure will adequately protect the public against the commission by the offender of murder or a serious personal injury offence.

The outcome of this application, therefore, turns on this question: Can the Court have this reasonable expectation, based on the evidence

adduced, that a determinate sentence followed by a long-term supervision order will adequately protect the public? Answering this question is difficult. Risk assessment and risk control are not exact sciences.

In making this decision, the evidence of Dr. Woodside and the evidence of Dr. Nesca is very important. But the Court must not simply defer to what the experts say. It must make its own determination informed by the evidence of the expert witnesses (as long, of course, as the Court finds that evidence reliable).

In this case, I found the evidence of both experts very helpful and very informative. They did not agree on everything, but they were each able to explain and outline the bases for their opinions. Neither of them answered questions that were put to them in cross-examination in a defensive or elusive manner. One is a psychiatrist, the other is a psychologist, and they were both careful, I thought, to remain within the parameters of their areas of expertise. They both acknowledged when a matter being raised did not fall within their area of expertise. I have no concerns about their qualifications, and I found both of their evidence quite helpful in reaching my decision.

They each provided detailed reports which have been made exhibits. They also testified at length at the hearing. My intention here is not to attempt to summarize or refer to everything that they said or to the full contents of their reports. I simply want to highlight some of the main features.

Starting with Dr. Woodside, he is a psychiatrist. He is the clinical head of the Sexual Behavioural Clinic at the Centre for Addiction and Mental Health in Toronto. For over 15 years, his work has involved the diagnosis and treatment of sexual offenders.

As I have already mentioned, Dr. Woodside's conclusion is that Mr. Bonnetrouge presents a high risk to reoffend. This conclusion is based on a number of factors that he explained in his evidence and are outlined in his report. Dr. Woodside also talked about some of the measures that could be put in place to control that risk.

Dr. Woodside's conclusions about the risk that Mr. Bonnetrouge represents were based, as I said, on a number of things. The first was Mr. Bonnetrouge's history of repeated sexual offending. Dr. Woodside considers that past behaviour can be a good indicator of what future

behaviour might be. But there were a number of other things that he considered. He considered results of actuarial testing using certain instruments. The tools he used, more specifically, were the Static-99, the Violent Risk Appraisal Guide, also called V-RAG, and the Sexual Offender Risk Offender Guide, also called SORAG. Mr. Bonnetrouge's score on each of these instruments placed him in the high-risk groups as far as recidivism. These tools measure the individual score against group data. Their scoring on the instrument places them in a certain bin or group. To each of these groups is attached a percentage of recidivism based on various samples taken from the prison population. Dr. Woodside said these instruments must be used with some caution. In particular, his opinion is that little weight should be placed on the recidivism percentage attached to each group. His view, though, is that there is some significance in the score on this type of instrument as far as the category where the individual places. It was one of the things that contributed to Dr. Woodside forming the opinion about Mr. Bonnetrouge's risk to reoffend.

Another factor that is relevant to risk, of course, is the diagnosis. Dr. Woodside's

specific diagnoses for Mr. Bonnetrouge are pedohebephilia, which means preference for prepubescent- or pubescent-aged partners. Secondly, non-consenting coercive sexual preference, which refers to the preference related to sexual activity with non-consenting partners. In his report, Dr. Woodside's conclusion about this particular paraphelia was not as firm as the first one, but it was reinforced by some things that came out in the hearing during Dr. Nesca's testimony, more particularly the admission by Mr. Bonnetrouge that at the time he was assessed by Dr. Nesca, he reported having active fantasies of rape and things of that sort.

The other diagnosis that Dr. Woodside arrived at was that Mr. Bonnetrouge suffers from antisocial personality disorder. He also diagnosed with substance dependance disorder. And Dr. Woodside concluded that Mr. Bonnetrouge suffers from cognitive deficiencies.

The conclusion that Mr. Bonnetrouge has antisocial personality disorder is not particularly surprising when dealing with someone who has had considerable difficulties with the law. It is a very common disorder in prison populations. This makes sense because it is a

disorder that relates to an individual's degree of antisocial or criminal orientation.

