IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended 1991, c. 43

AND

THE BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF THE DISPOSITION HEARING OF

ROBERT MITCHELL

HELD AT:	**Forensic Psychiatric Institute** **Port Coquitlam, BC.** **October 25, 1999**	
BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. J. Brink, psychiatrist**
		J. Budden-McMurdo
APPEARANCES:	**ACCUSED/PATIENT:**	**Robert Mitchell**
	COUNSEL ACCUSED/PATIENT:	
	COUNSEL DIRECTOR HOSPITAL/CLINIC:	**Dr.Wanis, M.Shieh**
	COUNSEL MINISTRY OF ATTORNEY GENERAL:	**L. Hillaby**

1.0 INTRODUCTION

On October 25 ,1996 the British Columbia Review Board (BCRB) convened a hearing at Forensic Psychiatric Institute (FPI) to review the disposition of Robert Mitchell.

The hearing was occasioned by a disposition made on May 4, 1999 which was to be reviewed within 4 months. This early hearing was deemed necessary in order to provide an early opportunity to review potential discharge plans for the accused presumably to be developed with the involvement/participation/partnership of the CLS branch of the Ministry of Children & Families [Ex. 93]. On May 4, 1999 the Ministry, the Review Board in its disposition designated the Ministry of Children and Families party to these proceedings pursuant to s.672.54(4) Criminal Code of Canada (C.C.C.): [Ex. 93]. Representatives of that Ministry attended today's hearing along with their counsel via teleconference.

2.0 BACKGROUND

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Mr. Mitchell's psycho-social and clinical history is outlined in excellent detail in Exhibit 44, the Reasons for Disposition of a hearing held on September 21, 1995:

> "Mr. Mitchell has had mental disorder since childhood. He has suffered seizures since a very early age, and in his third or fourth year was diagnosed as suffering from temporal lobe epilepsy. He still takes drugs to lessen the risk of grand mal seizures. He also suffers from an intellectual deficiency, having a borderline range of intellectual functioning, falling within the 4th percentile. In school he reached perhaps a Grade III or IV level. At age 15 he was admitted to psychiatric ward at Cranbrook because his mother had difficulty controlling him – he would fly into rages and destroy things. It is alleged that he also displayed inappropriate sexual behaviour with a four year-old girl and

> animals. (See Psychological Assessment by Kelly Reid, MA Psych, working under the supervision of Dr. Hans Veiel, October 22, 1992).
>
> The above Psychological Assessment also indicates that to that date Mr. Mitchell had had three admissions to the Forensic Psychiatric Institute ("FPI"), all for assault. In the index offence, Mr. Mitchell was found to have thrown a knife at someone in a continuous care home of which he was a resident. He was found not guilty by reason of insanity and ordered into strict custody to await the pleasure of the Lieutenant Governor. On January 28, 1993, when brought under the new mental disorder provisions, he was given a discharge subject to conditions (Exhibit 20)."

Initially following his admission to FPI Mr. Mitchell demonstrated some progress under medication, programs and counseling, including the benefit of a "one-to-one" worker to support his reintegration. In April 1994 he was transferred to reside in cottage accommodations on the Riverview hospital grounds.

Prior to his February 16, 1995 review hearing Dr. Riar indicated that:

> "Mr. Mitchell's condition was very stable. He caused no major management difficulties. He was very cooperative, polite, reactive and tolerable. His speech was good, his thinking concrete and his mood and affect appropriate (albeit a little silly sometimes). He displayed no hallucinations, delusions or suicidal or homicidal ideations. His attention and concentration were fair. His ability to judge certain social situations was poor and his insight to his situation was limited. He still remained passive aggressive and failed to accept responsibilities for his actions, tending instead to blame others. His diagnosis was
> Axis I – Organic Personality Disorder due to Epilepsy + sexually inappropriate behaviour
> Axis II - Borderline Mental Retardation
> Axis III – Epilepsy: [Ex. 27]

Dr. Riar reported that Mr. Mitchell was taking public transport unaccompanied to attend Vancouver Community College to learn about human sexuality, and this experience was also helping his socializing skills. Dr. Riar added that despite this general improvement, Mr. Mitchell still had a tendency to decompensate quickly and to regress, and he need structure, supervision and guidance in his life: [Ex. 44]."

