



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

JEFF PAUL HOOVER (JPH)

**HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
September 15, 2009**

**BEFORE: CHAIRPERSON: B. Walter
MEMBERS: Dr. P. Constance, psychiatrist
 Hon. D. Clancy, QC**

**APPEARANCES: ACCUSED/PATIENT: Jeff Paul Hoover
ACCUSED/PATIENT ADVOCATE: T. Reyes
DIRECTOR AFPS: J. Co Dr. L. Meldrum
DIRECTOR'S COUNSEL: D. Lovett / A. Westmacott
ATTORNEY GENERAL: L. Hillaby**

INDEX OFFENCE

[1] On December 24, 1996, JPH was charged by Indictment with aggravated assault contrary to s.268(2) of the *Criminal Code* (CC). The allegations giving rise to the Indictment were:

- On July 28, 1996, the victim AH was traveling in her motor vehicle with her 15 month old grandchild in White Rock. She entered the driveway of her home. Another vehicle entered her driveway behind her. That vehicle then started to reverse out of the driveway but stopped halfway. The victim approached the driver who exited his vehicle and asked for directions to Richmond. The driver re-entered his vehicle and again started to reverse down the driveway. The victim reentered to her own vehicle and took her grandchild from her baby seat. Suddenly the second vehicle again pulled up behind hers.
- The driver exited and approached the victim who was holding the infant. The accused grabbed the victim who began screaming for help. A struggle ensued during which the accused dragged the victim to the ground while she continued to hold the child.
- The accused stabbed the victim, AH, in the right chest. AH also sustained finger/hand wounds during the struggle. The accused entered his vehicle and left the scene. The victim, while still holding the child, was able to memorize the vehicle's Washington plate numbers. She then called 911.
- Within about 1.5 hours, following a short pursuit by vehicle and on foot, the accused was apprehended at gunpoint. A knife was eventually located under the vehicle's driver's seat. On arrest he was found with pepper spray.
- On investigation it was discovered that the accused was an American citizen. He had entered Canada on July 22, and again on July 27, 1996.
- The report to Crown Counsel stated that the accused, though very aware of his actions, "has a definite mental disorder": Ex.7

PSYCHIATRIC EVIDENCE AT TRIAL

Dr. L. Meldrum

[2] Dr. Meldrum, provided a psychiatric assessment regarding the accused's fitness to stand trial and mental state at the time of the index offence, dated March 4, 1997: Ex.8. She also provided extensive expert testimony at the accused's trial: Ex.3, 4.

[3] The following is a summary of Dr. Meldrum's written oral evidence:

- The accused was initially detained at Surrey Pretrial Centre for about a month. When seen by mental health professionals, he displayed no signs or symptoms of "florid or active psychiatric difficulties": Ex.8. According to Dr. W. Wanis, he appeared fit to stand trial and devoid of psychotic symptoms throughout his stay at Surrey Pre-Trial. On September 14, 1996, Dr. K. Riar saw JPH and did not detect any signs of active psychiatric difficulties.
- The accused was transferred to Fraser Regional Correctional Centre ('FRCC') on October 1, 1996. He did not display any overt signs of mental illness on admission.
- By November 5, 1996 (3 months after the offence), JPH demonstrated psychiatric symptoms including disorganized thinking and bizarre, persecutory and grandiose delusions. When referred to Dr. J. Noone in mid-November, he was considered floridly psychotic and certifiable. He made two self-harm attempts by asphyxiation and slashing his wrists.
- On January 23, 1997, JPH was admitted to the Forensic Psychiatric Hospital ("FPH") for assessment. On admission JPH endorsed delusional beliefs regarding being a serial sexual killer for the CIA and being in communication with extra-terrestrials. He also disclosed a "long standing pattern of deviant sexuality, of masturbation to coercive fantasies and the use of amyl nitrate". He apparently described himself as a "sexual psychotic": Ex.8.
- On Jan 27, 1997, after his admission to FPH, Dr. Meldrum found JPH, for the most part, thought organized, though endorsing odd beliefs about his past. She suspected

a significant possibility of malingering¹, and delayed regular treatment. He appeared indifferent to the possibility of prolonged incarceration. His observed behaviour was not bizarre or unusual and did not appear to be in response to internal stimuli: Ex.8.

- Despite Dr. Meldrum's concerns, Dr. Murphy did not find the accused was overtly malingering but that he appeared to be experiencing a first break of schizophrenia of at least a year's duration. When asked directly, JPH stated he had chosen to conceal his psychotic symptoms until given the "crown of life" at FRCC. He had come to believe he had been touched by God: Ex.3, pg.32.
- Dr. Meldrum elicited disclosures that in May/June 1996, the accused began to endorse delusional beliefs and ideas of reference, including beliefs via covert messages to murder women that, "he was being conditioned by the CIA to become a serial sexual killer": Ex.8, pg.6.
- JPH's account of the index offence does not differ markedly from the facts found by the Court (Ex.5). He disclosed his intent to "drag her (victim) into the house and rape her and kill her". He also disclosed that shortly after the attack, and before his apprehension, he had attempted to lure another woman into his vehicle: Ex.8, pg.6.
- On February 26, 1997, JPH was initiated on anti-psychotic medication and he responded briskly.
- Psychological testing for the presence of personality issues revealed no clear evidence of psychosis or of malingering. JPH's peculiarities were suggestive of a "schizotypal or schizoid personality disorder"², based on his historic social ineptness,

¹ The intentional production of false or grossly exaggerated physical or psychological *symptoms* motivated by external incentives such as avoiding onerous duties, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. There is often marked discrepancy between the person's claimed disability and objective findings. The person may be uncooperative during the diagnostic evaluation or fail to comply with the prescribed treatment (American Psychiatric Glossary, 7th ed., American Psychiatric Press, Washington, DC (1994)).

² **301.20 Schizoid Personality Disorder**

- A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
- (1) neither desires nor enjoys close relationships, including being part of a family
 - (2) almost always chooses solitary activities
 - (3) has little, if any, interest in having sexual experiences with another person
 - (4) takes pleasure in few, if any, activities
 - (5) lacks close friends or confidants other than first-degree relatives
 - (6) appears indifferent to the praise or criticism of others
 - (7) shows emotional coldness, detachment, or flattened affectivity
- B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.

301.22 Schizotypal Personality Disorder

- A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- (1) ideas of reference (excluding delusions of reference)

emotional aloofness, detachment, and odd or eccentric presentation: Ex.3, pg.22. At no time was JPH considered unfit to stand trial.

- Dr. Meldrum's assessment was not conclusive or definitive with respect to JPH's eligibility for a verdict of Not Criminally Responsible on Account of Mental Disorder ("NCRMD"): see also Ex.3, pg.2, line 33. His delusions and hallucinations were not entirely typical of schizophrenia. Yet she ultimately concluded that JPH was not faking his symptoms and that he was suffering from schizophrenia: Ex.3, pgs.9,30; see also Ex.3, pgs.45,46.
- In her testimony to the Court, Dr. Meldrum also identified a possible diagnosis of paraphilia or sexual deviancy since adolescence (Ex.3, pg.23), as reported by the accused, (although this diagnosis would require a more in-depth assessment): Ex.3, pg.42. This aspect of his diagnosis arose from the accused apparently drawing pictures of women being stabbed, according to JPH and a "former girlfriend". JPH also reported a "troubled" sexuality since 1992, including compulsive masturbation in response to violent fantasies and the use of violent pornography for the purpose of sexual arousal: Ex.3, pg.24. He disclosed trolling neighbourhoods looking for women to abduct.
- Dr. Meldrum ultimately concluded the accused was in a first episode of schizophrenia with onset around spring 1996.

Dr. J. Noone

[4] The Crown tendered a second forensic psychiatric, expert, Dr. J. Noone, at the accused's trial. Dr. Noone saw JPH at FRCC and at FPH on ten occasions in all, between November 21, 1996, and May 22, 1997. By November 5, 1996, he readily concluded that JPH was floridly psychotic, delusional, disorganized, and likely suffering from schizophrenia. Dr.

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- (2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
 - (3) unusual perceptual experiences, including bodily illusions
 - (4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
 - (5) suspiciousness or paranoid ideation
 - (6) inappropriate or constricted affect
 - (7) behavior or appearance that is odd, eccentric, or peculiar
 - (8) lack of close friends or confidants other than first-degree relatives
 - (9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

Noone tried to persuade JPH to take medication but the accused declined. JPH told Dr. Noone he believed his psychotic symptoms (ideas of reference) started around March 1996. As to his first presence in Canada, JPH confirmed his belief that he was being programmed and had been driving around Vancouver with the intention to kill a prostitute. He also indicated he had actually engaged a prostitute and received oral sex in his car: Ex.3, pg.57. JPH's account of the index offence was, in Dr. Noone's opinion, consistent with a florid psychotic illness: Ex.3, pg.58.

[5] In January 1997, JPH was remanded to FPH for assessment and treatment. When Dr. Noone next met him on May 9, 1997, he had been treated and was much improved clinically. He was no longer floridly psychotic. He also appeared to have gained some insight into his illness. JPH appeared to accept Dr. Noone's opinion that he had been floridly psychotic at the time of the index offence. Dr. Noone agreed that JPH suffered "some degree of schizoid personality": Ex.3, pg.64.

[6] Dr. Noone was more inclined to opine that JPH's sexually deviant interests, though of concern, were rooted in, or products of, his psychotic illness: Ex.3, pg.66.

VERDICT

[7] In concluding that the accused should be found NCRMD, the Court found, inter alia, that JPH's psychosis was related to his descriptions of violent pornography, not an independent sexual deviancy (Ex.5, pg.19), and that there "did not seem to be a pattern per se of observable deviant sexual behaviour in his background": Ex.5, pg.22. The Court did not accept Dr. Meldrum's explanation regarding the role of the accused's sexual deviancy as persuasive:

(American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000)

"I do not find Dr. Meldrum's explanation of (sic) possible reinterpretation of the act through the lens of current psychosis to be persuasive on a consideration of all the evidence": Ex.5, pg.26, per Mackenzie, J.

[8] On May 29, 1997, following two days of trial proceedings, the SCBC accepted the facts alleged and on the basis of the expert psychiatric evidence imposed a verdict of NCRMD on the charge of aggravated assault: Ex.5. The Court committed JPH to FPH, with further disposition deferred to the British Columbia Review Board (BCRB).

JPH'S PERSONAL HISTORY

[9] JPH was adopted as an infant. His adoptive parents separated when he was 12 years of age. He was considered temperamentally difficult, not socially adept and somewhat isolative and oppositional. He apparently had few long-term relationships including with women. Though considered "eccentric" he was not inattentive, hyperactive or impulsive. After his parents separated, JPH initially lived with his mother and then moved in with his father and stepmother.

