REASONS FOR DISPOSITION
CHRISTOPHER HIND (hearing: July 6, 1999)

1. Introduction

On July 6, 1999, a Panel of the British Columbia Review Board consisting of F.A.V. Falzon (Alternate Chair), Dr. G. Laws (Psychiatrist) and Ms. M. Anderson (Social Worker) held a hearing to review a custody disposition rendered by the Board on November 3, 1998 (Ex. 25). The accused was represented by counsel.

Based on the evidence and submissions before at that review, and applying the law as stated in *Winko v. British Columbia* (June 17, 1999, unreported, S.C.C.), the Panel ordered that the accused be detained in custody and reside at the Forensic Psychiatric Institute for one year, with conditions for 28 day visit leaves and unescorted absences into the community, at the Director's discretion. Due to exigencies of time, we reserved the reasons for our decision. These are those reasons.

2. Index Offences

On January 6, 1998, the Provincial Court of British Columbia made a finding that the accused was not criminally responsible for 3 offences on account of mental disorder ("NCRMD"). Those offences were assault, mischief and failure to comply with a probation order. The Court ordered that he be detained in custody for 45 days pending a disposition by the Review Board.

The facts giving rise to the assault charge involved an elderly couple who were taking a walk adjacent to a park on March 3, 1997. The following relevant summary arises in the report to Crown counsel (Ex. 7):

> They had observed Hind coming towards them … talking loudly to himself. He appeared dishevelled and dirty, the front of his jeans turned to his hip. As they approached each other, Hind made violent and menacing gestures toward them, "karate chop with his fists". Hind was about 5 yards away when he did this, ranting nonsensically all the time. The [couple] believed they were about to be assaulted and rapidly walked away, looking back to see Hind repeat this gesture and then disappear into Uplands park….
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> Hind is well known to the Oak Bay Police Department and was immediately identified through the description and actions provided…. Three officers … attended the area and located Hind… Hind appeared to understand who the officers were. When Hind was told he was under arrest for assault, he resisted violently, requiring all three officers to subdue him. It was the opinion of the investigating

> officers that Hind fit the parameters of s. 24 of the Mental Health Act and he was transported to Royal Jubilee Hospital for care.
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> Information: Hind was arrested on an identical matter 97.02.24. No struggle issued as the officers were able to talk him into the police vehicle at the time. He also appeared somewhat more rational in that investigation…. Hind is a very strong individual and if he resists arrest, can be very difficult to subdue. He does not appear to feel pain, nor does he react normally to pepper spray (it's been tried to no avail).

The mischief offence arose from actions of the accused just over one month later – April 28, 1997. The facts giving rise to the charge were described by Crown Counsel at trial as follows (Ex. 12, p. 3):

> [The victim] was sleeping in his apartment at 54, 711 Johnson Street, that is the York Hotel. At that time, the door to his apartment was locked. [The victim] woke up when he heard a noise at the door of his suite. He saw a male peeking into the room; that was the accused. He asked the accused what he was doing in his room. The accused asked, said – "I wanted to know if you took the soap from the shower last night". He then said, that is the accused said, he did not know why he broke into the room. He left the apartment. It was subsequently found that there had been damage to the lock on the door. It appeared to have been forced open. It was not a lock of high quality. Your Honour may be aware, this is a rooming house style hotel, and certainly not a deluxe suite.

It is noteworthy that, during the period of the two index offences listed above, the accused was already subject to a 3 year probation order issued by the Provincial Court on May 10, 1995 for a serious offence involving what Crown counsel described at trial as "assault and unlawful confinement", but which the Criminal Record describes as assault and "abduction of a person under 14 years of age". (We will have more to say about the events giving rise to these convictions below). The May 10, 1995 probation order included the following condition:

> You are to accept and successfully complete the Psychiatric, Psycholigcal, or Life Skills counselling and if directed you are to attend for counselling at Forensic Psychiatric Institute as directed by the Probation Officer.

On June 12, 1997, he was directed by his Probation Officer to attend at the forensic clinic. He failed to do so.

3. The Accused's illness

The accused has a lengthy history of paranoid schizophrenia. Dr. Miller's October, 1997 report to court notes that Mr. Hind, then 45, began to experience serious psychological problems shortly after completing Grade 12 and attending the University of Victoria. Since then he has had at least 18 admissions to various mental health facilities, including the Eric Martin Institute, Riverview and the Forensic Psychiatric Institute. The diagnosis has consistently been one of paranoid schizophrenia, which Dr. Miller described as a "severe disorder": Ex. 11, p. 3.