At the high end of the spectrum of antisociality, one would find psychopathy. Dr. Woodside did an assessment of Mr. Bonnetrouge using an instrument called the Hare Psychopathy Checklist-Revised (PCL-R). Using this instrument, the subject is scored against certain criteria and the result is a score between zero and forty. If the score is thirty, that supports a diagnoses of psychopathy. Dr. Woodside scored Mr. Bonnetrouge at 26.3, which is not sufficient for that diagnosis. Dr. Woodside testified that he nonetheless considered the results helpful and meaningful as an indication of the measure of Mr. Bonnetrouge's level of antisociality. Dr. Woodside views antisociality on a continuum. A person can be more or less antisocial. And to him, as I understood his evidence, a high score on the PCL-R that falls short the psychopathy diagnosis still demonstrates a high level of antisociality, which in turn is relevant to the risk of recidivism and also to possible response and amenability to treatment.

When he talked about treatment options in light of his diagnoses, Dr. Woodside outlined what types of options that he would view as

helpful in reducing the risk that Mr. Bonnetrouge presents. He said that antisociality is something that is difficult to treat and that in Mr. Bonnetrouge's case, there is an added challenge because he has some cognitive deficits. Dr. Woodside viewed the consumption of intoxicants as a significant factor contributing to Mr. Bonnetrouge's antisocial behaviour. So he viewed total abstinence from intoxicants as a key component in reducing Mr. Bonnetrouge's antisocial behaviours. I understood his evidence to be that as far as deviant sexual preference, those cannot be cured; however, in some cases they can be managed, and one of the ways that they can be managed is through intervention with medication, mainly sex drive reduction drugs.

Dr. Woodside testified about his experience with this medication. He has treated patients with this type of medication. He was careful to explain that there is very little by way of empirical research on this subject and much remains unknown about the long-term effects that these types of medications can have on people. But he did report on his anecdotal experience using this type of medication, and he said that he had some success with the patients that he has prescribed this to. He has observed significant

decrease in recidivism rates in those patients. He said that if, however, a person stops taking the medication, the sex drive returns rapidly. In the conclusion of his report, this is an aspect of the treatment that he recommends for Mr. Bonnetrouge in perpetuity in order to manage his risk effectively.

He explained that the medication can have significant side effects; in some cases, it could be harmful to the patient's overall health. Because of this, before he prescribes this medication, Dr. Woodside has the patient undergo a series of tests, and, in cases where the medication is prescribed, he ensures that patients are monitored closely from a medical point of view. For example, they would undergo regular blood testing, and they would be followed by an endocrinologist to make sure the medication is not compromising the patient's health in a serious way.

Dr. Woodside also testified about what has been referred to as "burnout" as a factor reducing the risk of recidivism. Burnout refers to the phenomenon whereby recidivism tends to decrease as a person gets older. Dr. Woodside says there is a decline in recidivism as a person ages, but there are variations depending on the

person and the type of offence. He said the rate of decline of recidivism for pedophiles on the whole is slower than it is for rapists. He said that pedophiles have been observed to start to show decline in recidivism at around age 50.

As I have already alluded to, Dr. Woodside's view is that if Mr. Bonnetrouge consumes alcohol, his risk is significantly enhanced. Alcohol has the effect of removing inhibitions and many violent offences are committed by persons who are intoxicated. Several of Mr. Bonnetrouge's sexual offences, including the predicate offences, were committed when he had been consuming alcohol. So Dr. Woodside considers total abstinence from alcohol would be an essential component in managing Mr. Bonnetrouge's risk.