[10] As an adolescent, his "impaired" social skills persisted along with some behavioural issues at school. He demonstrated, and devoted himself excessively to his extraordinary musical talents. His academic performance was below his assessed intellectual abilities.

[11] Despite labeling him as socially isolative, Dr. Meldrum later reported that he socialized and partied with a wide circle of associates, including excessive but not extraordinary drug and alcohol use.

[12] JPH disclosed to Dr. Meldrum, sexual arousal from violent fantasies involving women since adolescence, including drawing pictures of women being stabbed, which was discovered and for which he was disciplined by his father.

[13] By age 18, JPH, unemployed and no longer in school, enrolled in the US armed forces. JPH disclosed a "wild" sexual relationship (Julie), including use of amyl nitrate, while

stationed in Germany. The referenced “wild” sexual practices are not elaborated. There is no evidence that they involved violence or were anything but consensual.

[14] Once discharged JPH returned to the Seattle area. He focused on his musical pursuits. For a time, he served as a live-in caregiver for a female Alzheimer’s patient. Following her death, JPH’s employment was terminated. A physical confrontation with his employer (pushing) resulted in an assault conviction.

[15] JPH worked as an occasional music teacher and performer. He remained socially isolated. He continued to use nitrates for sexual arousal and he would at times masturbate “compulsively” in response to violent fantasies and while viewing violent pornography:

“[...] he recognized since 1992, that his sexuality was “troubled”. Mr. Hoover reports that from 1992, to the present he has at times “trolled” neighbourhoods, driving around looking for possible women to abduct. Mr. Hoover, however, states he never acted on these fantasies or the impulses until the time of his current index offence. Mr. Hoover denies any other forms of deviant sexual arousal such as fetishism, voyeurism, or any other paraphilias.”: Ex.8.

[16] Beyond seeing a counselor in his teens regarding some “family issues”, JPH’s first contact with mental health services was during his admission to Surrey Pretrial Centre after his arrest.

JPH’S PROGRESS AT FPH AND HISTORY OF BCRB PROCEEDINGS

[17] JPH was admitted to FPH on June 16, 1997, where he remains detained to date.

[18] JPH settled at FPH without behavioural problems. Except as noted below, he was, and continues to be, treatment compliant.

[19] Soon after his admission, JPH denied ongoing delusions or hallucinations, though he continued to consider whether his experiences were religious in origin. He embraced Christianity. He denied violent sexual fantasies. Dr. Meldrum believed JPH’s sexual interests required further exploration. Plans were made to have JPH psychologically assessed by a Dr.

Atkinson, an expert in sexual deviance: Ex.13. Dr. Meldrum assigned diagnoses of schizophrenia, substance abuse and schizoid and schizotypal personality traits: fn 2, supra. She considered him a significant risk of sexual violence. She was from the very outset suspicious that JPH was “covering” his symptoms. She considered his insight uncertain.

[20] At his first appearance before the BCRB, on July 23, 1997, on the basis of ongoing diagnostic uncertainties; the accused’s own admission of violent sexual fantasies and interests over several years; his ongoing delusions and his evident lack of insight, JPH was detained.

[21] During his first year at FPH, the accused remained generally appropriate. Significantly, he acknowledged or disclosed he had not been consuming his administered medications in part due to genuine side effects. This naturally heightened concerns about the accused’s candour with his treatment team. His medication was changed to Risperidone. According to his serum prolactin levels, his compliance was thereafter confirmed.

[22] JPH was labeled bright and articulate but “manipulative”. His personal beliefs about his illness remained unclear. His willingness for treatment and compliance were termed “self-serving”.

[23] On September 23, 1997, JPH was ordered deported: Ex.16.

[24] In February 1998, JPH was assessed psychologically with respect to personality issues and possible paraphilias. His score for psychopathy was low. No anti-social personality disorder was diagnosed. He admitted “addiction” to amyl nitrate and disclosed his sexual arousal, exclusively in response to violent pornography, satisfying the criteria for a diagnosis of “sexual sadism³”:

³ 302.84 Sexual Sadism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviours, involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.
B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty (American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000)

“On the basis of both interview and file information Mr. Hoover does meet criteria for Sexual Sadism. He has a long history of recurrent, intense, sexually arousing fantasies and sexual urges involving the real suffering of victims, and this suffering has been sexually exciting to him. There is evidence that these fantasies and urges have caused impairment in Mr. Hoover’s intimate relationships, and this paraphilia appears to have slowly evolved from fantasy into behaviour. This “pathway” would have such road markers as “angry attraction” to a same-age adolescent female, escalating interest in violent pornography, some use of bondage with a steady adult partner, actively looking for victims to sexually assault and kill, and the index offence, According to DSM-IV, sexual sadism tends to be lifelong and chronic, exacerbated by high levels of stress and co-occurring mental disorders, or an increased opportunity to engage in paraphilia. The symptoms of this disorder apparently did not occur exclusively during the course of Schizophrenic illness, the pattern of masturbating to violent pornography often appeared to be Mr. Hoover’s preferred or obligatory pattern of sexual behaviour, and this sexual behaviour was recurrent.”: Ex.17.

[25] This report considered JPH a “low risk of sexually motivated physical aggression” in high security at FPH. It, however, added the caveat that his risk for recidivism would be high if he were “unsupervised in a less restrictive environment for a prolonged period of time”: Ex.17, pg.10, repeated at Ex.36, pg.3.

[26] The assessment recommended individual therapy, a penile plethysmograph (“PPG”), to determine more specifically his arousal pattern, and consideration for sex offender programming at the Regional Treatment Centre (“RTC”) (Matsqui).

[27] At his next BCRB hearing (July 6, 1998), the accused appeared compliant and non-psychotic. He agreed to a transfer to RTC to attend treatment. Once again he was detained.

[28] On August 4, 1998, JPH was transferred to RTC to attend the Intensive Treatment Program for Sexual Offenders (“ITPSO”).

[29] On December 3, 1998, JPH was returned to FPH at his and the ITPSO program’s request. His participation/attendance had recently declined and he had deteriorated mentally. JPH blamed insomnia. He became more overtly ill once back at FPH. He disclosed a suicidal plan as well as an earlier suicide attempt at FPH. He disclosed intermittent communications from God (since his admission to FPH), including messages to hurt others. He indicated his

symptoms had exacerbated in the intense treatment environment of RTC. His Risperidone was increased and augmented. He was back at his baseline of mental stability within a few weeks.

[30] In March 1999, JPH again became more overtly thought disordered and delusional. Due to medication side effects, a trial of Olanzapine was initiated, with a partial response. He continued to attribute his symptoms to religious experience. Dr. Meldrum believed the accused remained psychotic but that he was choosing not to reveal his symptoms, citing a “long history of withholding”. She acknowledged he had become more disclosive recently.

[31] His sexual disorder diagnosis was not a primary focus of treatment.

[32] He was given no access to the community,

[33] A future referral back to RTC remained under consideration.

[34] At his June 21, 1999, hearing JPH appeared to acknowledge his illness and he freely disclosed his past delusional fantasies. Under questioning he admitted at least monthly thoughts of a sexually sadistic nature, which he felt he could control or “squash”.

[35] On June 25, 1999, JPH was started on Clozapine, the dosage of which was slowly increased over time. Again he responded only partially: Ex.23. Throughout the rest of 1999 and the first half of 2000, he continued to disclose auditory and visual symptoms and delusions regarding his communications with and from God. For example, he explained growing a beard and longer hair in response to instructions from God. His negative symptoms decreased. He appeared less isolative and more active and communicative. He agreed he had a mental disorder but did not consider his religious experiences as symptoms thereof, although he agreed they were not normal. At this point there was no evidence of anti-social content in his directions from God. He denied any direction to hurt others.

[36] In January of 2000, he disclosed masturbating every 2 days to coercive fantasies, not involving weapons, in the context of his ongoing psychosis: Ex.23. He began to express a desire for more opportunities including outings. He remained on (secure) A-4 ward.

[37] Dr. Meldrum decided to explore anti-androgen medication and individual psychotherapy.

[38] JPH had applied for a driver's license "several years ago". Because Dr. Meldrum and the treatment team were of the opinion that this was an elopement risk they did not contemplate JP be allowed community access. The accused evidently agreed with this interpretation at his June 13, 2000, hearing. Dr. Meldrum also testified that she believed a disposition condition allowing community access, even in the discretion of the Director, would have negative impact on the developing therapeutic relationship between JPH and his treatment team: Ex.24. Considering JPH's consistent cooperation and agreement with his team, and given the routine nature of this sort of delegation of discretion from the Review Board to the Director, her reasoning in that respect is difficult for us to understand.

[39] Following his June 2000 hearing, JPH was considered disclosive and forthcoming of his (less frequent) coercive fantasies involving females known to him as well as strangers. Eventually he consistently denied deviant fantasies.

[40] He continued to endorse delusions and hallucinations and ideas of reference, including suggestions from God. He disclosed "crappy little voices" ("clv's") which he attributed to his schizophrenia. He participated in psychotherapy and drug and alcohol counseling. His treatment relationships, though still considered "superficial", continued to improve. His schizophrenia was labeled "treatment resistant". His paraphilia remained untreated.

[41] On the basis of her estimation of JPH's risk, Dr. Meldrum continued to resist the possibility of even escorted access to the community. Despite her reservations, the BCRB

included a condition delegating the possibility of non-mandatory escorted outings in its June 12, 2001, Disposition: Ex.27.

[42] In the summer of 2001, JPH disclosed a resumption of coercive fantasies, including scenaria involving “forced oral sex and camcorders and the use of “sharps” or knives”: Ex.28. He expressed interest in anti-androgen medication. In September 2001, he was initiated on sertraline, to dampen his libido, with mixed results.

[43] JPH’s psychotic symptoms in the form of delusions and hallucinations were more frequent and intensive. His so-called “command hallucinations” from God influenced his behaviour but they contained no anti-social content.

[44] A concerning incident involving the Internet was documented in September, 2001:

“We became aware that he had attempted to find the location of a woman named Heather Jones. Jeff believed Heather Jones’ spirit was visiting him at night and communicating with him. Jeff became convinced that this spirit was in fact the spirit of a girl he had known in highschool. He stated that she had informed him during her spirit visit of where she lived and the fact that she was married. Jeff became delusionally convinced that she was going to be his wife in the future. He stated he sought her name on the Internet in order to prove to us that in fact his experiences were from God and not delusional, as well as to facilitate his contact with her. Jeff did immediately provide to the team a letter he had written to Ms. Jones, and to our knowledge had had no actual contact with her. The treatment team had a lengthy discussion about the need to contact this woman with respect to Jeff, and decided that as she could be a potential victim in the future should Jeff go U.A., she should be placed on our contact list and therefore warned. However, when we contacted her, it turned out that Jeff’s information had been wrong and no such person existed at the address he provided. Since that point in time, Jeff’s Internet privileges have been closely supervised.”: Ex.28.