The course of his illness is illustrated in some of the earlier reports before us. Dr. Riar's 1994 report notes that he did not show signs of overt psychosis during his stay at FPI during that year for a fitness assessment. In 1995, however, was described by Dr. Dilli as being floridly psychotic when remanded for a fitness and NCRMD assessment.

The present state of his illness is decribed in Dr. Collins' most recent report, dated June 29, 1999:

> Mr. Hind continues to suffer from severe chronic symptoms of Schizophrenia. This is most evident in the area of cognitive impairment and disorganization of speech. He has essentially no insight regarding the presence of his mental disorder or the need for treatment.

4. Procedural history

Prior to the hearing before this panel, the accused had already been subject to three disposition orders by the Board since the Court's January 6, 1998 verdict.

The Review Board held its first hearing on February 16, 1998. The Board noted:

> What seems to be your pattern when you leave hospital is that you tend to become non-compliant with your medication. You say this is because you suffer extensive and strong side effects from medication. Without the medication you tend to relapse or deteriorate in your condition and get yourself in trouble….
>
> Dr. Collins reiterates your history of non-compliance and supervision failure. In his words, although we all want you to get back out into the community, he states that you pose an unacceptably high risk to the public safety if discharged, and if as can be expected you were to get off your medication.

That panel split, not on the issue of risk, but on the question whether such risk could be adequately managed absent a custody order. The majority concluded that in all the circumstances, risk could not be adequately managed in the community. At the same time, the Panel considered that a short 6 month custody order was appropriate. The hope was that the recent introduction, in the controlled custody setting, of a new medication, Olanzapine, would offer this Board a fresh opportunity to consider some form of discharge order after 6 months.

The Board held its second hearing on July 21, 1998. In advance of that hearing, the Crown provided the Board with the Information and Report to Crown pertaining to the charge of attempting to entice a girl under 14 away "with intent to deprive her parents of possession of her", contrary to s. 281 of the *Criminal Code*, which is headed "Abduction of Person under Fourteen". The Report to Crown Counsel (Ex. 17) notes that the accused approached the girl at a busy Victoria park, near a beach. She was on the swings. The report reads:

> [The child] was on the swings and was approached by a male who made conversation with her. He was telling her stories about a man in Ontario who owned a liquor store and was talking to her about liquor. He was asking questions about her dad and where she lived. He then stated "I have a real nice car. A skylark. I think we should go for a ride."
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> [The child] then said "no". He then went on to say: "I think we should go for some cigarettes if you know what I mean. I would like to taste your tobacco. You are real sweet." (overheard and witnessed by [F]). The male then tried to get closer to [the child] and witness [F] intervened by putting her arm around [the child] and stepping between suspect and victim. Suspect left.

This is a disturbing event, made more disturbing by the fact that during our panel hearing, the accused volunteered that if he received a discharge, he felt that parks and beaches would be dangerous places for him. While the accused did not elaborate under questioning about what the danger, we are extremely concerned that deeper issues of risk and temptation involving children may well arise in this case, which issues have not yet been fully explored by the Treatment Team.

The July, 1998 panel also had the benefit of Dr. Collins' opinion (Ex. 21), which noted that while there had been a gradual improvement in symptoms following the new medication, his other risk factors, considered in light of a thorough risk assessment, were significantly severe that discharging him into his desired independent living situation would place the community at undue risk:

> The possibility of Mr. Hind being discharged into an independent living situation has been considered. However, several factors indicate that a boarding home facility would be a more appropriate placement. He suffers from severe and continuous symptoms. He has few social supports in the community. He has a history of non-compliance with medication as an outpatient and currently does not believe he needs to take medication. For community placement to be successful, Mr. Hind will need adequate psychosocial support and supervision. These requirements could be provided by a boarding home environment but are unlikely to be met by independent living.

This Board's second disposition was a one year order, issued July 21, 1998. All parties, including the accused, said that a continuation of the existing order was appropriate. The Board unanimously agreed that the appropriate disposition was custody with generous provision for visit leaves to permit a gradual transition to supervised living. The Board considered but rejected the idea of an absolute discharge. Its reasons (Ex. 23, pp. 6-7) are noteworthy:

> …if he were given an absolute discharge where there is no obligation upon him to take medication, given his history of non-compliance in the past and his numerous admissions to psychiatric facilities both in Victoria and here on the mainland, the Review Board has no confidence that he would continue to take his medication. And if he went off his medication is reasonably clear, from his previous history, that he deteriorates and then becomes a threat to the public – maybe not a threat in the sense of trying to go out and beat people up, but he does things that are nevertheless dangerous and are considered by the public to be quite threatening, such as walking around shouting, waving his arms, making threatening gestures and perhaps worst of all, approaching young children who are really unprotected. We just simply do not know what would have happened if the woman had not intervened in the case that ultimately became a conviction for attempted abduction.