In mid 1995 Mr. Mitchell was the object of allegations of sexual impropriety resulting in the loss of his privileges including community access. Further allegations that he had submitted a false expense claim and non-compliance with house rules at the cottages resulted in a transfer to the more restrictive environment of R2-N. Mr. Mitchell tended to blame others for these things.

A further summary of events and progress is found at Ex. 44, p.p 2-3:

> In a Progress Report dated July 27, 1995, Dr. Simon Hearn, Psychologist, wrote that it was hard to be optimistic concerning Mr. Mitchell's future ability to control prosocial behaviour in sexual and other areas for the long-term. Dr. Hearn added that he may have reached a ceiling on how much he can improve (exhibit 36). In preparation for the July 31 hearing of the Review Board, Dr. Riar wrote to Dr. D. Eaves, July 28, 1995 (exhibit 37) that since the last Review Board hearing he had not noticed any improvement in Mr. Mitchell's behaviour. "In fact", he said, "his behaviour had deteriorated at times." However, in assessing risk, Dr. Riar said that Mr. Mitchell was able to control his behaviour and act appropriately whenever properly supervised and instructed. On July 31, the Review Board extended the conditional discharge, granting a right of unescorted access to the community subject to the authority of the Director, Adult Forensic Psychiatric Services ("the Director") to set rules of supervision for such access.
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> In the middle of August three further events occurred that led once again to withdrawal of privileges. On August 13, Mr. Mitchell was sitting with his girl friend in a public area of the hospital, in front of a window, with his penis out. He was seen by a staff member who confronted him about it. At first, he denied the allegation categorically, calling the staff member an "f…..g liar", along with some racial slurs. However, his girl friend is alleged to have acknowledged that the allegation was true, and that Mr. Mitchell had indeed asked her to fellate him. Later, Mr. Mitchell is reported to have admitted to a staff member that it happened, but he refused to discuss it in a formal setting. The second incident occurred on August 14, when he persistently rang a buzzer on a hallway door, and when told that this was inappropriate conduct he became argumentative, refusing to talk it out, adding that he had "the right to remain silent". On August 16, he was reminded that use of his own cup to get ice from the ice-machine was prohibited on sanitary grounds, and he became argumentative and agitated (exhibit 41).
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> In response to his apparent disregard for the rules, the treatment team decided to place him on a strict behaviour modification program. All his privileges were withdrawn, and he was told that they would restored if his behaviour remained appropriate: (see letter of September 18, 1995, from Dr. K. Riar to Dr. D. Eaves, exhibit 42).

As of December 15, 1995 Mr. Mitchell's privileges were withheld after it was alleged that he was soliciting sexual partners for a mentally handicapped woman (his "girlfriend").

In anticipation of his June 26, 1996 hearing a significant body of new disposition information was generated.

Dr. Simon Hearn, psychologist provided an update to his earlier (1995) assessment:

> He has always generated unusual amounts of attention at FPI, for instance, has a one-to-one worker when no other patient has, and weekly sessions with a psychologist where few others have.
>
> Since 1995 the patient has transgressed behaviourally a number of times in serious ways. These incidents have entailed crossing sexual boundaries with women without consent, crossing sexual boundaries with consent but in public places, or conning staff. The team, through individual members and as a group, has explored how best to understand and ameliorate Mr. Mitchell's behaviour.
>
> What has become apparent ins that his worldview and behaviour are unvaryingly egocentric, and that asking him to understand and use abstract principles, such as taking into account the other person's point of view, will not work, because such notions are beyond his intellectual capacity and out of his character. Mr. Mitchell is an unfortunate mixture of entrenched antisocial attitudes and intellectual limitation. He lacks abstract reasoning ability, and taking another person's point of view requires that ability.
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> Mr. Mitchell's behaviour did improve notably over his initial few years at FPI, and that raised expectations. Some team members now suspect he has reaching a ceiling of capacity.
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> While the patient can parrot statements of understanding principles such as those learned from human relationships courses he took at Douglas College, such attitudes are not internalized. For him, all situations are still about naïve self-interest, and actions are defined in terms of punishment and reward.
>
> Mr. Mitchell's capacity for relationships and bonding with others is entirely limited. He was attached to Mike Best, his on-to-one worker, because Mike was a supportive and relatively undemanding companion. However, the concepts of trust, commitment, loyalty, or wanting the best for others, are not in Mr. Mitchell's repertoire. Not only do his intellectual limitations stop him from experiencing empathy, but his abusive, painful past seems to have taught him not to expect anything from anyone else