[45] JPH’s medication regime was augmented with some reduction in the frequency of his messages from God.

[46] In November, 2001, JPH was allowed an outing for his birthday, in the company of his parents, which went well. He was also permitted an outing with his mother along with staff escort in May, 2002. JPH continued to attend psychotherapy and to see the FPH pastor. He also participated in other offered programs.

[47] In Reasons for Disposition dated May 13, 2002, the BCRB noted the absence of any actual elopement attempts throughout JPH’s admission. In ordering a further period of

detention, the Board delegated to the Director the discretion to permit JPH unescorted access to the community: Ex.30.

[48] Despite maximum dosages of Clozapine, JPH's delusions and hallucinations including "clv's" continued. He continued to adhere to the belief that his religious experiences were reality based.

[49] As a result of his co-operation with an individualized behavioural modification program ("bmp"), JPH began to demonstrate further improvement in social skills and "earned" regular escorted community outings with no negative effects or reported problems.

[50] JPH's self-reports (2002/2003) with respect to the content of his sexual fantasies varied. He disclosed that at times 80% of them involved coercion (but no weapons); at other times he reported minimal to no such content. More specifically, chart recordings, with respect to this central issue, state:

"Jeff did report having increased preoccupation with bondage fantasy '...' "

but

"he did state the fantasies weren't violent but he was aroused sexually by fantasies of having complete control over a woman for long periods of time": Ex.32

[51] Dr. Meldrum opined that JPH's sexual sadism disorder had "failed to adequately respond to treatment". She decided to seek a second opinion on the possibility of introducing an alternative anti-androgen medication: Ex.31.

[52] Health concerns relating to JPH's escalating weight were noted.

[53] JPH continued to endorse his special relationship with God.

[54] Dr. Meldrum concluded that aggressive treatment with Clozapine had failed to achieve significant response. In June 2003, JPH was initiated on Risperidone with partial

effectiveness in reducing the frequency and intensity of his frank auditory and visual hallucinations and his negative symptoms.

[55] Shortly after JPH's April 2003 BCRB hearing (Ex.34), Dr. Meldrum obtained a second opinion assessment from Dr. K. Riar. His report is dated June 6, 2003. In summary Dr. Riar reported that:

- JPH disclosed his sexual development since puberty, including fantasies about his teacher, older girls and his mother (and stepmother) and use of pornography. He denied violent or rape/torture fantasies. He admitted trying cross-dressing at age 25 and frequenting an establishment to watch naked ladies simulating sex. He also mentioned using amyl nitrate to enhance sexual effect.
- JPH disclosed drawing pictures of rape and brutality at age 14 or 15; he used a magazine of naked women with faces indicating fear or being attacked. A girlfriend introduced him to bondage and they used handcuffs in their 1.5 year relationship to within a year prior to the index offence.
- In terms of sexual history, JPH acknowledged less than 10 sexual partners and that at times he thought about rape during sex to arouse himself. He denied any past sexual assault or rape or being violent or assaultive towards partners. He expressed a need for help with his sexual difficulties.
- JPH admitted coming to Canada twice to look for victims and admitted the intent to perform sexual "stuff" on his victim.
- JPH reported having a lot of rape fantasies in the past and he felt that rape was a "kind of natural form of sex for him". He claimed there was never any "correlation between violence and sex in his mind" but "back then" he enjoyed "violent rape and used to become sexually aroused with these thoughts". These fantasies were present around the index offence, but as a result of his spiritual experiences at Surrey Pre-trial, he had a change of heart; that "after being raped a woman's life is changed and ruined, so he stopped thinking about it". Though he admitted relapses to violent fantasies he said he was able to take a lot more control of them.

- JPH disclosed masturbating 4-6 times a week, including fantasies of bondage (tying up) and “full” control over and obedience from his partner, which enhances his sexual experience.
- JPH reported ongoing fantasies of giving piano lessons to a 15 year old and taking her into the woods and having sex with her by forcing himself on her. He would not do anything brutal beyond vaginal sex and denied use of rope or other violent fantasies.
- On interview he was not actively psychotic, angry or hostile, and displayed reasonable insight into his mental disorder and sexual difficulties.
- JPH admitted that for 24 hours prior to the index offence he was looking for a victim for sexual purposes: Ex.35.

[56] Dr. Riar concluded:

“In summary, with Mr. Hoover who (sic), in addition to suffering from a major psychiatric disorder also suffers from what I believe to be a sexually deviant disorder in the form of sadism. He clearly has a longstanding history of violent and brutal rape fantasies since his preteen years, and these fantasies have fluctuated in frequency and intensity. To my understanding, besides the index offence, he has not engaged in any violent or sadistic sexual acts towards any other stranger. There were times when he was into bondage with his girlfriend and has used his violent sexual fantasies in an obligatory fashion when engaging in sexual activities with his partners. In spite of his serious paraphilia, he did not seek help from anywhere and, presently, he is thinking about doing something about it.

In my opinion, the combination of two very serious disorders place Mr. Hoover at great danger and risk for engaging in similar activities in the future. I believe that, whenever he is actively psychotic, his deviant sexual fantasies become incorporated into his psychotic thinking, making him extremely vulnerable and dangerous, as he may act on it. Even if his fantasies do not get incorporated into his psychotic thinking, in a psychotic state he has poor judgment and very little control of his volition, again putting him at high risk for engaging in potentially violent behaviours and situations. Even if his psychosis is under control, he continues to harbour rape fantasies, even today. Mr. Hoover actively masturbates to similar fantasies. I believe that, even in the absence of active psychosis he is at risk of acting on his fantasies after finding a suitable victim if he is living in the community”: Ex.35

[57] In his blunt assessment, Dr. Riar clearly considered the accused a high risk of offending not only while actively psychotic but even while not psychotic, when he might choose to act on his long-standing fantasies.

[58] Dr. Riar recommended treatment for JPH’s sexual disorder including psychotherapy and anti-androgen medication to reduce his sex drive and fantasies. JPH was started on the

anti-androgen Lupron in July/August 2003 with an overall decrease in his libido and sexual ability.

[59] In furtherance of Dr. Riar's recommendations, Dr. Meldrum referred JPH for further psychological assessment "to assess his suitability for short-term psychotherapy aimed at preparing him for more intensive sex offender programming": Ex.36. The assessors report, as signs of positive progress, fewer hallucinations and delusions, possibly representing a good response to medications. They indicate JPH should be given credit for his abstinence from drugs and alcohol at FPH.

[60] The report confirms the accused's initiation on Lupron in August 2003 with consistent reports of significantly reduced libido and sexual fantasies. JPH reported his fantasies had become non-violent over time, though still focusing on power and control. He claimed to be in control of his fantasy life. He denied any sexual fantasies or masturbation in three months. Despite the Lupron, however, he acknowledged periodic, short, and intense, but controllable, physical sexual urges. He ultimately acknowledged that issues surrounding his sexuality would likely be an ongoing problem. The report also notes JPH's limited benefit from psychotherapy with Dr. Hanley in 2001-2002.

[61] On interview, JPH demonstrated (inconsistently) some ongoing delusional content but no active hallucinations. His response style continued to reflect a tendency to use jargon, to intellectualize, and to "impression management". He presented as having little insight into the depth and range of his mental health problems: Ex.36.

[62] Exercises imposed during assessment interviews by Drs. Hervé and Jack, demonstrated:

"[...] Mr. Hoover was also asked about the pros and cons of masturbation (vs. no masturbation) and fantasizing (vs. no fantasizing). These exercises demonstrated, among other things, that, despite his voiced desire to control his sexual deviancy, Mr. Hoover nevertheless admittedly prefers deviant/illegal sexual practices to socially sanctioned ones in that he needs the victim's fear to feel true power and control. These

exercises also demonstrated that he continues to find it difficult to openly discuss sexual topics, has limited insight in the motivation underlying his sexual deviancy, takes an all-or-nothing approach to his sexual deviancy (e.g., complete abstinence vs. full relapse), and places a great deal of weight on his religious beliefs/messages from God for control of his sexual deviancy": Ex.36, pg.7.

[63] The report concludes:

"Given his level of insight and reported treatment motivation, Mr. Hoover impressed as being at a 'Precontemplative' level of change regarding his sexual deviancy; although he understands that he is prone to sexual deviancy, he does not necessarily appreciate the need to explore the roots of his deviancy in therapy given his belief that it is adequately controlled by his religious convictions and, to a lesser degree, medication. This, in combination with the following treatment counter-indicators, suggested a 'Poor' treatment prognosis: Lack of insight into positive symptoms of schizophrenia, personality disorder characterized by a sense of privilege and entitlement, a defensive response style that makes it difficult for him to focus on topics of importance in therapy, a tendency to intellectualize conversations that functionally results in avoidance of affective connotation, manipulative behaviour (e.g., underreporting for positive gain), and resistance to homework, alternate explanations, and confrontations": Ex.36, pg.8.

[64] It recommended that JPH be considered for a further referral to an intensive sex offender program for mentally ill offenders, such as that offered at RTC.

[65] For JPH's March 2004 BCRB hearing, Dr. Meldrum reported that with the addition of Risperidone in June 2003, the accused had demonstrated a reduction in the frequency and intensity of visual and auditory symptoms and ideas of reference. His clv's reportedly reduced. He denied any behavioural response to voices or commands from God, though he continued to exclude these religious experiences from his understanding of his schizophrenia. After seven years he remained on the secure A-4 ward, despite increased socialization and having become less isolative. He participated in Occupational Therapy and Community Living Skills programs. JPH was becoming noticeably obese with a risk of developing cardiac problems: Ex.37.