On the question whether a conditional discharge was appropriate, the Board held (pp. 7-8):

> He has not had the experience of getting out into the community on his own, so we have no idea at all whether he would be able to cope even to go to the corner store.
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> The Olanzapine that he is now taking seems to be making considerable improvement in his symptomatology but it is still there just underneath the surface. It is a chronic condition; it's a very difficult condition; it will take time.

> We all hope that with proper medication and reintegration into the community he will be able to live in the community in a fairly normal way. But at this stage, it would be, in our view, setting you up for failure to give you a conditional discharge order when you have not had even the opportunity to go out for a half day on your own.

The Board convened for a third time in November, 1998, only four months later, as a result of a restriction of the accused's liberties. This occurred after a visit leave to Manchester House in Victoria where staff noted signs of decompensation in August and again in September, 1998. The circumstances are described in the Board's reasons:

> As of August 11th, Mr. Hind was permitted to go to Manchester House in Victoria for what was then planned to be a one week visit leave, to assess his ability to live and remain in the community. As of August 14th, as a resut of staff at Manchester House having noticed some symptoms of decompensation in the form of hallunications, agitation and poor hygiene, he was asked to return to FPI where his medication was adjusted. Up to September 4th he was in the hospital exercising his day leave privileges. Those were stopped on September 14th, as a result of, again, an apparent heightening of his symptoms. As of October 6th, he was moved to the somewhat more restrictive environment of the Elm residence here at FPI.. He has since settled according to Dr. Collins. His symptoms, including paranoia, suspicious ideas, hygiene problems, lack of cooperation and direction, have remained at a level which is greater than was the case at the time of the planned visit leave in August. With respect to compliance, there is at least a suspicion, though inconclusive, that Mr. Hind may not be complying with his oral medication. That suspicion arises as a result of low blood level readings in terms of his medication in his bloodstream.

The November, 1998 Board confirmed its previous order. The hearing itself did not go smoothly. The accused left the hearing room during the giving of reasons.

The November, 1998 panel concluded with these comments:

> …throughout the hearing he did present himself as rambling, interruptive, inarticulate, at times unresponsive. It's clear that he harbours substantial denial or doubt about the fact that suffers from a mental illness. We do acknowledge our earlier comments in February, that indeed this gentleman's risk and the index offence that brings him here are at the low end of the spectrum vis-à-vis third parties.

5. R. v. Winko

Between the last Review Board order and this panel's hearing, the Supreme Court of Canada rendered its decision in *R. v. Winko*, *supra*.

The Court in that case confirmed in the discharge of our statutory function, Review Boards are governed by the criteria set out in s. 672.54 of the *Criminal Code.* These provisions require the Board, in making a disposition, to take into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused and then to make the least restrictive disposition in respect of the accused. Where the Board forms the opinion that the accused is not a significant threat to the safety of the public, the Board is required to grant the accused an absolute discharge.

A major insight provided by the Court in *Winko*, which represents a departure from the law as stated by the Court of Appeal, is that when the Board sits in its capacity from time to time, it must answer, in a decisive manner, the issue of significant threat. It cannot defer the question to a later date, as had previously been accepted as the most reasonable interpretation of the section by our Court of Appeal and by Justices Gonthier and L'Heureux Dube in the Supreme Court of Canada.

The need to be "decisive" having been articulated, it would be a significant error to confuse the need for decisiveness about risk with the question whether harm will certainly happen. We are doing our utmost to responsibly predict the future, and by definition, questions about future risk cannot be answered with certainty or empirical precision. If they could, these inquiries would not be about "risk". Consequently, while doubt about the question of "significant threat" entitles a person to an absolute discharge, doubt about the question whether a criminal act will certainly occur does not entitle a person to an absolute discharge. Even in the face of a finding of significant threat, there is always doubt about whether something will occur. A finding of significant threat does not demand omniscience, psychic foresight and the absence of doubt. Such a requirement would be entirely unrealistic and a serious misreading of the judgment.

