BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

REASONS FOR DISPOSITION
IN THE MATTER OF

C.F.S.
a Young Person

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
October 3, 2007

BEFORE:

CHAIRPERSON:	**B. Walter**
MEMBERS:	**Dr. G. Laws, psychiatrist**
	F. Jeffries

APPEARANCES: **ACCUSED/PATIENT: C.F.S.**
ACCUSED/PATIENT COUNSEL: D. Nielsen
HOSPITAL/CLINIC: H. Snyder Dr. E. Wang
ATTORNEY GENERAL: L. Hillaby
HOSPITAL COUNSEL: D. Lovett
FAMILY PARTY: G. Trimble

***Pursuant to s.672.501(1) of the Criminal Code, the British Columbia Review Board hereby prohibits the publication, broadcasting or other transmission of any information that could identify a victim or a witness under 18 years of age in this matter. Failure to comply with this order is an offence.**

****Publication of information identifying the young person or any minor victim or witness is prohibited pursuant to s.110 of the Youth Criminal Justice Act and s38 of the Young Offenders Act.**

INTRODUCTION

[1] On October 3, 2007, the BC Review Board convened an early disposition review hearing in the matter of CFS (a young person) now aged 25.

[2] CFS last appeared before the BCRB on February 13, 2007. At that time, the Review Board imposed a short order reviewable within 6 months, including conditions requiring the Director (AFPS) to develop and submit additional detailed disposition information and assessments with respect to the accused's sexual interests; the treatment and supervisory requirements and resources considered necessary for his safe reintegration; as well as a comprehensive assessment of the accused's potential threat to others: **Ex.85**, **cl.10 and REASONS FOR DISPOSITION, paras 21, 25.**

[3] The Director, relying on the disposition information filed, and the oral evidence to be adduced at this hearing, recommended a further disposition of discharge subject to currently relevant conditions, of 12 months' duration. Counsel for the Attorney General of BC supported this position. Designated party G. Trimble and counsel for the accused requested CFS's absolute discharge.

[4] On convening the current hearing, the Board, and in turn, the parties, were provided with new disposition information consisting of reports from CMC Snyders (May 19/07 and July 13/07) **Ex. 86 and 88**; an assessment from Dr. Wang (July 6/07), **Ex. 87**; a letter from one L. Powell (July 15/07), **Ex. 90**. A "Psychological Risk Assessment" authored by Dr. E. Lopes, a psychologist, in July 2007, was received at the hearing as **Ex. 91**.

[5] The Review Board considers the new submissions to be in compliance with, and to satisfy, its orders of February 13, 2007.

[6] We also adopt the historic evidence and findings as summarized at **Ex. 81 and 85** in these materials.

EVIDENCE OF THE DIRECTOR

H. SNYDERS (F.L.W.)

[7] Mr. Snyders has seen CFS monthly. Mr. Snyders' submissions **(Ex.86; 88)** communicate that, insofar as CFS has not apparently demonstrated any inappropriate

sexual interests in children, his family considers the current continuous supervisory requirement unnecessary and has expressed its frustration that the accused remains under our legal jurisdiction/regime. The family feels the accused's risk to children has abated.

[8] The accused now attends his Chilliwack community living program 5 days per week. Reports regarding the accused's behaviour and his peer and program relationships have been entirely positive (this was confirmed by witness Lawson from CLBC). The accused is mentally stable. There is no evidence of drug or alcohol use. There have been no reports or complaints from law enforcement agencies. CLBC's involvement in service provision may expand to include caregiver respite care and possibly the services of a 1-1 worker for CFS.

[9] As to the supervisory requirements of CFS's disposition, the Director and CFS's family have developed a list of approved adult supervisors.

[10] Dr. Lopes, the author of **Ex. 96**, who is a specialist in the assessment and treatment of developmentally disabled sexual offenders, may be available to see CFS for therapy starting in October or November.

DR. E. WANG (AFPS)

[11] Dr. Wang has seen the accused on three occasions since February 2007. He confirmed the absence of any behavioural issues at CFS's day programs.

[12] Dr. Wang's written assessment **(Ex.87)** documents to a considerable extent CFS's interactions with assessor Dr. Lopes:

> *"In June 2007, Mr. (CFS) was seen on two occasions by Dr. Evan Lopes, a psychologist specializing in the treatment of developmentally delayed sexual offenders, to assist in further clinical assessment. Mr. (CFS) had a good rapport with Dr. Lopes. Dr. Lopes reported that Mr.(CFS) had a full recollection of the offences and could describe them in detail, and that this level of recall contrasted with Mr.(CFS) claims that he could not remember details of his relapse plan with Dr. Peter Johnson because it was 'too long ago'. Dr. Lopes expressed concern about the limited amount that Mr. (CFS) had internalized from his work with Dr. Johnson and about whether Mr. (CFS) would be able to use the tools learned when necessary. Dr. Lopes described Mr. (CFS) version of events from the incident in Kincolith in August 2006, as "not completely coherent and not entirely plausible." Mr. (CFS) described to Dr. Lopes problems with getting angry and easily frustrated, and incidents where he became violent or assaultive. Dr. Lopes noted that Mr. (CFS)'s level of frustration could play a role in his inability to be left unsupervised or to adhere to prescribed plans. Mr. (CFS) also disclosed that around age 15 he had had a same-age girlfriend named "Trisha" and that he had sex with her. Dr. Lopes noted that this was around the same age that Mr. (CFS) was offending against younger children. Mr. (CFS) also reported*

that when he was a 'baby' he became sick and ended up in a coma for a considerable time, and that brain damage from this incident could be relevant in addressing management of impulsivity."