Dr. Woodside talked about other factors as well, including the possible benefits of therapy. His view was that Mr. Bonnetrouge would have access to cognitive behavioural therapy while in custody, potentially intense programming, and that he could also continues this type of therapy in the community, albeit in a less intensive way. Dr. Woodside's opinion is that it has not been demonstrated that this type of therapy actually reduces recidivism rates. He would recommend it for Mr. Bonnetrouge in case it worked, but I

understood his opinion to be that he would not place great reliance on this type of measure as a risk management method, and certainly not on its own. Dr. Woodside noted that Mr. Bonnetrouge has been exposed to therapy while in custody and has not done well in those programs, which he felt could be an indication of the chances, or lack thereof, of success of this type of measure for him in the future. Dr. Woodside also noted that Mr. Bonnetrouge's cognitive deficits would present an additional obstacle for him because whatever treatment or therapy is delivered to him would have to be adapted to his circumstances.

Dr. Woodside's overall assessment was that he thought it unlikely that Mr. Bonnetrouge's risk could be managed in the community in the context of a long-term supervision order coupled with a determinate sentence. His view is that Mr. Bonnetrouge's risk will remain high throughout his lifetime and he will require mandated treatment throughout his lifetime.

As for Dr. Nesca, he is a doctor in clinical psychology. He has extensive experience working in correctional settings, in-patient psychiatry units, academic studies, and private practice. He does not disagree with Dr. Woodside's diagnosis of Mr. Bonnetrouge, and, as I have

mentioned, some of the things that came out in his interview with Mr. Bonnetrouge seem to support Dr. Woodside's diagnosis relating to sexual preferences, in particular with respect to the preference for non-consensual sexual activity.

In Dr. Nesca's opinion, however, Mr. Bonnetrouge's sexual preferences are non-exclusive. In other words, he is not solely attracted sexually to children and he is not solely attracted to the concept of sexual activity with a person who is not consenting. Dr. Nesca felt this was very important from a risk management point of view because sexual preference, in his view, is not something that can be treated per se. So where the deviant preference is exclusive, there is, in a sense, nowhere to go with a patient other than simply trying to manage the sexual impulses. On the other hand, if the preference is not exclusive, then there can be a treatment and therapy strategy that is focused on shifting towards the non-deviant sexual preference of the patient.

Dr. Nesca testified about the burnout theory. He said that, in his view, as Mr. Bonnetrouge gets older, the effect of burnout would be to make him more amenable to treatment.

He considered it significant that Mr. Bonnetrouge scored low on the core psychopathic traits on the PCL-R because those traits are not effected by burnout. So not having those traits, in Dr. Nesca's opinion, as I understood it, increases the chance that the risk would, in fact, be reduced by the operation of burnout.

Dr. Nesca scored Mr. Bonnetrouge on the PCL-R. He did arrive at a slightly different score than Dr. Woodside's, but considering the margin of error on the instrument, they essentially arrived at equivalent scores.

Where Dr. Nesca disagreed with Dr. Woodside, though, was about the use that could be made of the result of Mr. Bonnetrouge's score on that instrument. In Dr. Nesca's opinion, the only use that can be made of the PCL-R instrument is to pose, or not, a diagnosis of psychopathy. He disagreed with Dr. Woodside's use of the tool as a means of assessing a person's level of antisociality and extrapolate that onto the risk factor or the amenability for treatment. If his view, the only relevance of Mr. Bonnetrouge's result on the PCL-R is to say that he is not a psychopath, which makes his prospect for treatment and management in the community better than if he were a psychopath.

Another reason advanced by Dr. Nesca for not putting any weight on the results of the PCL-R, is that he said Mr. Bonnetrouge's score is in line with the average score for aboriginal inmates; it does not distinguish him from other aboriginal inmates in any way.

Dr. Nesca disagreed entirely with Dr. Woodside as far as the use of actuarial tools such as the Static-99, V-RAG, or SORAG in assessing the risk that an individual poses for recidivism. His view is that these instruments provide results for group behaviour and are entirely useless to predict individual behaviour. He also gave evidence about the statistical calculations that were used in the development of these models and the models used within these instruments. He expressed a strong view that these models are not useful at all when it comes to predicting risks of individuals behaving in a certain way. I will not attempt to summarize what he said in this regard. I think what matters is that his view, and it was clearly expressed at the hearing, is that these tools should simply not be used as risk assessment tools in this context.