[66] Psychologists Hervé and Viljoen provided a treatment summary in April 2004 (submitted to BCRB Feb 25/05, Ex.40), documenting JPH's progress over eight sessions of psychotherapy between January and March 2004, and which contextualizes exhibit 36, discussed above at paras.60-66. In contrast to previous assessments, the report included positive findings with regard to his progress, including that:

- JPH impressed as genuinely motivated and had made significant and clinically relevant gains;
- His motivation to complete inter-session assignments, though initially low, quickly improved and stabilized;
- He was able to generalize what he learned to new topics;
- Beyond a few occasions, there was little objective evidence of manipulative behaviour on JPH's part;
- He gained insight into his interpersonal style and behaviours;
- He showed a moderate increase in insight into his mental health. Importantly, the report characterized JPH's religious delusions as "protective" factors, providing better personal control during periods of stress or anxiety, including over both sexual and non-sexual impulses.
- Therapy helped JPH understand the importance of establishing an internal rather than external "focus of control" and its impact on self-esteem/confidence; it appeared he might be willing to reconsider the nature of his spirituality;
- His insight into his sexual deviancy increased, through logging his triggers and the consequences and context of his fantasies;
- He showed less insight into how to control his interests without God or Lupron;
- Importantly, by the end of treatment JPH appeared significantly motivated to participate further in sex offender programming; he had progressed from a pre-contemplative to a "contemplative" state of treatment readiness with respect to paraphilia:

"By the end of treatment, however, he impressed as being at a "Contemplative" state of change; he acknowledged ongoing problems associated with his sexual deviancy, that – over the long-term – he needs to take more control over his behaviour (as opposed to relinquishing control to "spirits" and/or medication), and the need/usefulness of psychotherapy. Moreover he impressed as being on the verge of being at an "Active" state of change; although motivated for psychotherapy, he continued to harbour some fears regarding returning to RTC. In other words, he would likely be at an "Active" state of change should an alternate treatment program be available. Indeed, Mr. Hoover regularly inquired about other programs, even suggesting that FPH develop a program of its own. Given his treatment motivation and positive treatment outcome, Mr. Hoover's treatment prognosis impressed as "Guarded-to-Good" over the long-run. Nevertheless, it is important to note that he will likely require several bouts of sex offender therapy to affect any reduction in his risk level (see Psychological Assessment Report by Drs. H. Hervé and L. Jack, dated 06/01/2004).

Treatment Outcome. *Mr. Hoover made significant and clinically relevant gains in each targeted area (see above). While susceptible to regressing when experiencing external stressors, empathically helping him process his stress within a motivational framework proved quite effective in recuperating previous therapeutic gains. He responded well to (and admittedly very much enjoyed) the structured therapeutic approach. Similarly, he easily grasped the Cognitive-Behavioural Model and, more importantly, demonstrated – with time - a tendency to implement this model as a problem solving tool (even though this was not a major focus of therapy). Motivational techniques and psychoeducation proved quite effective in achieving therapeutic goals (e.g., limiting counter-therapeutic behaviour; increasing insight). He also responded well (both interpersonally and behaviourally) to positive reinforcement of good behaviour and to challenges/confrontations of counter-therapeutic behaviour.*

Despite Mr. Hoover's positive treatment outcome, he would nevertheless benefit from further treatment targeting his sexual deviancy, difficulty coping with interpersonal confrontations (especially those initiated by (sic) peers), and problems with identifying, labeling, and processing affect. It is important to note that therapy had no impact on Mr. Hoover's sex offender risk factors and/or risk levels, as these issues were not the focus of treatment. Consequently, it is our opinion that Mr. Hoover appeared in need of and prepared for participation in an SOP. The major challenge remaining is getting Mr. Hoover to agree (should it be necessary) to transfer to the RTC for treatment. Motivational techniques, psychoeducation, and support from his Treatment Team, as well as family involvement, are likely to be most useful in achieving this goal." Ex. 40

[67] In May 2004, JPH agreed to a further referral to RTC. After meeting with program staff in September 2004 he reported an increase in psychotic symptoms, including ideas of reference. Unfortunately by the end of October, he was once again declining to consider a transfer to RTC as he was not ready to "face" his sexuality.

[68] His fantasies continued to fluctuate with the timing or periodicity of his Lupron injections. Some incipient side effects including gynecomastia were identified. He remained obese and continued to exercise community outings with family and staff escort.

[69] At his annual BCRB hearing on March 14, 2005, JPH indicated he would be willing to attend RTC.

[70] JPH attended RTC's North Star Program for nine months, from March 31, 2005, to December 6, 2005. A comprehensive Progress Report is filed at Ex.44 of the evidence.

[71] The program is organized and conducted in three trimesters. The first trimester focused on sexual deviance and disclosure, anger management and communication skills. The second trimester focused on sexual deviancy, crime cycle, anger management and

relationship skills. The third trimester consisted of sexual deviance and relapse prevention, feelings, and thinking errors.

[72] The accused completed all offered modules. In individual sessions he was seen as refreshingly disclosive and candid about his history. He did not show misogynistic rage associated with a serial killer. Again his ideas are clearly linked to his psychotic illness.

[73] His previously identified tendency to intellectualize did not reach a point where it sabotaged his program performance.

[74] This report also identified the accused's emerging "institutionalization" insofar as "all major decisions and care are provided for him" in contrast to Dr. O'Shaughnessy's and Dr. Meldrum's opinions referred to later.

[75] His overall participation and performance in the North Star Program were termed "excellent". Furthermore, he served as a positive influence on peers in group settings and on his living unit. His schizophrenia seemed manageable for him. Interestingly, he appeared much more childlike in the presence of his FPH treatment team.

[76] Given ongoing fond reflections of past alcohol use, JPH indicated he would like to attend a drug and alcohol program back at FPH.

[77] JPH's gains from his attendance at North Star program were not a focus of discussion or analysis in Dr. Meldrum's report submitted for JPH's February 2006 BCRB hearing: Ex.45.

[78] In its February 8, 2006, Reasons for Disposition, the BCRB noted that despite nine years of compliance, abstinence and positive behaviour, Dr. Meldrum's opinion of JPH's risk remained essentially "unaltered or unabated": Ex.46, par.10. Despite the absence of any tangible evidence, she continued to characterize him as an elopement risk.

[79] While the Board did not relax JPH's disposition, it saw fit to comment:

“We do think it timely to mention that in our view Mr. Hoover has now demonstrated almost a decade of compliance with treatment recommendations while remaining abstinent and non-violent. He has acceded to, accepted or complied with each and every treatment recommendation that has been made. He has extended himself in terms of agreeing to a transfer to a corrections setting in order to access, and where he has reportedly done quite well in, a variety of intensive programs. In our view it is time for the treatment team to acknowledge that his manifest compliance with treatment, the learning which has been provided and which he has undergone as a result of his program participation, and of course the risk reduction aspects of the administration of Lupron, all need to be taken into account in acknowledging that overall this man’s risk must by now have abated to some extent.(Sic) We therefore believe that while Mr. Hoover is continuing to accept the treatment recommendations of his team, and while he remains in this secure setting, it would be an opportune time for the treatment team to give some ground in terms of relaxing some of the restrictions upon him while he is under such close supervision. We therefore recommend that Mr. Hoover be considered for the opportunity to progress to less restrictive units within this hospital, if for no other reason but to test his compliance and reliability while under close supervision”: Ex.46, par.12.

[80] The BCRB also commented, for the first time, about the “degree of institutionalization or inertia” in JPH’s presentation and suggested, inter alia, the possibility of “prudent, incremental time-limited periods of unescorted community access”:

“We are concerned that a degree of institutionalization or inertia is beginning to assert itself quite dramatically in this man’s presentation. We see the possibility of movement in two areas. One is to allow him to be accommodated on a less restrictive ward of this hospital; the second, to allow or consider the possibility of prudent incremental time-limited periods of unescorted community access”: Ex.46, par.12.

[81] Through 2006 JPH continued to deny that his communications with God were due to his schizophrenia. He also demonstrated some amotivation and isolation associated with negative symptoms of the illness. Despite his robust participation at RTC’s intensive programming he was considered “not appropriate” for FPH’s community based sex offender groups or for a dual diagnosis program, despite disclosure of some cravings for alcohol: Ex.47.

[82] JPH consistently denied any coercive sexual fantasies. To demonstrate that his insight into the potential risk of his sexual disorder varied, Dr. Meldrum cited his long term plan to teach guitar in his own apartment, despite the fact that “raping and murdering an adolescent music student” was one of his frequent coercive fantasies: Ex.47. The only mention in the record of material approaching this content is contained in Dr. Riar’s report of June 2003 (Ex.35) where JPH reports one ongoing fantasy of giving piano lessons to a 15 year old and forcing himself on her for sex. He denied any violent content, certainly murder.

[83] Nevertheless, JPH was finally transferred to the less restrictive Elm ward with the potential of placement at Hawthorne (an open unit), a future possibility.

[84] Dr. Meldrum also raised the spectre and stress potential of Deportation should JPH achieve conditional discharge. The BCRB's decision in ***Seyoum*** (BCRB, May, 2007), provides a clear and definitive answer to that concern.

[85] During his January 2007 hearing JPH disclosed tactile hallucinations for ten years.

[86] In early 2007 the accused reported masturbating weekly and picturing a woman with "blood on her breasts" which elicited a considerable concern in his treatment team. He also appeared to suffer a deterioration in mental state including the addition of communication with Satan.

[87] JPH was now morbidly obese. The treatment team gave no serious consideration to unescorted outings due to the potential for "catastrophic harm to others": Ex.49.

[88] JPH was placed at the (open) Hawthorne unit on May 9, 2008. He settled well into his new environment but volunteered increased "clv's" and communications with God in June, though he did not find them distressing. He also continued to endorse auditory and tactile hallucinations, with no direction to harm others. Some of his increased symptomatology was attributed to medication prescribed for weight control.

[89] Once again Dr. Meldrum's assessment tendered for JPH's scheduled January 2008 hearing, in contrast to other assessors, reflected no reduction in her view of JPH's potential risk.

[90] At his request JPH's 2008 annual hearing took place in camera on the basis of consensual extension of his disposition, pursuant to the provisions of s.672.81(1.1) of the *Code* (SC, 2005, c.22), until January, 2009: Ex.57.

BCRB HEARING OF JANUARY 19, 2009

The Director's Evidence

[91] Despite having some initial difficulties meeting expectations on the closed Elm South unit, JPH actually functioned quite well once he was transferred to the more open Hawthorne unit, May 9, 2008. He remained morbidly obese and acknowledged he was "food addicted".

[92] In June 2008 he endorsed an increase in frequency of "clv's" and communications from God, albeit free of distressing or concerning content. JPH also continued to experience "tactile" hallucinations. He denied any deviant sexual fantasies, admitting to infrequent masturbation involving "normal" thoughts.

[93] He remained medication compliant (though not self-administering). As he had been doing for some years, JPH was documenting his symptoms in a log which was, at all times, routinely accessible to his treatment team. He denied any concerning cravings for alcohol or drugs.