> and to look out for number one in every case. If he gives, there is an attached expectation of something in return. Among FPI patients, he is know as one of those who live by the "con code:" life in the Institute is a struggle between staff and patients; rules are to be worked around where possible; never tell, always deny; every one for himself. Mr. Mitchell has no close friends in the patient population: Ex. 50.

With what appears to have become an insightful and prescient statement, Dr. Hearn states:

> "Essentially, the Institute's 'dialogue' with Mitchell is about control and Power": [Ex. 50, p.4].

Dr. Hearn's report also indicates that Mr. Mitchell had consented to treatment with Androcur to lower his libido: [Ex. 50 p.6]. Mr. Mitchell withdrew his consent to such anti-androgen treatment May 31, 1996.

In the overview spanning 7 months Ms. Richardson, the accused's CMC stated:

> Over the last year the treatment team has attempted to accelerate his activity in the community including ten months of community college courses for the mentally handicapped. He has continued with a one-to-one worker for well over 2.5 years to assist him to understand expectations of community living and appropriate social behaviour. He has one-to-one counseling and group counseling since the summer of 1995 and is on a fairly strict behaviour modification program. Although there have been periods where Robbie's behaviour has been acceptable for periods at a time. The behaviour can just as quickly deteriorate into argumentative, defiant, egocentric behaviour. He has been involved in sexually inappropriate behaviour which may have included the fact that he charge co-patients for the services of his girlfriend: Ex. 51].

On October 1, 1996 Dr. Wanis assumed responsibility as Mr. Mitchell's assigned, supervising psychiatrist. Dr. Wanis considered Mr. Mitchell a high risk as:

> "There has not been any outstanding changes in his thinking or behaviourally pattern. He continues to show minimal insight as to what brought him into the hospital and he has a distinctive ability of displacing blame onto others. His response to medication has been minimal. Hence, overall, Mr. Mitchell presents a high risk of reoffending": Ex. 55.

During the period June 1996 to May 1997 the following incidents were documented (Ex. 56):

- August 30, 1996: bothering a female patient for 2 weeks asking for sex.
- October 7, 1996: verbal aggression toward staff; he apologized.
- November 1996: refusal to take direction from vocational supervisor.
- November 23, 1996: inappropriate behaviour on an S.E.O.
- December 2, 1996: observed with female patients' head between his knees.
- December 28, 1996: female visitor observed fondling Mr. Mitchell's genitals; accused taken to sideroom.
- January 17, 1997: verbal threats to one-to-one worker.
- January 21, 1997: observed kissing female patient

On June 23, the BCRB encouraged high level Inter-ministry discussions of Robert Mitchell's housing needs.

In September 1997 Robert Mitchell was found out-of-bounds and engaged in sexual relations with a female co-patient.

In November 1997 Mr. Mitchell's treatment team approached Ministry of Social Services to discuss a 24 hour supervised community placement. Funding for such an opportunity

was to be pursued at management levels between FPI, the Ministry of Health (MOH), and the Ministry of Children and Families (MCF).

Mr. Mitchell was introduced to staff from South Surrey residence a possible placement, but refused to visit the facility or accept his need for 24 hour supervision: Ex. 68. This facility would consider housing Mr. Mitchell at $300.00 per day: Ex. 70.

Subsequently Ministry of Children and Families rejected Mr. Mitchell for its S.P.M.H./C.L.S. mandate: Ex. 69.