Another one of Dr. Nesca's significant disagreements with Dr. Woodside's conclusion has

to do with the relevance of Mr. Bonnetrouge's cognitive difficulties. In Dr. Nesca's view, Mr. Bonnetrouge's lack of success in the past with cognitive therapy says very little about what success he might have in the future. In his opinion, Mr. Bonnetrouge's lack of success in the programs that he has taken can probably be explained in large part by his cognitive difficulties. As I understood him, he thinks the significance of Mr. Bonnetrouge's cognitive problems was underestimated and understated in Dr. Woodside's report. Dr. Nesca thinks it is in error to look at past failures of these methods as an indication that Mr. Bonnetrouge could not have better outcomes in the future. He also noted that programs not tailored to his needs (for example, a program that would be delivered in a classroom-type setting) would not have been suited to him, would have been difficult for him to benefit from, and would probably have been very frustrating for him. This would affect not only Mr. Bonnetrouge's chances of success in those programs but also his ability to participate, and his behaviour during the program. So it may well result in manifestations that could erroneously be interpreted as lack of motivation or an unwillingness to participate,

which are some of the things that are reported in the correctional records.

Dr. Nesca talked about a therapy model that has been developed more recently, which is called the "Good Lives Model". This model is intended to be tailored to the offender's specific needs and limitations and which may provide a better chance of success with Mr. Bonnetrouge.

On the whole, Dr. Nesca's conclusion about the prospect of managing Mr. Bonnetrouge's risk is not as pessimistic as Dr. Woodside's. He believes that there is a reasonable possibility that the combination of the burnout effect due to aging, substance abuse treatment, and biological interventions, as well as therapy, could result in his risk being controlled in the community.

Each of these experts formed an opinion about the level of risk that Mr. Bonnetrouge now presents (on that, they were in agreement) and about how that risk might be managed and what was the likelihood of that being achieved.

As I have said, it is for the Court to decide, in light of the evidence, whether it is satisfied that there is a reasonable expectation that a jail term, followed by a long-term supervision order, could adequately protect the public.

A number of cases have discussed what the term "reasonable expectation" should be taken to mean in this context. One of those cases was a case from this jurisdiction, R. v. Kudlak, 2011 NWTSC 29. I want to quote briefly from it at paragraph 102. The Court was talking about this subject and said, after having referred to other cases:

> The other principle that emerges from this discussion is, as articulated in much of the case law that "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" ...

And here there is a reference to a number of cases. The Court continues:

> Arguably this principle has been reinforced by the use of the expression "reasonable expectation" in s. 753(4.1) as opposed to the term "reasonable possibility" used in s. 753.1(1)(c). A "reasonable expectation" may require a higher level of certainty. And in this regard, as noted in Johnson and G.L., the offender's amenability to treatment and the prospects for success are critical factors to address.

I agree with these comments. What is required here is more than the expression of hope. What is required is that there be evidence that the specific offender, within a definite

period of time, can be treated in such a way as to reduce his risk. The implication is that by virtue of the combined effect of the determinate sentence and the period of long-term supervision, the risk will have been reduced to an acceptable level and that it will remain at that level even in the absence of exterior controls.

The possibility that the risk might be controlled is also not sufficient. In the case of R. v. Goforth, 2007 SKCA 144, which was decided under the provisions of Part XXIV of the Code before the 2008 amendments, the trial judge had approached the matter by saying that an indeterminate sentence should only be imposed if there was no possibility of management in the community. The Court of Appeal underscored that this was not the correct test and said that the mere possibility that the risk could be managed in the community was not enough. Goforth, paragraphs 53 and 54.

As noted by the Court in Kudlak, in the excerpt that I quoted earlier, it is arguable that the language of the existing provision creates a standard that is even more strict than the one that applied under the previous regime. Given this, what the Court of Appeal said in Goforth on this issue is not only still

applicable, but even more so perhaps.