As recognized by the Supreme Court of Canada, the test we have to concern ourselves with is concerned with potential dangerousness and in particular, whether the accused poses a significant threat to the safety of the public. In arriving at that conclusion, stereotypical notions that mentally ill persons are inherently dangerous must be avoided. There is no presumption that an NCRMD accused is a threat unless they prove otherwise. The Review Board's job is to make that assessment on all the facts within our inquisitorial process, with the benefit of our experience and skills, and on an individualized basis. In making our decisions, we must take into account and resist tendencies toward the over-prediction of dangerousness.

The Court in *Winko* made clear that it was not suggesting that Courts and Review Boards apply the test in a fashion that would expose the community to undue threats to its safety and well-being. To the contrary. Where the Board opines that there is a real risk to public safety, no absolute discharge can follow.

An opinion of significant threat must be based on the evidence rather than speculation. It must be significant in the sense that there must be a real risk of physical or psychological harm to individuals in the community that is serious in the sense of going beyond the merely trivial or annoying. The potential anti-social conduct of concern must be criminal in nature. There must be a forseeable and substantial risk that the accused would commit a serious criminal offence if discharged absolutely. In making these determinations, we must have regard both to the interests of individual liberty and public protection.

If the RB determines that the accused is a significant threat, it must, in choosing between custody and a conditional discharge, make the disposition least intrusive to the accused in light of the preamble factors.

6. The present hearing – evidence and decision

Together with the information before previous panels of this Board, the Panel had the benefit of new written reports from Nurse Poquiz and Dr. Collins. On the positive side, Nurse Poquiz noted improvement in Mr. Hind as compared to the condition he was in during the November, 1998 hearing. There have been no incidents of physical aggression. He attends programs and recently started day leave privileges. On the other hand, he has shown little improvement with respect to insight towards his illness and the need for treatment. He has been observed spitting out medications. He has been observed exhibiting bizarre behaviors. He informed the team that he does not want to attend the outpatient clinic when he discharged. The report states:

> With respect to community placement, Christopher prefers to return to the Victoria area. The team had attempted a trial placement at Manchester House last August but this was unsuccessful due to ongoing symptoms of his mental illness. It is the treatment team's intention to assess his suitability for Manchester House in the future but at this time he has not made significant improvement to consider placing him on the waiting list.

Dr. Collins' report adds that in February, 1999, an antipsychotic medication (Haloperidol) was added, but that "he has not been fully compliant with the medication despite the best efforts of the nursing staff to ensure that he receives it as prescribed". He states that the current treatment plan calls for ongoing institutional care until a significant further improvement in the core symptoms of Schizophrenia occurs. Dr. Collins summarizes his opinion as follows:

> Mr. Hind has a significant history of violent and antisocial behavior. There are two convictions for assault recorded in 1983 and 1995, and a conviction for Abduction of a person under 14 years of age in 1995. Mr. Hind's mental illness is a major risk factor for future violence. His illness has not responded well to treatment. In the past, his treatment has been complicated by lack of insight, poor compliance and Alcohol Abuse Disorder. Alcohol abuse is a major risk factor for violence, even in the absence of other risk factors.
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> There is no feasible community placement or discharge plan for Mr. Hind. The major obstacles to his reintegration into the community are the ongoing symptoms of Schizophrenia, poor insight and poor compliance. He would face multiple severe stressors in the community including unemployment, poverty, lack of personal support, social isolation and difficulty coping with the basic tasks of daily living.
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> In my opinion, Mr. Hind represents a significant risk to the safety of the public. If he were released into the community at this time, there is a high likelihood that he would again display antisocial or violent behavior similar to the index offence.

In the oral evidence before us, Nurse Poquiz noted that, unfortunately, the introduction of the new medication has not given rise to a dramatic difference in symptoms. He elaborated on the issue of medication compliance, including incident of the accused "cheeking", spitting or trying to vomet medication. Nurse Poquiz did not rule out using Manchester House again as a visit leave, and was liaising with Mr. Vollert in Victoria to that end. He confirmed that the accused has not been involved in an incident of physical violence since being under Review Board order since February, 1998. We take this as evidence of some success in this Board's disposition orders.

The issue of injectable medications was discussed at the hearing. We were told that the accused refuses to take them and that he has taken them in the past and still decompensated. Dr. Collins noted that he is presently taking medication "under protest". The accused stated that he feels the schizophrenia is "in remission" and reinforced that he finds it very difficult to take the medication.

The issue of the accused's previous record was also explored at the hearing. There is a 1983 conviction for assault causing bodily harm, for which the accused received a suspended sentence and 3 years probation. We asked the accused about this conviction. He could not recall the details at first, but later recalled that the incident involved an altercation at UBC.