[94] Once again Dr. Meldrum reported no diminution in JPH's risk:

"there has been no significant improvement in his psychiatric diagnosis, symptomatology and risk factors. He continues to exhibit a highly unusual grouping of symptoms which includes his treatment refractory schizophrenic illness, his disorder of sexual sadism, a very unusual personality style marked with schizoid and schizotypal traits in the context of above-average intelligence and his distant history of substance abuse. The combination of these disorders in particular that of Schizophrenia and Sexual Sadism, has posed a very unique treatment challenge, and has resulted in a markedly escalated risk as compared to other individuals even in the face of his compliance to treatment in hospital and relative behavioural stability." Ex.53, par.3.

[95] She also indicated that the accused continued to experience a variety of hallucinatory symptoms and "ideas of reference" which, in her view, he had "difficulty describing": Ex.53, par.4. She opined that JPH grossly underestimates his own risk, is highly stress vulnerable and fragile, and has limited insight. Therefore, his risk remains too elevated to consider unescorted access to the community. She acknowledged no benefits in terms of risk reduction gained from his successful program participation at RTC.

[96] The BCRB had no difficulty on the evidence in continuing JPH's custodial status. It remarked on its statutory duty to nevertheless impose the least onerous and least restrictive disposition conditions compatible with the accused's circumstances and with public safety:

*"The Review Board is of course obligated and legislatively admonished to impose the least onerous and least restrictive appropriate disposition; that which least infringes the accused's rights while adequately protection the public from dangerous persons. The Supreme Court of Canada in the **Tulikorpi** decision reminded us that the duty to impose the least onerous and least restrictive decision related not only the actual choice or nature of the order but also the conditions which form an indivisible part of that order. As we understand judicial precedents from **Mazzei** through **Wiebe** in recent years, the Board not only has the option, but the duty, to prudently and appropriately maximize an accused's liberties in accordance with his clinical progress. Therefore, although we have no criticism of Dr. Meldrum's treatment of the accused and although we do not diminish her concerns or cautions, at the end of the day the matter of an accused's freedoms and liberties falls squarely within the purview and mandate of the Review Board. We are concerned that, given Dr. Meldrum's unwavering assessment of this man's elevated risk to others, his progress and reintegration will be delayed well beyond what is absolutely necessary and warranted by his clinical and behavioural presentation."*: Ex.54, par.21.

[97] The Board found that, despite the discretion delegated to her in the accused's previous dispositions, it was not Dr. Meldrum's "foreseeable intention to allow unescorted access into the community" (par.15).The BCRB unanimously determined to mandate "brief but incremental periods of unsupervised access to the community" at least twice monthly: Ex.54, par.22. Condition 3 ("the impugned condition") of the BCRB's Disposition reads:

3. THAT notwithstanding clause 2 he shall be granted brief but incremental periods of unsupervised, unescorted, access to the community no less than twice per month, provided that if the accused is not provided with such access to the community during any one month period, the Director shall serve notice of increased restriction on the liberty of the accused in accordance with s.672.56 of the Criminal Code:
Ex.54

CIRCUMSTANCES GIVING RISE TO THE CURRENT PROCEEDING

[98] On February 25, 2009, the BCRB received notice as required by s.672.56, that JPH's Board-ordered, unsupervised access to the community, had been withheld, resulting in a significant increase in restrictions on his liberty and triggering a mandatory hearing under s.672.81(2.1) CC: Ex.56.

[99] Despite the filing of this notice, the Director's counsel wrote to the Board on March 2, 2009, requesting clarification of condition 3 of JPH's disposition, specifically, "what the Review

Board would view to be brief unescorted community access”, in particular “an indication of what specific time period is intended”.

[100] Although the Board, as well as JPH’s counsel, identified concerns that the Director was in fact seeking to appeal the Board’s January 19, 2009 order, it acceded to the somewhat unusual request of all parties that the required mandatory hearing would be heard before the same panel which issued that order. The Board was not initially advised that additional independent expert opinions were being sought by Dr. Meldrum and by the Crown.

EVIDENCE AT PROCEEDING OF JUNE 17, 2009

[101] JPH’s hearing, convened under s.672.81(2.1) and s.672.82(1) (Crown request), commenced on June 17, 2009.

[102] Disposition information (documentary evidence, s.672.51(1)) filed, consisted of a further report from Dr. Meldrum (Ex.56) and a “review of records and documents” to “evaluate” JPH’s “potential risk to the community”, prepared for Crown counsel by Dr. R. O’Shaughnessy (Ex.57). At the outset of the hearing counsel for the Director also submitted a further independent assessment from Dr. K. Riar, received as Ex.59. Dr. Riar was not tendered or available to provide oral evidence on June 17, 2009.

[103] The Director and the representative of the AGBC requested a further disposition of custody, without the mandatory provision of unescorted community access ordered in paragraph 3 of the January 19, 2009, disposition (the impugned condition): Ex.54.

[104] The accused agreed.

EVIDENCE OF DR. MELDRUM

[105] Dr. Meldrum's report at Ex.56 adds little new to the established historic picture. It seeks to explain why the Director did not comply with the Board's January 19, 2009, order, in particular, the impugned condition 3.

[106] The report essentially repeats, in stronger language, Dr. Meldrum's concerns about her patient; she labels his lack of insight as "profound" and his unescorted access to the community as potentially "catastrophic" and an "unacceptable risk": Ex.56, paras 12,13,15.

[107] Although Dr. Meldrum indicates a desire for "clarification" of the impugned condition, her evidence leaves little doubt that, on her assessment of the accused's risk, she would refuse to comply therewith in any event. She commissioned a second opinion from Dr. Riar, a forensic psychiatrist and an expert in sexual disorders.

[108] Dr. Meldrum had not had the opportunity to fully consider Dr. Riar's report (Ex.59) prior to the hearing. She was nevertheless questioned extensively about its content orally. She was able to agree with Dr. Riar that JPH could, in fact, manage unescorted community access with close monitoring of his mental state: Ex.60, Proceedings of June 17, 2009, pg.19.

[109] In her oral evidence, Dr. Meldrum remained unwavering in her opinion regarding the accused's risk, while acknowledging that JPH's "unique constellation" of diagnoses is extremely unusual. She agreed that the paucity of professional literature with respect to such individuals renders prediction of their behaviour very difficult.

[110] Under questioning, she stated that to be able to support JPH's unescorted access to the community she would need to see:

- a diminution of psychotic symptoms;
- better insight into the nature of his illness;
- more timely and immediate disclosure of psychotic symptoms;

- better skill at living “more adaptively with his illness” – not modifying his behaviour in response to tactile hallucinations or messages from God;
- more consistent and reliable reporting about sexual activity, coercive fantasies.

[111] She did not consider the accused “institutionalized”. She termed the accused’s amotivation a product of negative symptoms of his schizophrenic illness. She acknowledged that “institutionalization” is not a psychiatric term.

EVIDENCE OF DR. R. O’SHAUGHNESSY

[112] Dr. O’Shaughnessy was retained by the AGBC to evaluate JPH’s risk on the basis of a review of 39 historic documents: Ex.57. He did not conduct an in-person interview of the accused.

[113] The BCRB has no reservation whatsoever, in accepting Dr. O’Shaughnessy as a highly experienced, prominent, and recognized forensic expert. He has, in our memory, not previously testified in BCRB proceedings.

[114] Dr. O’Shaughnessy’s review of the documents concludes, inter alia:

- that JPH satisfies diagnostic criteria for schizophrenia, sexual sadism and schizotypal or schizoid personality traits
- that JPH continues to demonstrate significant positive (auditory, tactile hallucinations, delusions) and negative symptoms of schizophrenia.
- that JPH’s long standing deviant sexual fantasies evolved when in 1997 he began to develop symptoms of schizophrenia
- that JPH’s unusual combination of diagnoses makes it extremely difficult to predict behaviour; therefore, risk assessment instruments are of limited reliability or value:

“their accuracy diminishes substantially when the person studied is substantially different from... the study group”: Ex.57; see also Ex.60, Proceedings, June 17/09, pg.40.

- that JPH's deviant sexual interests, desires, and capacity would have diminished in frequency and intensity given his treatment with Lupron; though Dr. O'Shaughnessy expresses reservations about "assuming" this.
- that at a general level the most dangerous sexual offenders are those who harbour and behave in response to sadistic or rape/murder fantasies:

"once the offender breaks this boundary they are likely to repeat the behaviour. I note some caution in this statement given the limited empirical data. Most of this information comes from discussions of treaters of sexual sadistic offenders who are actually released into the community." Ex.57, pg.3 (emphasis added).

[115] In terms of an assessment of JPH's potential risk, Dr. O'Shaughnessy essentially adopts Dr. Meldrum's long standing formulation:

"I think likely the evolving schizophrenic illness did play a significant role in his decision to go from fantasy to behaviour in his sexually sadistic crime. I concur with Dr. Meldrum's opinion that any destabilization of his schizophrenic illness would likely cause an increase in risk of his sexual aggressive behaviour. On a more pragmatic note, it would be more likely that increase in his schizophrenic illness would trigger other behaviours that in turn could increase in risk of sexual offences, e.g. a decision to run away, consume alcohol or drugs, become more isolated with the result that he has increased hallucinations or delusions, etc. Any such increase in these symptoms would be a clear indicator of increased risk for sexual aggressive behaviour related to his sexual sadistic interests. I also concur with Dr. Meldrum's opinion that his controls are minimal and certainly he has affirmed to others his desire to say what is socially expected of him as opposed to what may truly reflect his thoughts, behaviours and intent." Ex.57.

[116] We note that JPH has not actually demonstrated the risk-triggering behaviours identified by Dr. O'Shaughnessy.

[117] In his penultimate paragraph Dr. O'Shaughnessy dismisses concerns about JPH's "institutionalization", and expresses doubt that JPH would ever be able to function outside of an institution. He renders the opinion that the goal should be to "improve the "quality of his life"... "within the confines of the institution".: Ex.57.

[118] In addition to his report, Dr. O'Shaughnessy attended and gave oral evidence.

[119] Insofar as the matter became the subject of submissions by parties, the BCRB considers Dr. O'Shaughnessy's decision to not personally interview JPH in the preparation of his opinion, an issue of considerable significance, even more so because the Board was asked to assign different evidentiary/persuasive weight to the various assessments.

[120] Dr. O'Shaughnessy's rationale for not seeing JPH in person was:

"The – this was – I was actually retained more as a general witness in the area of risk assessment of particularly unusual cases such as that presented by Mr. Hoover. When I reviewed the material it was clear there was in fact very little discrepancy in either the clinical material related to the diagnosis or treatment of contention regarding those issues. I decided it wasn't worth doing a personal interview simply because that would not have been productive. There would have been no information I could have pulled out of the situation that was not already there after ten years of – of review. And I concentrated instead on more issues of empirical nature and general issues related to the unusual presentation of Mr. Hoover and how it complicates doing a risk assessment." Ex.60, Proceedings of June 17/09, pg.38 (emphasis added).