Considering the whole of the opinions expressed by Dr. Woodside and Dr. Nesca, I find that the areas where they agreed on are more significant, for the purposes of my decision, than the areas where they do not. First, they substantially agree on the diagnosis and on the level of risk that Mr. Bonnetrouge currently presents. Second, they agree that as he ages, burnout is a factor that may reduce his risk, but neither of them suggested that this burnout factor ought to be relied on in and of itself to manage the risk. Third, they both considered biological intervention to be one of the components required to manage his risk and to manage Mr. Bonnetrouge's substance abuse problem.

Some of the areas of differences in their opinions do not matter much in the circumstances of this case. For example, as far as their disagreement on whether actuarial instruments should be used to measure risk, their difference of opinion is inconsequential because, in the end, they both agree that Mr. Bonnetrouge presents a high risk to reoffend. Their difference of opinion as to the use that should be made of the result on the PCL-R, I do not find is particularly significant either. They both

arrived at essentially the same score and they both agree that Mr. Bonnetrouge is not a psychopath.

Dr. Nesca was critical of Dr. Woodside's use of the high scores on the instrument as suggesting a high level of antisociality, and he suggested that this tool should only be used to arrive or not arrive at the diagnose of psychopathy. But in his own evidence, Dr. Nesca also used the instrument for a purpose that was other than simply this diagnosis or non-diagnosis of psychopathy. He said that because Mr. Bonnetrouge did not score high on the core psychopathic traits on the PCL-R, burnout would, in fact, be a factor that would reduce his risk because, he said, burnout does not affect psychopathic traits. So even Dr. Nesca, in a sense, used the results on the PCL-R beyond simply the determination of whether Mr. Bonnetrouge is a psychopath or not. But all that said, Dr. Nesca's point is well taken that Mr. Bonnetrouge's score does not distinguish him from other aboriginal offenders who are incarcerated. So while I did understand why Dr. Woodside explained that he considered it relevant as a measure of antisociality, I would not place great reliance on the score on the

PCL-R as far as deciding, ultimately, what to do in this matter. I also note that Dr. Nesca agrees with Dr. Woodside that Mr. Bonnetrouge suffers from antisocial personality disorder. Their disagreement on the use of the PCL-R is, given this, not as significant as it might otherwise be.

Perhaps the most significant disagreement between the two experts is the effectiveness that therapy could have for Mr. Bonnetrouge and, in a somewhat related way, what to make of his past lack of success with the programming.

I understand Dr. Nesca's point about how Mr. Bonnetrouge's cognitive deficiencies would no doubt have impacted on his ability to benefit from the treatment that he was offered. Dr. Nesca's views, to put it bluntly, is that there is a shared responsibility for Mr. Bonnetrouge not having had success with treatment. Dr. Nesca attributes some of the responsibility for that to the correctional authorities for not having provided him with treatment and programs that he could actually benefit from. This is in the same vein as an argument made by Mr. Bonnetrouge's counsel about the failure of the correctional authorities to allow Mr. Bonnetrouge to benefit from treatment

early on in his correctional history.

Because the very first time Mr. Bonnetrouge was sentenced as a youth, the Court had recommended that he receive treatment, something that the correctional authorities at the time decided not to do because they felt he was too young, and something that was apparently never followed up on.

Defence also argued that more could have been done to explore into more detail what were the factors that contributed to Mr. Bonnetrouge doing well in a certain time frame, when he resided with his cousin in Vancouver, and appears not to have been convicted for any offences. This is referred to in Dr. Woodside's report, and it is stated in there, among other things, that Mr. Bonnetrouge did not have contact information for his cousin. Dr. Woodside acknowledged in his evidence that he did not follow up on this or make any inquiries to try to track this cousin down and try to find out more about what factors may have been at play during this period of time where Mr. Bonnetrouge had better outcomes in the community. Defence argued that more steps should have been taken to follow up on this. The Crown's position, as I understood it, was that Dr. Nesca did not follow up on this aspect of

things either and that if it was deemed important, the defence could have brought out additional information about this. But Defence emphasized these various points, urging the Court to conclude that the failure of past programming to reduce Mr. Bonnetrouge's risk is not based solely on the fact that he his not treatable or that therapy cannot work for him. I think the evidence bears this out at least to some extent.