"On the first day of the assessment with Dr. Lopes, Mr. (CFS) reported no sexual interests toward children. However, on the second day of the assessment, in an exercise that involved responding to scenarios that included situations where he would have direct access to children, Mr. (CFS) responded in a manner where he chose a safe path, in which he would not be left alone with children. When asked his reasons, Mr. (CFS) replied that he did not want to be in a situation where 'the temptation is there.' When he was asked why he chose young girls as his victims as opposed to older or 'same age' girls, Mr. (CFS) explained that 'kids are easy to grab'"

"Dr. Lopes concluded, 'Overall, Mr. (CFS) continues to pose a moderate to high risk for reoffending. A decrease in the present level of supervision is not recommended and is advised against, as it would increase his risk level to high. Other than Mr. (CFS)'s statement that he would not want to be left alone with children, he has not been able to demonstrate a working safety plan or the ability to think through issues of impulsivity or sexual drive. Mr. (CFS) has static difficulties such as the considerable mental handicap, possible brain damage, and possible deviant sexual interests as well as dynamic difficulties such as his present defensive denials, lack of insight, and lack of experience and possible inability to operate in an unsupervised environment. Although I support Dr. Wang's recommendation of a stepwise reintegration plan with a gradual reduction in the level of direct monitoring, it is as a future long-term plan. In other words, I would like to see Mr. (CFS) progress to a less supervised environment, but he still requires a great deal of work before this can be safely done…. Mr. (CFS) should, for the time being, remain in the same level of supervision. His risk level has not changed from before. Moreover, he has not shown an increased understanding of his issues or an ability to even remember his relapse plan…a decrease in supervision at this time would decrease Mr. (CFS)'s interest in participating in further treatment and further decrease in his interest in understanding his risk…. Mr. (CFS) must resume psychological treatment similar to the treatment that he was receiving from Dr. Peter Johnson. At this point, Mr. (CFS) will have to start treatment from the beginning as it is not possible to assess what he has learned from the past treatment.'" : **Ex. 87.** *[Accused name changed to initials]*

[13] Dr. Wang confirmed that it is CFS's mother's opinion that CFS will not re-offend and that he does not require anti-libidinal medication.

[14] Dr. Wang concluded that it is important that the accused's treatment plan include the possible administration of SSRI's to dampen/suppress the accused's potential for impulsivity and his libido; a PPG (phallometric) assessment (to assess his sexual responses/interests); long term specialized psychological treatment including a gradual reduction of direct monitoring or supervision over time; alternate supervisor for CFS and respite services for his family.

[15] After some delay, the accused submitted to a further PPG assessment on July 11, 2007. Dr. Wang reports some difficulty in interpreting the resultant data but did confirm a somewhat prominent response or attraction to pre-pubescent females.

[16] In response to the Review Board's request for a comprehensive risk assessment, Dr. Wang cited:

- the accused's lack of insight regarding his sexual offending issues;
- the risk of impulsive behaviour under unsupervised circumstances and the accused's likely difficulties/limitations in controlling his own behaviour;

- inconsistencies in the non-disclosures regarding his sexual interests related to Dr. Wand and Dr. Lopes;
- though the accused honestly does not want to re-offend, he acknowledges the possibility:
  Ex. 87, pp. 3, 5, 7

[17] He summarizes:

> *There are two important factors to consider in an assessment of Mr.(CFS)'s sexual functioning and risk of reoffending. The first is developmental delay and the poor social judgment associated with this. The second is access to children and the potential for sexual behaviour towards children as a function of opportunity. Whether or not Mr.(CFS) is considered to be a pedophile, these two factors are still the main issues in his risk management. Unfortunately, they are chronic issues and are difficult to manage. Mr.(CFS)'s participation at the CLBC workshop appears to be a sustainable, long-term endeavour that he enjoys and that provides him an appropriate social outlet and respite for his family. Beyond this form of structured, supervised activity, because of the nature of the above two factors (i.e., developmental delay, access to children), reducing Mr.(CFS)'s long-term risk of sexual offending is very challenging, even if Mr.(CFS) is fully engaged in the treatment plan outlined previously.*: **Ex. 87.**

EVIDENCE ON BEHALF OF CFS

[18] On behalf of CFS, his mother D.S. gave evidence that the accused has not demonstrated any inappropriate activity or touching of children. She undertook that CFS's family would ensure his continuing safety vis-à-vis others. She said that even if he were absolutely discharged, the levels of familial supervision of CFS would not decrease.