[121] With respect to the complexity presented by the combination of JPH's diagnoses, Dr.

O'Shaughnessy elaborated:

"Generally we don't see the combination of a true sexual sadism and a schizophrenic illness. I mean I had been consulted on cases like this when I gave lectures elsewhere because of the same dilemma, what to do with a person with dual problems of this magnitude, and – and really we don't know what to do with them frankly because we simply – there's so few of such persons that there's no empirical literature on this in terms of guiding us. So the treatment is generally to treat both disorders as if they're separate, if you will, and I think which has happened in this instance." Ex.60, pg.40 (emphasis added).

[122] Dr. O'Shaughnessy went on to qualify or explain the limited utility of standardized risk assessment instruments in their application to individuals like JPH:

"In a person like Mr. Hoover, what was interesting about them, he clearly acknowledges longstanding sexually sadistic fantasies but no aberrant behaviour. And, if you look at all the scores regarding his antisocial traits, they're really modest, they're not severe, he's not a psychopath. The PCL scores are – are clearly well below the level of cut-off or criteria for that. That really if you look at that he's – he's never been engaged in any of these behaviours. He did it in this instance in where I understand to be probably as the schizophrenic illness was evolving, and that probably – but again it's speculative – but probably that was a precipitating factor for him acting out on his sexually deviant fantasies': Ex. 60, pg.42 (emphasis added).

[123] On the issue specifically of risk prediction, Dr. O'Shaughnessy responded:

'In Mr. Hoover's situation it's not easy to predict because he lacks those antisocial traits. For him it's more the schizophrenic illness that seems to be relevant, and that's where he's an anomaly. If he's – if he was just a straightforward schizophrenic offender who committed a violent act in – because of psychotic thinking versus a sexual sadist who did it without schizophrenia, we have good predictors for both those respective problems. We don't have any good data on when they're combined.': Ex.60, pg.46.

[124] On the issue of the contribution of vulnerability to psychosocial stressors on JPH's risk, Dr. O'Shaughnessy responded:

'I think more – well, stressors play roles both in sexual sadism and in schizophrenic illnesses. That is, individuals who are sexual offenders often will have an escalation in offence behaviour when they're stressed in their life and in particular the stressors that are critical and most commonly seen are loss events,

self-esteem problems. So they lose a job, they get criticized, you know, the girlfriend dumps them, things of that type.

And certainly even some of the material that – that we've seen, Canada's one of the leading researchers in – in sexual offender work, and in particular Karl Hanson and his group, but the Federal Corrections Canada have done some wonderful ongoing research on outpatient – pardon me, outpatient – parolee sexual offenders. And if you look at these – these issues on of the things that's clear you – you can't predict at the beginning whether a sexual offender will re-offend based on emotional vulnerability because it changes too much.”. Ex.60, pg.47 (Given the source or attribution of Dr. O'Shaughnessy's comments, we assume that they are restricted in their reliability or relevance to non-mentally ill sex offenders, rather than anyone like JPH).

[125] Farther on Dr. O'Shaughnessy expanded:

“Stress issues for schizophrenia is a very different issue because there it's clear that it's much more immediate. So stress is – is a more prolonged one for sexual offending. For schizophrenia it's a much more immediate effect. So individuals – and I think it's clear in the records that whenever he's under even the modest amount of stresses he has an increase in symptoms there I think you're seeing the vector, if you will, of stress, probably affecting more through his schizophrenic illness than through the paraphilic illness.”. Ex.60, pg.47.

[126] On the central question of unescorted community outings Mr. Hillaby asked:

“Just as an example, if Mr. Hoover was entrusted with leaving the hospital for the day on his own, do you have an opinion as to whether from what you know of him there would be a risk posed by that?”. Ex.60, pg.47.

[127] Dr. O'Shaughnessy responded:

“I don't know much about him. I'd be – just he's – if he was just a straightforward schizophrenic offender who committed a violent act in – because of psychotic thinking versus a sexual sadist who did it without schizophrenia, we have good predictors for both those respective problems. We don't have any good data on when they're combined.”. Ex.60, pg.48 (emphasis added).

[128] Dr. O'Shaughnessy's response went on to comment at length on the treatment and programs provided to JPH for more than a decade, in largely general terms, as well as on the notion of institutionalization, which he describes as a sociological and 'politically labile' term (P.49) and which he does not identify in his review of the records: Ex.60, P.51. With respect, Dr. O'Shaughnessy was not tendered and is not accepted as an expert in “institutionalization”, which is not a psychiatric term; nor as an expert in “quality of life”, or “least restriction”. These are areas reserved to the BCRB as trier of fact and law. His comments with respect to these

areas are not within the purview of an expert and were afforded little or no weight in our decision making: see also par.188, infra.

[129] In our view, especially as he did not take the time to interview or even meet JPH personally, Dr. O'Shaughnessy's comments respecting JPH's future prospects might well be experienced by the accused as highly discouraging:

'Well, I think you have to – you have to recognize that some people are not going to get better. You know, there's an old rule of thumb in schizophrenia, the rule of thirds. A third do well, a third do very badly, and a third are some place in the middle, and he's at the end of the spectrum in the third who – who have ongoing chronic symptoms, who probably will not get a whole lot better. And the goal is not to eradicate symptoms. It's to improve the quality of his life. We're really talking about a tertiary care rehabilitation kind of model. So make it as comfortable and pleasant for this man as one can but don't expect that – that he will ever be able to function outside of an institution. I don't think that's – that's realistic, not with the ongoing symptoms and susceptibility to stress that he's experienced.' Ex.60, pg.52.

[130] Finally, no doubt in contemplation of submissions to follow on the matter of the weight to be assigned to their respective assessments, Dr. O'Shaughnessy's was asked to critique Dr. Riar's report in terms of the latter's methodology.

[131] On the critical issue of the reliability of self-reported information, and despite the fact that he did not consider it useful or necessary to interview JPH in person, Dr. O'Shaughnessy volunteered the rather glib observation:

"We all have our little sayings in these matters. The one that we always say is – is – ask the question when is a sexual offender lying, and the answer is invariably when he moved his lips. That's not being facetious but it really tells you you cannot accept at face value people who have committed a sexual assault who then tell you that things are fine now. So we are very cautious about that, with all the sexual offenders. Ex.60, pg.54

[132] Dr. O'Shaughnessy went on to say: "In fairness to Mr. Hoover, he is not the prototypical sexual offender. So that may not be applicable as much to him as to this who have repeated sexual offences in the past": Ex.60, pg.54. Dr. O'Shaughnessy acknowledges JPH is not a "prototypical sex offender". The comment is therefore neither responsive nor relevant to the matter before us

[133] In questioning by the Board's psychiatric expert, Dr. O'Shaughnessy's attention was once again directed to the significance of the accused's reduced sexual interest and its bearing on his risk:

"EXAMINATION BY DR. CONSTANCE:

Q *With regards to again Mr. Hoover's risk, the evidence is that Mr. Hoover is masturbating relatively infrequently, probably once a month, and a decrease in coercive fantasies.*

A *Yeah.*

Q *Would that have any bearing on his risk?*

A *It does. Again, it probably reflects – with the reduction in drive and – interest and – and ability. So sure it does. There's no question that antiandrogens – if you think – again, absent the schizophrenic illness, if you think of all sexual offender therapy, the data on actual sexual therapy --- sexual offender therapy is very poor, as you probably know. The better studies show that psychosocial treatments are no better than doing nothing, the better studies. I know that's a heresy in some sectors, but that's the analysis if you look at the better – the better quality of studies. The one area that really does show benefit is the medications, the antiandrogens in particular. As long as people take antiandrogens the risk of reoffending is diminished substantially. So there's no question that the antiandrogens diminish risk of – of sexual reoffending."*

Ex.60, pg.60.

[134] On the central issue of the risk associated with the accused's access to the community, Dr. O'Shaughnessy acknowledged in the following exchange:

Dr. Constance:

"Q *You also stated that the hyper drive is not present?*

A *I don't think he's a hyper drive. You can't have on Lupron. You know, it just – it's physiologically impossible.*

Q *Right. So if Mr. Hoover was out for ten minutes a day once a week would – and he was taking Lupron, his hyper drive wasn't present and he – there was no evidence of making any cascade of stress and bad decision-making, would that have any reflection on his risk in terms of –*

A *I think that when you put it, you know, to the extreme levels, a ten-minute walk around the grounds obviously doesn't carry an inherent risk.*

Q *I mean I'm talking about outside the institution, unescorted –*

A *Well, outside, you know, for ten minutes, not going very far. I mean it's – you know, he couldn't even walk to --*

Q *Right.*

A *The issue isn't that. I don't think he's run out in ten minutes and find somebody to offend. That – that would be highly unlikely. The bigger risk for him would be out ten minutes, then they'd make it 15 or 20, or decide not to come back. That's the risk issues you get into there. Or you have the misfortune of bumping into somebody and that would trigger some kind of reaction that you can't predict. Those are the things that – it's the unpredictables that you really have difficulty with in a situation like this. A scenario of five or ten minutes outside the institution and back is no more than a short stroll. If you're out for a day, all bets are off.*

Q *In your opinion would it be possible to monitor his deterioration or improvement with very brief unescorted passes literally in terms of less than half an hour, less than 30 minutes?*

A *Oh, sure, no question about that. I mean I – I – it's like anything else, it's – in the short term we're very good at predicting risk. I mean, you know, it's really simple. It's – the problem is in the longer term, and the longer it gets the more difficult the prediction becomes. But predicting then minutes is – I mean any idiot can do that. Yeah, we can be comfortable there, unless of course he has in his view that he's – he's going to use this as a way of getting away and, you know, he doesn't tell you, he doesn't disclose his plans to elope, as an example. Then you look stupid. But, you know, for – for ten minutes, yeah, nobody*

would be saying he – he’s be high risk for a ten-minute timeframe.”: Ex.60, pg.61 (emphasis added).

[135] Panel Member Clancy pursued a similar line of questioning:

Mr. Clancy:

“Q Doctor, I think Dr. Riar, if I may summarize, said if the situation was tightly controlled then unsupervised leaves would be appropriate. I don’t know that you’ve ever really come down and given us your opinion on that. Do you agree with that assessment?

Dr. O’Shaughnessy responded:

A Well, let me hedge it this way. I think that a tightly controlled, brief outing would be of relatively limited risk. But then you have to ask yourself what is to be gained by that – what is – what is the purpose? In my view when you’re doing activities there should be a clear goal and a purpose in mind, something that’s tangible. Will a brief outing really improve a man’s quality of life or his mental condition? I don’t think it’ll make a big difference in his mental condition. I don’t think he is institutionalized, I don’t think it’ll counteract that. Does it put him at risk for other things? Yeah, misadventures of various types. I think it really—in medicine we always want to look at balancing benefits and risks. So I really think you need to think through what is the benefit of a brief timeout and what is the risk and is that benefit/risk worth his interests in going out.”
Ex.60, pg.62.