On February 4, 1998 the BCRB convened a hearing to receive further evidence relevant to the inter-ministerial or "systemic" issues which posed barriers to funding an appropriately supervised out-patient program for Mr. Mitchell. The following is an excerpt of the reasons for the Board's custodial disposition:

> On November 26, 1997, the Regional Operating Officer, East Kootenay Region of the Ministry of Children and Families wrote to Mr. Westell, a social worker at FPI that Mr. Mitchell was not eligible for Ministry of Children and Families services. According to Mr. Phillips, the Ministry of Children and Families' Child Family and Community Service Policy Manual defines adults with a mental handicap as those assessed at or below and IQ of 70.
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> As Mr. Mitchell had been assessed at an IQ of 72, he was deemed ineligible for Services to Persons with Mental Handicaps (SPMH) and accordingly: "We have no ability, nor is it within our mandate, to provide the type of service and supervision that he requires…" [Exhibit 69].
>
> Mr. M. Quinn, FPI Director, attended the hearing to provide an update on the progress of negotiations with respect to service funding for Mr. Mitchell. We were told that senior management of the Ministries of Health and Children and Families had met to discuss revising the existing protocol between the Ministries in relation to funding responsibilities. Agreement in principle, has been achieved to raise the SPMH IQ limit for eligibility to 75. Pending finalization of this agreement,

the Ministry of Children and Families has approved interim funding for 3 FPI inpatients, including Mr. Mitchell, who meet the new criterion for eligibility.

However, this acceptance of responsibility for funding translates in practical terms to a commitment of only $96.00 per day. Previously submitted disposition information [Exhibits 69 & 70] indicate that appropriate programming for the accused would cost $300 per day. The question of responsibility for this shortfall remains unresolved.

We were then told that no concrete, comprehensive community based care/treatment plan for Mr. Mitchell had in fact been developed and that therefore, it was not possible to ascertain its final cost. Moreover, we were told that the resource proposed in Exhibit 70 would not be available to accommodate Mr. Mitchell until the end of February. In conclusion, we were left with the message that despite the adjournment, and although Ministry of Health's Adult Mental Health Services would be expected to contribute to Mr. Mitchell's service plan neither the services for the funds were in place on the day of the hearing.

Dr. Wanis, Mr. Mitchell's supervising psychiatrist attended to provide information with respect to the level of risk which Mr. Mitchell might pose to the safety of the public.

Dr. Wanis' opinion is that the accused would remain a high risk (80-100% likelihood of re-offending) even with 1 to 1 supervision. He believes that level of risk is unlikely to abate or respond to intervention given the organic basis for Mr. Mitchell's affliction.

He acknowledges that the accused is not now nor had he been psychotic, but rather that his overall mental condition or his diagnostic issues in combination, as well ass his "predatorial" nature render him a possible public threat.

Dr. Wanis defines "mental condition" as a broader constellation of psycho-social elements, including organic factors, than the narrow legal concept of "mental disorder".

In coming to his assessment of Mr. Mitchell's risk, Dr. Wanis cited a number of HCR 20 factors.

In summary, Dr. Wanis would be reluctant to discharge Mr. Mitchell under any service plan beyond an institutional setting.

On Mr. Mitchell's behalf, Mr. Arbogast argues that insofar as the accused's "mental condition" is deemed to be permanent/constant, the BCRB ought to place greater emphasis upon the companion elements of s.672.54. He also argues on the basis of the *Chambers* decision that despite the treatment team's pessimistic view of the accused level of "clinical" risk, the BCRB ought to focus its attention on risk of "criminal" behaviour. No evidence was rendered which would assist us in separating these two notions: [Ex. 74].

In conclusion the Board maintained the status quo:

> Under the circumstances, it appears that notwithstanding the issues of funding and despite the arrangement of a second hearing, no plan for this accused exists. Clearly, the high level of case management, coordination, assessment, service brokerage and negotiation required by the accused's unique configuration of needs, has not occurred despite the hiatus of 1 ½ months.
>
> Whether this is due to the lack of consensus amongst the treatment team or the unresolved allocation of funding responsibility is unclear and perhaps ultimately secondary.
>
> What is clear is that this accused, like any other is entitled to a full exploration of program options which have some likelihood of meeting the competing considerations dictated by Parliament under s.672.54. Failing such a fulsome exploration, the accused's current disposition is tantamount to a life sentence.
>
> In the face of the Director's strong views as to Mr. Mitchell's potential threat to public safety and in the absence of any alternative at this time, we have no choice but to continue Mr. Mitchell's custodial situation.
>
> We are however concerned that custodial dispositions do not become Mr. Mitchell's fate by default and consequently, this disposition is further review able by April 30, 1998.
>
> We trust that on or before that date, the BCRB can be provided with a clear position and plan for Mr. Mitchell's future, in lieu of the need to continue this rather wasteful pattern of having to marshall the extensive clinical, legal and BCRB resources required to conduct proceedings which result in inconclusive dispositions: Ex. 74.