[19] The family and extended family is also prepared to enrol him in a First Nations Men's program with a residential component, and which includes sexual and violence issues or modules.

[20] Under questioning, Ms. S. did acknowledge that she does not believe CFS poses a level of risk which requires 24 hour direct supervision. She admitted CFS is unable to spontaneously recall all the elements of his written relapse prevention plan, but said that he does possess more in the way of self-regulating skills/capacity than suggested by Dr. Lopes.

EVIDENCE OF CFS

[21] She indicated that there is no need for respite care because it is not unnatural or a burden to be with CFS on and on-going basis. While it ma be inconvenient at times, e.g. for a quick run to the store, the need for constant supervision is not considered a burden for which respite is required. However, she considers this level of supervision unnecessary.

[22] The accused told the hearing how much he enjoys his program activities. He confirmed he is exposed to or is around young children at home and said he discloses when he has any inappropriate thoughts and he is also able to redirect himself. If absolutely discharged, CFS said he would agree to see Dr. Lopes for treatment.

DISPOSITION

[23] In assessing whether or not CFS continues to pose a potential significant threat such as justifies our ongoing jurisdiction over him, we considered, in particular, the following:

1. The Index Offences are now 10 years in the past. Without minimizing the seriousness of such behaviours, we do note that they included no actual penetration and were unaccompanied by any coercion or violence.
2. CFS is aware that his behaviour was wrong and unacceptable. He benefited from psycho-therapy with Dr. Johnson before the latter's retirement. Contrary to some of the evidence provided at this hearing, CFS was actually readily able to identify a few strategies he would utilize to avoid re-offending.
3. CFS enthusiastically attends his CLBC program which does not depend for its continuation on FPS or Review Board supervision. He is prepared to see Dr. Lopes whose therapy may be able to be funded outside of FPS auspices.
4. While we must obviously consider seriously the expert opinions of Forensic and collateral professionals with respect to issues of risk, there is some evidence to question the relationship or perhaps the level of mutual trust and real understanding that exists amongst these professionals and the accused's primary caregivers, his extended family. One example of this disconnect maybe the professionals' apparent acceptance of the 2006 Kincolith incident in the face of the family's vehement denials and explanations, especially bearing in mind Mrs. S.'s disclosure of the Index Offence and allegations in 2001.
5. The accused's admission of temptations and his fear of re-offending is interpreted by the experts as indicative of elevated risk; presumably CFS's denial of such temptations or fears would be interpreted in a negative way, as non-disclosive or as a lack of insight.

6. We consider that positive responses on a PPG, while useful indicia, are not direct predictors of a risk of offending or re-offending. Moreover, the current PPG was not standardized for the unique intellectual and cultural circumstances of this accused.

[24] Our analysis must also consider that CFS has the benefit of a number of protective factors or resources:

[25] He is fully integrated and lives in a somewhat traditional, closely-knit, extended First Nations family with considerable relevant strengths including:

- Both CFS's parents have personal experience with sexual abuse and are committed to ensuring that future generations do not repeat this experience.

- There is a natural acceptance, love and a bond between CFS and his family. These will be the basis of any release plan.

- The extended family lives together in the family home, offering considerable opportunity for both natural surveillance of and support for CFS.

- Members of the family are in touch with various culturally appropriate resources that will be of considerable assistance in reducing the risk CFS poses.

- He is very well supported by his family and will always be dependent on them. The family itself is remarkably cohesive with no identified dysfunctions.

[26] It is unclear to the Panel whether, or to what extent, the assessments of CFS's risk and the plans for his eventual release take this environment/context into account.

[27] On the strength of the Director's evidence, the Review Board determined, on balance, to continue its jurisdiction over CFS in the form of a further disposition of discharge subject to less restrictive and onerous conditions.

[28] For example, our elimination or removal of the requirement for continuous adult supervision should provide an opportunity for CFS's family to demonstrate its willingness and capacity to implement a supervisory scheme which it believes will suffice or prove adequate in terms of protecting vulnerable children.

[29] We are, however, concerned about the pace of progress towards the provision of specialized, relevant and responsive services to this young accused as we continue to balance the potential for serious harm, against the restrictions his freedoms imposed under the current regime.

[30] CFS's family, in particular Ms. Trimble (designated party), presented evidence of the existence of a range of resources that are based on culturally compatible strategies. This includes a First Nations male support group; First Nations psychological counselling and the First Nations Mental Health program of the provincial health authority. What remains is for the development of a concrete community-based treatment plan that will enable CFS and his family to continue without the need for a Review Board order.

[31] The Panel's decision to continue its disposition of conditional discharge for 6 months is rendered with the expectation that the Director and the family will collaborate in the quest for an array of culturally compatible and effective services to manage this accused's residual risk beyond the auspices of FPS. We look forward to seeing a reasonably well-developed and concrete treatment and safety plan to be presented at the accused's next hearing.

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