[136] Mr. Clancy reminded Dr. O’Shaughnessy that, indeed, JPH had expressed a desire for outings:

“Q Mr. Hoover expressed a desire for unescorted leaves at that time. Now, it seems to me there may be benefit in acceding to that request. That’s what he wants. It’s not going to be a risk if it’s tightly controlled, or it’s unlikely to be a risk. Isn’t there a benefit in making him feel better?

A If it would. I guess I don’t know enough about the situation to offer an opinion on that, whether it’s a good thing or not, and – and I think that’s something that you’re probably in the better position to judge than I am. In fairness, that’s not a medical issue, you know, whether you feel better by – by an unescorted pass or not, you know. You folks can make that decision as well as any doctor can. I guess our job is really kind of pointing out what is the risk of that and is that benefit worth the risk.

Q You don’t then, I take it, see any long-term prospect of unescorted risks escalating incrementally, ten minutes turning into twenty minutes turning into half an hour turning into an hour and so on, as being a long-term goal for Mr. Hoover?

A I’m not sure I agree with that. And I don’t really have a position on that, haven’t thought that through. I think – again I – I’d really want to talk with him a bit more in a clinical sense about what – what do you want to do with those things, I mean just go for a walk, and that’s really all you’re talking about, ten minutes of walk, you know – you know, is that --- you know, do you want to go walk on – on that grounds and back. I don’t see any major problem with that per se. The issue of course he doesn’t come back, you call the police, he gets picked up, it’s a mess and – and misery. And can he control his impulses? Probably. Can you be sure about that? No. No, you can’t be sure about that. Will he in fact – could he be harbouring plans to escape? Absolutely, you’ll never know about them, you know. And getting back to the issue, what’s to be gained by that?

Q Well, the long-term gain, if you continue to incrementally increase the – the use, it is surely beneficial to him. You said you haven’t formed an opinion of that, and perhaps I’m wrong” (emphasis added):
Ex.60, pg.63.

[137] Finally, Mr. Clancy framed the question most directly:

“Q Dr. Riar’s opinion does differ from yours in the sense that he says tightly controlled leaves would be all right. He must have thought that through, one would think anyway. Do you see any benefit in you having a talk with Dr. Riar and seeing whether his opinion might affect yours?”

A No, I think you misunderstood me. I don’t see any major problems with short, ten-minute absences. I made that clear right?

Q No, I understood that.

A I think we’re pretty – so I think in that sense we’re probably in agreement in that – that very circumscribed period of time. If that’s all it is. You know, I think under the assumption that he’s telling us the truth, that he’s not really planning an elopement, which you’ll never know. More to the point I’m getting at is, what ultimately will those gain you; apart from having a nice pleasant walk, will he ever be able to go out for a day?”. Ex.60, pg.64.

JPH’S EVIDENCE

[138] On the issue of community access generally, JPH said:

Dr. Constance, continuing:

“Q Suppose if clause 3 stays as is –

A Right.

Q -- in other words, that you will have unescorted leaves, what would be your reaction? How would you deal with that?

JPH’s Response:

A Well, I’d have to confer with Dr. Meldrum to see what kind of leaves they would be, how long. I mean, if we’re going to start with ten-minute leaves, I guess that’s enough time to go walking down there and come back. But that’s a way I can use to prove myself, so, you know, eventually, I mean, I do have plans for day leaves, I’ve thought about it. I’d love to be able to go to Chapter’s, Starbucks and drink coffee and read” Ex.60.

[139] When he was specifically asked why he had abandoned his request for community access in the context of the current proceeding and decided to accede to the position of his treatment team, JPH stated:

“A Yeah, actually we discussed day leaves even – we discussed this situation even before it ever arose last year, if it was mandated, and she – Dr. Meldrum made it clear to me then that she would take legal action to prevent the mandate from going forward.

Q Is it fair to say that she conveyed that she had some concern about risk but she didn’t try and convince you you shouldn’t be pursuing it?

A You mean she didn’t try to convince me that I shouldn’t?

Q Right.

A No. Actually she just said if the case arose, that she would – she would refuse to grant me the day leaves.”: Ex.60, pg.77.

[140] Out of respect for its statutory mandate to pursue its duty to inquire and to reach an independent decision with respect to the least onerous and least restrictive order, and given the apparent divergence in the expert opinions tendered in evidence, the Board determined to

adjourn (the hearing), with the consent of all parties, so that Dr. Riar could attend to speak to, and to be questioned regarding, the content of his recently filed report.

EVIDENCE OF DR. K. RIAR:

[141] The hearing reconvened on September 15, 2009, to receive the evidence of the Director's independent psychiatric expert, Dr. K. Riar. Dr. Riar was accepted as an expert in forensic psychiatry with a sub-specialty in the assessment and treatment of sexual offenders. Dr. Riar's assessment, ordered in March 2009, was submitted and filed as Ex.59 on June 17, 2009. We remind ourselves, of course, that Dr. Riar had previously assessed JPH in 1996, and again more recently in 2003: Ex.35. He spent two hours with JPH on May 12, 2009, in the preparation of his current report which is dated June 7, 2009.

[142] Dr. Riar's report also mentions reviewing five reports in addition to his in-person interview with JPH. In cross-examination on the point, Dr. Riar made it clear that he had access to all the documents filed in this matter and had reviewed certain other documents not specifically mentioned in his report: Transcript of Proceedings, Sep 15, 2009, pg.39.

[143] Dr. Riar's report states that:

- JPH continues to experience, at times, a "vast plethora" of different kinds of, at times, bothersome voices, but he endorsed benefits from his medications;
- The voices have receded in strength but still tell him what to do; usually he does not listen to them and he feels they no longer affect his mood; they contain no major negativity.
- JPH experiences vivid images or symbols including "crucifix", "666" and pieces of music.
- JPH continues to believe that he has communications from God.
- He admitted to occasional thought insertion sometimes including the number "6".

- JPH also experiences tactile or somatic hallucinations which may carry meanings or significance, depending on their location on his body. He believes Christ is intertwined in this.
- When tempted to look at women on TV, he distracts himself by looking elsewhere. He recently declined an offer of pornography. He saw some pornography at RTC which “got him in trouble” with God and he decompensated.
- Lupron has diminished the frequency of his masturbation (involving thoughts of “regular sex”) to “once every couple of months”. Apparently he is able to achieve orgasm which he finds disruptive to his “thought process”. He acknowledged that if he masturbated daily he would think about rape.
- JPH said he does not wish to go back to the way he was when he combined pornography with nitrates; that the resulting intensity made him worry he might lose control, or that:

“if he is out by himself for a number of years and does not have a girlfriend and things are going well in his life, then he might buy porn. To make the enjoyment intense, he might buy nitrate, then he might have a criminal intent, ultimately re-offending and going to jail.” Ex.59.

- JPH documents masturbating to coercive thoughts or inappropriate fantasies. He acknowledges sadistic thoughts, within the past year, of encountering a woman in a forest wearing a bikini and raping her but not hurting her in any other way.
- He has distracted himself from any other sadistic thoughts in the last six months. He denies any thoughts of stabbing a woman in the chest and raping her for years. He denied that the thought he had a few months ago, about bleeding breasts, turned him on.

[144] Dr. Riar found JPH co-operative, polite, open and accessible and not guarded or restless. His speech was, at times, over-inclusive and tangential. Despite his ongoing hallucinations and delusions, his reality testing was relatively intact. His understanding of his delusional thinking was much better than in past years.

[145] Dr. Riar identified no homicidal ideation, anger or hostility and no undue preoccupation with sexual thoughts. JPH’s insight and judgment were much improved.

[146] Longitudinally, Dr. Riar stated:

“Looking at his functioning over the years, I saw him exactly six years earlier, and at the time, he was clearly floridly psychotic with little insight and also his sex drive was quite high and his sexual fantasies and behaviours were marred by coercive and sadistic acts towards women. He entertained those sexual thoughts quite regularly while masturbating, almost every day. In the spring of 2005 he was admitted to the Regional Treatment Centre where he attended a sex offender treatment program for the next eight months or so. His participation was good and according to the discharge note, he did very well and he happened to gain insight in ways to manage his risk. Subsequent to my consultation in June 2003, he was started on an anti-libidinal medication, Lupron, and he has been taking it all along. He has had some side effects, but by his admission, it helps him. He does not get preoccupied with various sexual thoughts, his overall libido is low, he can control his deviant sexual thoughts better and he only masturbates only once every couple of months.” Ex.59.

[147] Dr. Riar concluded that while JPH continues to harbour symptoms of schizophrenia he has “gained the ability to recognize his symptoms as part of his illness, rather than his reality”. Moreover, with the administration of Lupron and psychological treatment “there is certainly a reduction in his sex drive, sexual preoccupation, fantasies and related behaviours”. He termed JPH’s sadistic fantasies as “few and far between” and less intense:

“He claimed to have not entertained them or bring them to his sexual arousal and masturbation. He still considered himself at high risk for engaging in any potential aggressive acts towards woman, but at the same time recognizes various strengths he has gained, and how he can stay away from perusing those fantasies or related behaviours. The fact that since he has been in the Forensic Hospital, to my understanding, he never or perused (sic) female patients or staff in a real way or in his fantasies and this also mitigates his risk somewhat. Although he is in a protective environment, there is no indication that he engages in any behaviours to gain access to any illicit substances. His advancing age also has some positive effect on his future risk of offending. I concur with Dr. Meldrum regarding the fact that he continued to have active symptomatology of schizophrenic illness. He is fragile, and decompensates with minor stressors, and during even minor relapse, he has tendency to not disclose his symptoms to his treatment team.” Ex.59.

[148] Finally on the central issue of risk associated with community access, Dr. Riar states:

“In my opinion, I believe that Mr. Hoover’s risk of offending sexually has had a significant reduction since I saw him six years ago. Having said that, he continued to pose some risk, which can escalate to a significant degree if there is deterioration in his schizophrenic illness, as well as if he engages into substance abuse and stops taking anti-libidinal medication or takes something to enhance his sex drive. I believe that with his present mental state and the stability of his overall functioning, he can manage unescorted outings, provided his mental state should be monitored very closely before and after him going out by himself. If he is given this privilege, the duration should be gradually increased, depending upon his mental state and response. Of course, other issues like his risk of elopement should be considered before giving him any outings, and I have not addressed that issue.” Ex.59 (emphasis added).