On April 28, 1998 the existing order was extended for a further period of two months at the request of Mike Quinn, Director, Adult Forensic Psychiatric Services (AFPS):

> I write to report that discussions are still ongoing between the Ministries of Health and Children & Families with reference to the above patient. I have received financial support for three patients, who come within the category of MCF, and am awaiting a decision with respect to the remaining three patients, making a total of six patients.
>
> In discussions with the proprietor of the home in Surrey, they would need a minimum of 4/5 residents to 'open' the house.
>
> I will continue with discussions to hopefully bring this issue to closure, and would request that the present order be allowed to continue: Ex. 75

Clearly the Director appeared to hold out hope of establishing/achieving a suitable discharge program for Mr. Mitchell.

On May 29, 1998 a new hearing was convened resulting in a reserved decision. Following evidence and submissions the Board awarded yet another disposition of custody, essentially by "default":

> All parties agree that Mr. Mitchell does not need to reside in a hospital setting, and he could function in the community if there were available an appropriate community facility that would provide the kind of structure and supervision that he requires in order to ensure public safety. In the absence of this, the default position is a custodial disposition in a hospital: *Brockville Psychiatric Hospital v. McGillis* (Ont. C.A., Oct. 4, 1996).
>
> Like previous panels of the Review Board, the members of this panel are very concerned that the effect of the shortage of supervised community placements in British Columbia is to prevent many mentally disordered accused, like Mr. Mitchell, from being granted the least onerous and least restrictive appropriate disposition on the basis of the considerations set out in sec. 672.54. The Review Board therefore urges the ministries and agencies involved to redouble their efforts to resolve this systemic inadequacy as soon as possible. The Board is sure that development of appropriate community resources would be welcomed not only by those persons detained in FPI primarily for security reasons, but also by the administration and staff of FPI who could then concentrate more attention on those patients who really need hospital care.
>
> The Review Board also noted that unless a suitably supervised placement can be found, it is likely that Mr. Mitchell will remain in custody at FPI for the rest of his life. This is because the psychiatric assessment that he is a sexual predator, preying upon intellectually challenged females, is likely to stay with him as he is incapable of learning abstraction such as the need to respect other people's rights and feelings. The Board believes that given the extremely serious consequences of concluding that he is a high risk sexual predator, Mr. Mitchell is entitled to an independent psychiatric assessment of his level of risk, preferably by someone who is knowledgeable regarding supervised residential facilities for the mentally disordered and who carry the diagnosis of Axis I Organic personality disorder and Axis II Borderline mental retardation significant anti-social personality traits. The Board stresses that this does not indicate any lack of confidence in the expertise of Dr. Wanis, but rather a recognition of the patient's right to a second opinion. Accordingly, the Review Board has provided its disposition for another hearing to take place before November 30, 1998,

> to review Mr. Mitchell's case once again, and to receive the assessment prepared by the independent psychiatrist: Ex. 82.

A further hearing was scheduled for November 12, 1999. In the interim Mr. Mitchell's former one-to-one worker, M. Best was "encouraged to submit a written proposal" to Mr. Mitchell's treatment team regarding his capacity to provide a 24 hour supervised, structured and staffed residential environment: Ex 83.

Mr. Mitchell was offered a trial of Sertraline to decrease his sexual drive which he refused: Ex. 84.

On October 8, 1998 a female Riverview patient reported an offer of money for sex from Mr. Mitchell.