Of course this court has to be very careful in assessing why things were or were not done years ago with respect to an offender. What I do accept is Dr. Nesca's opinion that some of the programs that were used with Mr. Bonnetrouge were not the best suited for him given his cognitive deficits, and I also accept that some of the instances where lack of success and apparent lack of motivation were noted in the correctional records may have been due to how these programs were delivered and the fact that they did not work for him. And it is also true that there are other instances where the correctional documents do show a more positive picture about his motivation and attitude.

But without deciding the point, even if I went as far as making a finding that Mr. Bonnetrouge's failure at treatment is a

shared responsibility, that the authorities did fail him when he first came into the correctional system at a young age, and even if I discounted the failure of past recent attempts as a way of predicting success of future treatment attempts, the question remains whether, bearing that caveat in mind, there is a basis to have the reasonable expectation referred to paragraph 753(4.1).

As I have said before, the question that I must answer is not whether there is a possibility that other treatment methods might work or the possibility that Mr. Bonnetrouge's risk may be controlled in the community if, for example, he were released in an environment including positive models. It may well be that a new therapeutic approach such as the Good Lives Model, or something else, will achieve better results for him than what has been done in the past. And it is likely true, and I think everyone would agree, if released in the community, his success will depend in part on who he associates with and what supports he has.

I accept the submission that these possibilities exist. I accept that some things that have not been tried should be tried to assist him in the control of his risk. But possibility or hope is not enough at this stage.

There is nothing concrete in the evidence, in my view, to find that based on these factors alone, there is a reasonable expectation that within a determined period of time Mr. Bonnetrouge will no longer present a risk to the public. Saying that some of the things that have been tried have not worked and it is not all his fault because they may have been ill-suited for his needs is one thing. Saying that there is a basis to conclude that the things that have not been tried can be reasonably expected to succeed is quite another.

There is no question, as I said, that Dr. Nesca, in the end, is more optimistic than Dr. Woodside about Mr. Bonnetrouge's prospects. But even taking Dr. Nesca's evidence at its highest and accepting that the therapy along the Good Lives Model line would have better chances of success because it is better suited for his needs, even Dr. Nesca did not say that therapy alone could control Mr. Bonnetrouge's risk, nor does he say that burnout alone can be expected to do so. Both experts envisaged more, including biological intervention, getting the alcohol dependency disorder under control, and Mr. Bonnetrouge complying with treatment. To me, this raises a number of concerns.

First, with respect to the biological

intervention, Mr. Bonnetrouge would have to be able to take this medication. The possibility of treatment with a sex drive reduction medication is often a proposed method of treatment when dealing with repeat offenders who face a dangerous offenders designation and the potential for an indeterminate sentence. This type of evidence has been presented and this type of treatment option has been referred to in several dangerous offenders' hearings that have taken place in this court in recent years. In R. v. Kudlak, there was evidence about that. It was also the case in R. v. Sassie, 2012 NWTSC 27, and R. v. Melanson, 2011 NWTSC 39.

Here there are indications that Mr. Bonnetrouge has expressed he would be willing to take this type of treatment, but he has never taken it. There are also a lot of unknowns about this. Dr. Woodside said there was no immediate reason to think Mr. Bonnetrouge would not be a candidate for this type of treatment, but the evidence is also that before he would prescribe it, he would have to have certain tests done on Mr. Bonnetrouge and he would also want to monitor him regularly for potential adverse side affects. So there is a possibility that this treatment could be available to him, but there are also a

lot of unknowns.

The second question has to do with compliance. Biological intervention would be part of a number of long-term strategies that would, once Mr. Bonnetrouge is back in the community, require him to comply with the treatment plan with the medications but also comply with other things like alcohol abstinence conditions and following whatever therapy session or programs would be deemed beneficial for him.