There were two assaults in 1995. The accused said that one of assaults arose after he punched a female fast food employee (3 months pregnant) who took "aggressive steps" after he spilled his drink. The accused hit her in the face and she received a ½" cut to the face. The accused also hit a man who chased him during this incident. The other 1995 assault involved an incident on Menzies Street in Victoria and again involved a female victim.

We very much appreciate the accused's disclosure about these incidents, and we have taken into account Ms. Neilsen's emphasis on the sentences which the court imposed for those assaults. We are aware that sentencing is a product of many factors. We do not have the reasons for sentencing in any of these matters. In each case, the accused reports that he was in some fashion acting defensively, yet convictions were imposed. We think it is important to know more about these convictions. In accordance with our mandate in *Winko*, the Board makes a formal request the Crown, in advance of the next hearing, to obtain relevant details regarding these assault convictions so that they may be weighed by the Board in its assessment of risk.

The issue of the attempted abduction was also explored. The accused stated that the girl in question was 10 years old. He had seen her in the neighbourhood. He said that she was very interested in talking to him. He also said he did not have a car at the time of the offence. Later in his evidence, in another context, the accused volunteered statements, without elaboration despite questioning from the Board, that if discharged parks and beaches could be "dangerous". Earlier in the hearing, Dr. Collins had been asked about this prior offence, particularly as there has been some assertion on behalf of the accused in past hearings that this incident was not necessarily related to his illness. He stated that he did not address it in his report because he was focused on the index offences.

We are of course concerned with all relevant risk factors, and we would encourage the treatment team to explore this issue with the accused prior to our next hearing.

Consistent with the Supreme Court of Canada's direction that one ought not to draw stereotypical assumptions between mental illness and risk, the issue was raised regarding *this* accused's risk to the public if he were acutely psychotic. The evidence before us confirmed that just as it is an erronous stereotype to assume that mental illness necessarily gives rise to a significant threat of violence, it is wrong to assume that mental illness is never relevant to the risk of violence.

In this particular case, the treatment team confirmed that without medication, there is high likelihood that the accused would rapidly revert to a psychotic state and engage in assaults and threats of assaults. While it is true that the particular index offences committed, including the assault, are not at the most serious end of the spectrum, we find that any assault – as a blatant invasion of the physical

and emotional integrity of others – is a serious matter. To use the words of Justice McLachlin, the assault against the elderly couple was not a merely "trivial" or "annoying" incident. In that particular case, the accused threatened them because he perceived that they were threatening him. Because of his illness, he perceived provocation where none existed. Directed at vulnerable groups such as children or the elderly – both of which have been implicated in the events in this case - even a "minor" assault in which only threats are made, can reasonably be expected to have significant repercussions, particularly when one adds the fear factor which has been commented upon in the reports. We do not read *Winko* as being authority for proposition that, in striking the balance between the liberty of the accused and the liberty of the public, it is acceptable for members of the public, including the elderly, to be subject to a high risk of random assaults, as long as they are "at the low" end of assaults. He has shown himself as being capable of assaults causing harm when he has subjectively felt provoked. This is quite apart from the risks to children which are raised and need to be further explored by the Treatment team.

Based on the information before us we have no hesitation in concluding that based on the numerous risk factors present in this case which have been catalogued in the materials before us including the reports of Dr. Collins, that this accused would pose a significant threat to the safety of the public if he were to be discharged absolutely.

The issue then becomes whether the least intrusive disposition, consistent with public safety, is a conditional discharge order or a custody order. The evidence before us confirmed the wisdom of the decisions of the previous panels of this Board. The accused has no insight into his illness. He has minimal supports in the community. He does not want to take medication, something which he cannot be compelled to do if he receives a conditional discharge. He has no plan, other than wanting to live in the York Hotel again. He feels that all risks will be addressed if he does not drink and stays away from parks and beaches. He has a history of non-compliance with various probation orders which have been issued by the courts. The easing of liberties, even to a supervised setting last fall, was not successful.

We have concluded that it is appropriate to confirm the existing custody order. That order allows the treatment team to plan for a successful reintegration into society, one which best serves the protection of the public and the needs of the accused based upon real improvements in his condition. We agree with the Treatment Team that an order structured to provide for a gradual transition into a supported setting best meets the language and intent of the *Criminal Code*. We conclude that at present, the risks he present cannot be adequately managed with a conditional discharge order. To its credit, the Treatment Team is continuing to explore opportunities to once again test the accused at Manchester House at the earliest opportunity.

7. Conclusion

The Board confirms the accused's custody order.

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