In addition an independent psychological assessment by Dr. Peter Johnson was submitted by Mr. Mitchell's counsel. Dr. Johnson's assessments provides, inter alia:

> Given that Mr. Mitchell has spent so many years living at FPI, there can be little doubt that the environment has significantly influenced his behaviour. From his point of view, it is largely an environment of mentally-ill patients, secure buildings, and a complex system of rules. Relationships with trained staff are transitory. Staff change shifts and wards, and doctors are only available for a few hours a week. Supportive friendships between patients are unusual. Clearly, the negative environment factors outweigh the positive influences in this man's life.
>
> Mr. Mitchell has been criticized for having adopted the "con" lifestyle, i.e. not trusting staff or other patients and trying to manipulate the system in order to meet his own needs. From his point of view, this appears to be a method of dealing with a hostile environment. In spite of staff's promises and their best intentions, he is still confined in FPI. He now seems to lack the level of trust of professional staff which might bring about positive changes in his status. Further lengthy confinement at FPI is unlikely to improve this man's behaviour: Ex. 87.

The Board imposed a further disposition of custody for 6 months noting Mr. Mitchell's progress.

In preparation for Mr. Mitchell's next hearing scheduled for May 4, 1999 Dr. Wanis indicated that Mr. Best's "proposal" to provide residential care would be critically reviewed contingent upon funding commitments: Ex. 89. The "Best proposal" is at Ex. 91. In April the MCF and MOH executed a protocol agreement respecting collaboration in discharge planning for developmentally disabled adults from FPI: Ex. 92. In reviewing the document at its May 4 hearing the Review Board remarked:

> "Now the Treatment Team in conjunction with MCF social worker Gordon Towers should be able t o move forward to identify a suitable placement. Mr. Quinn believes that Robert Mitchell's name is near the top of the list of those persons needing specialized placement facilities:" Ex. 93.

The Board ordered a further period of custody in the hope that either the "Best proposal" or another suitable placement would be identified by September 1999.

3.0 HEARING OF OCTOBER 25, 1999

This early hearing was convened to allow the Board to review anticipated discharge program proposals; to learn about the extent of MCF Community Living Services (CLS) participation in providing and funding services for Mr. Mitchell pursuant to the "protocol" (Ex. 92); to learn of the outcome of any visit leaves enjoyed by Mr. Mitchell since May 1999.

3.1 EVIDENCE AT HEARING

MCF staff and counsel advised the Board that:

- MCF is currently funding Mr. Mitchell's one-to-one worker at a cost of $25,000 per annum.
- Gordon Towers is the assigned CLS social worker in the East Kootenay region. He has explored both the "Best" and South Surrey proposals.
- Given Mr. Mitchell's constellation of needs and challenges a placement opportunity might be more likely to develop in the lower mainland.
- MCF does not see Forensic Services' role of safeguarding public safety as part of its mandate or expertise.

For AFPS Mr. Shieh, CMC provided an updated progress report citing occasions when the accused's behaviour has brought about suspension and reinstatement of privileges. On June 23, 1999 the accused was transferred to Elm Unit for increased supervision due to an escalation of verbally abusive and threatening behaviours directed at female staff.

On July 22, 1999 it was reported that Mr. Mitchell had threatened his one-to-one worker to the point where Dr. Wanis later told the hearing he was considering removing this benefit from his patient. Mr. Mitchell later apologized though it is difficult in the context to consider the incident described as anything amounting to a threat of violence or to imagine it inspiring fear in the recipient, although it has resulted in the loss of the accused privileges as well as having raised the potential for his transfer to the most secure unit at FPI.

Mr. Shieh summarizes his patient's behaviours over time:

> Mr. Mitchell's behaviour appears to have been escalating and deteriorating since May of this year, resulting in his transfer to Elm House and suspension of privileges.
>
> He continues to lack insight, refuses to accept responsibility for his behaviour and instead projects blame onto others. Recently, he has been more demanding, argumentative and verbally aggressive with nursing staff and his 1-1 worker, threatening to report them or speak to his lawyer when given directions or when confronted about his inappropriate behaviour: Ex. 74.

Dr. Wanis' evidence is that he continues to consider Mr. Mitchell as a high risk to re-offend and not suitable for community placement. He believes the level or risk posed by Mr. Mitchell is currently so unmanageable as to obviate even a consideration of a community program. Dr. Wanis gave as grounds for his assessment Mr. Mitchell's impulsive behaviour, his brain damage, and borderline retardation, his need for structure, his consistent historic "acting out behaviour" and lack of insight.