It cannot be overlooked that Mr. Bonnetrouge's level of compliance with court orders while in the community has not been great. This is not surprising considering his substance abuse problem, his antisocial personality disorder, and his paraphilia. A long-term supervision order would entail a higher level of supervision and potentially more immediate consequences in the event of a breach of something like a probation order. Still, the status of being on parole and at risk of immediate and indeterminate custody is the most stringent regime of supervision that a person can be under in the community. It is the one that presents the highest incentive for compliance.

The breach of a long-term supervision order does not have the same consequence, as

Mr. Anderson explained, as the breach of a parole condition while on release for an indeterminate sentence. When it is alleged that a person has breached a long-term supervision order, the person may go back into custody for a period of time but only up to a maximum of 90 days unless a charge is laid. If a breach charge is laid, then it is dealt with by way of prosecution on that charge. It is not at all the same as the immediate consequence of revocation of parole.

The last aspect, and, really, this is the most significant, just as it was in Kudlak, is that some controls appear to be required in perpetuity.

On the whole of the evidence, I am satisfied that Mr. Bonnetrouge will require supervision and controls for a very long time and, in some respects, for his whole life. A determinate sentence followed by a long-term supervision order will only provide a finite period of time where those controls can be in place.

Mr. Bonnetrouge is now in his mid thirties. He has been on remand for fours years. If a determinate sentence in the range proposed by defence were to be imposed, he would receive, in effect, a further jail term of three to four years followed by a maximum of ten years of

supervision if he got credit for his remand time on a one-to-one ratio. If he got enhanced credit for his remand time as defence suggests he should, the further jail term would be in the range of one to three year. So the time frame for which he would be under some form of control or other could be anywhere between 11 and 14 years from today's date. This would take him to the end of his 40s or just around the time he would turn 50. At that point, he would be without any supervision or controls. Any measures employed up until then to hopefully successfully control his risk would no longer be mandated by anything, whether it is the sex drive reduction medication, possibly medication to assist him in abstaining from alcohol, or any other measures required to maintain his sobriety, or therapeutic efforts. All of this continuing would, at that point, be dependent solely on his choice to continue with it or not.

There is of course the possibility at the expiration of his sentence, Mr. Bonnetrouge would continue to take sex drive reduction medication, would continue to abstain from alcohol, and would continue to address his issues through therapy and whatever supports would be required at that point. That is an unknown.

I recognize that Mr. Bonnetrouge has been on medication before while on release. There is reference to this in the reports from 2002 about his parole being temporarily suspended to allow a change in his medication regime. Those medications, though, were antidepressants and mood stabilizers. They are medications that can also have side effects. But the type of medication we are talking about here is really quite different.

The only evidence I have about people's inclination to continue taking them when they are no longer compelled to do so by a court order or by an order of the Parole Board is that according to Dr. Woodside, the people he has had -- at least treated with these drugs, stop seeing him when their sentence is over. Whether Mr. Bonnetrouge would be an exception and continue with his medical regime is an unknown.

It is not possible to predict the future. The knowns at this point are that Mr. Bonnetrouge's paraphilia are not curable. They are, at best, treatable with the view of managing his risk. His antisocial personality disorder is a condition that is difficult to treat. His alcohol addiction, again, is not something that can be cured. It is something that can be, at

best, managed. His cognitive difficulties are fixed, although from a therapeutic perspective, according to Dr. Nesca, they could be overcome in the sense that therapy suited to his specific needs could be more successful than what he has been exposed to so far. But my assessment of the evidence as a whole leads me to this conclusion: If Mr. Bonnetrouge's risk is to be controlled in the community, it will be through a combination of various things which, I am satisfied, will have to be in place for a very long time. I am not satisfied that there is a reasonable expectation that the combination of a determinate sentence and a long-term supervision order would adequately protect the public because I am not satisfied that Mr. Bonnetrouge's risk can be reduced in that timeframe to the point that he could then be completely free in the community and the public still protected.

The Supreme of Canada, in R. v. Ipeelee, 2012 SCC 113, stated that the special considerations that apply in sentencing aboriginal offenders apply to dangerous offender proceedings. I have not overlooked the fact that Mr. Bonnetrouge is an aboriginal offender. I have not overlooked the fact that he has faced very difficult circumstances as a child that no doubt

contributed to his antisociality and his addiction to alcohol. Sadly, many children in this jurisdiction continue to grow up in circumstances that are difficult and are exposed to alcohol abuse and neglect.

This court was dealing with another offender who had a very difficult background in Kudlak, and in addressing whether that offender's aboriginal status could justify a different outcome, the Court said the following at paragraph 107:

> I have taken into consideration Mr. Kudlak's difficult childhood. He had a chaotic family life marked by alcohol abuse and violence. Sadly many of our northern aboriginal communities are afflicted by similar problems. I have no doubt that part of the reason for the difficulties that confronted the Kudlak family thirty some years ago was the dislocation of the family from a more traditional, land-based way of life to the settled community of Cambridge Bay where they became dependent on welfare. I am also sure that some of Mr. Kudlak's early problems were due to a lack of resources available in Cambridge Bay for diagnosing and effectively treating childhood problems. These types of disruptive childhoods are all too common as well in many of our communities.
>
> Mr. Kudlak's psychological problems and the sexual deviance cannot, however, be traced to his aboriginal heritage. These are traits that developed at an early age. His victims have, for the

> most part, been aboriginal as well, including members of his family, and they have been affected by his uncontrolled behaviour. The need for protecting the public is just as acute in a northern aboriginal community as anywhere else. In a case such as this, where public protection is paramount, incarceration is the only alternative, whether one is considering an aboriginal or non-aboriginal offender.

The same can be said here. The sad reality is that Mr. Bonnetrouge has proven to be very dangerous for members of his community, who are in majority aboriginal. He has caused great harm to young children and others who, by virtue of various circumstances, were in vulnerable positions. He has done this consistently over the years and he did so again in 2009 when he committed the two offences that he must be sentenced for today.

One can have empathy for the situations that he himself has faced when he was growing up and for the fact that throughout all these years, in and out of the correctional system, he has not had access to programing that was suited to his specific needs or to the type of treatment and programming he would have needed at a much younger age when he first came into contact with the criminal justice system. But as the Court

said in R. v. Evans, 2008 Carswell Ont 994, at paragraph 127: "Sympathy cannot ground the conclusion that there is a reasonable expectation of controlling his risk in the community."

It must be remembered as well that an indeterminate sentence does not mean that Mr. Bonnetrouge can never be released back in the community. It does not leave him without hope of eventually being released. The various measures to control his risk that were discussed at length at this hearing remain relevant. The type of therapeutic approaches referred in the evidence, tailored to his needs and taking into account his cognitive deficit, should be explored. The use of sex drive reducing medication, when the time is appropriate, should be explored as well, especially if he is willing to take this type of medication. Anything that could have been developed under the term of a determinate sentence followed by a long-term supervision order can be attempted just the same under the parameters of an indeterminate sentence with a view, if the risk can be controlled, that he could be released into the community on parole. It is not uncommon for people who have received a dangerous offender designation and been sentenced to an indeterminate term of imprisonment to

actually be able to be released as on parole. The fundamental difference is that if that happens and if he is released on parole, he will be under a regime that will ensure that if he is unwilling or unable to follow through on the risk-reducing measures, the authorities will be in a position to act immediately. And I have concluded, sadly, that in this case that is the only way to adequately protect the public against the risk that he represents.

For those reasons, I declare Mr. Bonnetrouge to be a dangerous offender pursuant to Section 753 of the Code, and, under the same provision, I sentence him to an indeterminate term of imprisonment.

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Certified Pursuant to Rule 723
of the Rules of Court

Jane Romanowich, CSR(A)
Court Reporter