Dr. Wanis was not able or willing to couch his patient's risk in the context of likelihood of violence. He stated that this was not the threshold or criteria by which FPI assesses risk. Rather he interprets Mr. Mitchell's non-cooperation as indicative of his inability to function outside FPI or in a "Min-FPI" with 24 hour supervision, locked doors at night and professional and one-to-one staffing during the day.

On the other hand it is Dr. Wanis' view that his patient has essentially exhausted the benefits of the programs and services which have been provided to him at FPI.

On behalf of Mr. Mitchell the Board heard from Mr. Best who had submitted the proposal to accommodate Mr. Mitchell in the community: Ex. 91 and 97.

Despite the apparent earlier trajectory of case planning for the accused as well the evidence noted in the Reasons at Exhibit 93, the proposal remains unassessed and not responded to. No visit leaves have occurred.

DISPOSITION

Mr. Mitchell thought his counsel essentially agreed to a further short disposition of custody in the absence of an identified placement, but pleaded with the Board to remain active in Mr. Mitchell's case and requested that we direct the provision of overnight visit leaves to the "Best" home.

Notwithstanding the apparent agreement of the parties the Review Board is required to consider the available evidence and to exercise independent judgment in relation to the requirements of s.672.54 of the C.C.C.

Moreover in order to maintain its jurisdiction over the accused, the Board must be satisfied that the evidence supports the threshold conclusion or opinion that the accused poses a significant threat to the public. The significant threat under discussion is for the purposes of these proceedings defined as a foreseeable and substantial threat of serious physical or psychological harm of a criminal nature: *Winko*. By implication any lesser risk

is one which Parliament and the Supreme Court of Canada have determined to be assumable within the Canadian community; one which entitles an accused to be discharged absolutely from the criminal justice system of which FPI is an agency. With respect, Dr. Wanis' characterization of FPI's non-acceptance of a "violence model of risk assessment" is not responsive to the legal framework which governs the Review Board, these proceedings and indeed the Forensic Psychiatric System: see ***Burrell***, BCRB (October 6, 1999). Moreover given the evidentiary nature of the hearing process we are unable to take any one individual professional's opinion (however respected) as to this pivotal issue without inquiring into the objective factual and analytical basis for that opinion. It is the very essence of the NCR-Review Board framework that conclusions be justifiable or explainable by the applications of professional judgment to objective facts or observations.

Given the totality of the historical record we are able to form the opinion that Mr. Mitchell could pose a significant threat. This is conceded. He is not entitled to an absolute discharge at this time. We are then required to once again examine the evidence in light of the considerations of s. 672.54 C.C.C., and having done so, to select one of the remaining available dispositions which is the least restrictive and least onerous to the accused: ***Winko,*** Par. 62.

We have no evidence before us of recent overt physical violence or serious aggression, beyond persistent, unpleasant, inappropriate, annoying, testing even anti-social behaviour. We also know that the accused has exhausted the services of FPI to the point

where at this time much of his behaviour is likely dictated, by or reactive to his environment.

This state of affairs was foreshadowed by Dr. Hearn in 1996 at Exhibit 50 and reflected by Dr. Johnson at Ex. 87. It also emerged clearly in the course of this hearing.

It is our unanimous opinion that the level of public threat posed by Mr. Mitchell is manageable and ought to be managed in a sufficiently supervised, structured and equipped community program model. It is our belief that there are two potential settings which currently or with altogether reasonable modifications or adaptations could accommodate and manage Mr. Mitchell. We therefore propose to delay the implementation of this disposition until December 1, 1999.

We also strongly believe that it is important to attempt to reintegrate Mr. Mitchell now, before his current circumstances become the fulfillment of the potentially prophetic statement found in ex. 74 supra:

> What is clear is that this accused, like any other is entitled to a full exploration of program options which have some likelihood of meeting the competing considerations dictated by Parliament under s.672.54. Failing such a fulsome exploration, the accused's current disposition is tantamount to a life sentence.

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Bw/ss