[149] Dr. Riar was further examined by the parties and BCRB members. As anticipated following the June 17, 2009, proceeding, he had discussed any discrepancies in terms of his findings regarding JPH’s symptoms with those of Dr. Meldrum. Their respective discrepancies

did not alter Dr. Riar's opinion regarding JPH's risk of sexual offending: Transcript of Proceedings, Sep. 15, 2009, pg.24.

[150] Asked about the historic concern that JPH had not been consistently disclosive of his psychotic symptoms or thoughts in a timely manner, Dr. Riar felt that the issue was not one of non-disclosiveness on the part of the accused, but rather the need to ask the patient the right questions. Dr. Riar did not see JPH as overly concerned with impression management or manipulative. He opined that the simple occurrence or presence of coercive sexual fantasies did not automatically predict that an individual would re-offend, but that a reduction in the frequency of such fantasies equates to reduced risk. Dr. Riar also stated, at a general level, that JPH's advancing age, and corresponding lower testosterone levels would also lower his risk.

[151] On the other hand, Dr. Riar acknowledged that JPH's fragility, vulnerability to stress and tendency not to disclose during relapse could serve to elevate his risk, especially if he were alone and his mental state were not monitored.

[152] In repeating his assessment that JPH's mental state should be monitored or assessed prior to community outings, Dr. Riar provided the observation that:

"I think there are two things we are here mentioning. One is his risk for sexual offending; other one is general offending. So for general offending he's very disorganized still. So leaving him alone it's going to create a problem. Sex offending I'm more comfortable saying that he's not at risk as much as general offending.": Transcript of Proceedings, Sep. 15, 2009, pg.10.

[153] On the libido reducing effects of Lupron, Dr. Riar testified:

"I mean we know Lupron – I know, I use it all the time in young offender or older offenders. It's very effective medication to reduce the libido and reduce the behaviours and related issues. And the age, as I said, they get wiser, they get kind of – the testosterone is not that great, other hormones go lower in the person's life. So that also reduces the risk. And his psychosis is a little bit better and he is in a kind of environment where he can be checked on or observed 24-hours-a-day. So keeping all those things in mind I – I believe that risk for reoffending sexually is substantially lower as compared to when he offended.": Transcript of Proceedings, Sep. 15, 2009, pg.13.

[154] On the matter of risk assessment instruments, Dr. Riar stated that he had considered a number of these in assessing JPH, but felt overall that on standardized risk formats, JPH would score even lower than what he was expressing the accused's risk to be.

[155] Mr. Hillaby asked Dr. Riar why he had more confidence in Mr. Hoover's safety in the community than did Dr. Meldrum or Dr. O'Shaughnessy. Dr. Riar responded:

'I explain it to you why I say so because I don't see (sic) that there's only one offence, and in the past there was very strong sadistic fantasies, he was young at the time and there was no structure in his life. But now it's – everything is changed. He's older, he has less sadistic fantasies, he sees them as wrong, he doesn't do those pornographic, amyl nitrate (indiscernible). He's on Lupron, his psychosis is kind of controlled, and he's in a structured environment.... So all kind of things combined that's what make me feel a little bit comfortable than his risk is low.' Transcript of Proceedings, Sep 15/09, pg.15.

[156] On the defining issue of community access, Dr. Riar testified that he thought this would enhance JPH's quality of life and improve his social skills, and that durations of two hours, or even longer, given appropriate structure and the purpose of the outing, could be considered.

[157] Dr. Riar was questioned about the persistence of JPH's residual visual symptoms. In contrast with other assessments, Dr. Riar characterized these religiously-themed phenomena not as hallucinations but as mental images or thoughts which JPH pictures in his mind, rather than that they exist independently: Transcript of Proceeding, Sep. 15, 2009, pg.29.

[158] Dr. Riar also described what could have been interpreted as "satanic" communications, involving the numbers "666", in benign terms, as things JPH seeks to avoid: Transcript of Proceeding, Sep. 15, 2009, pg.31.

[159] He further characterized the accused's choice to avoid potentially arousing or seductive images on television as an insightful way of circumventing temptation: Transcript of Proceedings, Sep. 15, 2009, pg.32.

[160] On a subsidiary issue but one of importance to JPH, that of access to his guitar, Dr.

Riar was asked and responded:

“... does spending time alone with the guitar and doing music, is that a socially isolative factor that you would be concerned about?”

A When a person is playing guitar I don't think they're isolated because their mind is in there because they're – that's working.”

Q They're engaged.

A They're engaged. So, as such, playing is not isolation but if he's not hanging out with people, sitting down there by himself, that's more isolation than playing guitar.”: Transcript of Proceedings, Sep. 15, 2009, pg.37.

[161] When asked by Mr. Hillaby, Dr. Riar answered:

“Q Okay. So to isolate doing something prosocial is not a risk factor for Mr. Hoover?”

A No.

Q So it would be fine if he chose to practice 12 hours a day on his guitar in your view?”

A Well, I'm okay with that, yes.

Q Or to read literature?”

A Yeah, yes.”: Transcript of Proceedings, Sep. 15, 2009, pg.37

[162] Finally, simply by way of contrast, on the issue of JPH's institutionalization, Dr. Riar, who actually saw JPH personally and over a period of thirteen years, in contrast with Dr. O'Shaughnessy who did not, said that JPH was becoming much too comfortable in the hospital: see par.128, supra, par.188 infra.

EVIDENCE/UPDATE FROM DR. MELDRUM

[163] Dr. Meldrum made it clear in her responses that her opinion, with respect to granting JPH access to the community, remained unchanged, though under questioning she was able to acknowledge that, according to both Dr. O'Shaughnessy and Dr. Riar, for short outings, JPH would pose a minimal risk: Transcript of Proceedings, Sep. 15, 2009, pg.58.

JPH

[164] JPH was asked about his position regarding the matter of outings in the community.

He responded:

“I'd be happy with day leaves but at this point I think it's more important to be kind of like in agreement with my treatment team. Did I understand – I trust Dr. Meldrum's judgment. I think that when she

thinks it's ready for me to have these – these privileges then I'll have them. That's been the case thus far and there have been no problems. I'm at Hawthorne now and I was at the max security for like eight years. I was there for a long time, so one of the things that taught me was that when I get – since I've gotten to this position I definitely don't want to go back to that one. It would be a long time.”: Transcript of Proceedings, Sep. 15, 2009, pg.61.

DIRECTOR'S SUBMISSIONS

[165] Ms. Lovett made eloquent submissions on behalf of the Director, in summary arguing that:

- the index offence was serious and horrific and JPH remains a significant threat to public safety, to a degree that warrants a custodial disposition;
- the sole issue to be determined at this hearing is the matter of periodic, relatively brief, unescorted access to the community, consistent with public safety and the requirement that JPH's disposition be the least onerous and least restrictive;
- JPH suffers from a unique and challenging combination of diagnoses; the combination of treatment resistant schizophrenia and sexual sadism make behaviour and risk prediction very difficult and, in combination, increase risk;
- JPH continues to experience active symptoms of schizophrenia and will modify his behaviour according to direction from his symptoms;
- JPH, according to Dr. Meldrum, continues to display a profound lack of insight into his illness and underestimates his potential risk. Dr. O'Shaughnessy agrees. Dr. Riar disagrees;
- JPH is fragile and vulnerable to mental state deterioration due to stress with a potential for sequential bad decisions and “catastrophic” consequences. Decompensation (destabilization) may contribute to a significant and unacceptable risk impulsive sexual violence;
- JPH is considered, and has been, unreliable in terms of reporting his symptoms and sexual fantasies; more so if decompensated. He has had a coercive sexual fantasy in the past year which he did not disclose to his treatment team;
- JPH is manipulative, deceitful and prone to impression management;

- JPH should only be considered for unescorted community access in the sole discretion of the treatment team - which discretion would likely not be exercised in favour of such access.

[166] On behalf of the BCAG, Mr. Hillaby argued:

- That this proceeding should be considered a hearing de novo including a full consideration of all the evidence.
- That all experts agree that JPH should only be afforded unescorted outings in the discretion of the Director.
- That Dr. O'Shaughnessy's opinion is to be preferred over that of Dr. Riar.

[167] On behalf of JPH, Mr. Reyes did not pursue the ongoing inclusion of the impugned condition.

THE STATUTORY/LEGAL FRAMEWORK

Jurisdiction

[168] The circumstances or chain of events which precipitated the current proceeding are somewhat circuitous and a departure from the usual manner by which early or mandatory hearings are convened under s.672.81,(2) or 672.82. Whether this proceeding is deemed to have arisen as a result of the Director's imposition of significant restrictions on the liberty of the accused (s.672.81(2.1)), or due to a request from the AGBC (s.672.82(1)), is ultimately a formality. No party raised any objection with respect to the jurisdiction of the Board to further review its January 19, 2009, disposition in accordance with s.672.54.

Process of Review Under s.672.54

[169] Any disposition must be made or reviewed in accordance with the considerations or criteria in s.672.54. That provision does not presume that an NCR accused is a significant threat to society. It requires the Review Board to gather and evaluate evidence and determine whether a significant threat exists in each case, and then to impose the least onerous and least

restrictive disposition. Absent a positive finding, on the evidence, that the accused poses a significant threat to public safety, there can be no constitutional basis for restricting an individual's liberty and the Review Board must order an absolute discharge: **Winko v. BC (FPI)**, [1992], 2 S.C.R., 625, paras.27,35,48,49.

[170] “Significant threat” is a purely legal construct. It was extensively defined and commented upon in **Winko** (supra at par.57,62,69) and in countless decisions since: see for example **Beauchamp** (ONCA, June 1999); **Campagna** (SCBC, 1999); **Owen** (SCC, 2003)

[171] If the BCRB concludes that an accused satisfies or continues to satisfy the definition of significant threat, it must once again consider the factors in s.672.54 in order to arrive at the disposition which is the least onerous and least restrictive to the accused, but which at the same time does not expose the public to un-assumable risk: **Winko**, supra at par.69,62.

[172] The BCRB's responsibilities however, do not end once it has selected one of the three dispositions available under s.672.54. Mindful of the admonition that any restrictions on the liberties of an accused must be imposed for rehabilitative, not penal purposes, the BCRB must go on to impose as part of or attach to its disposition, such conditions as it considers appropriate: **Winko**, supra at par.94; s.672.54(b),(c).

[173] In **Penetanguishene Mental Health Centre v. Ontario (AG)**, [2004], S.C.C.20, (“**Tulikorpī**”) the Supreme Court of Canada determined definitively that:

“[...]The liberty interest of the NCR accused is not exhausted by the simple choice among absolute discharge, conditional discharge, or hospital detention on conditions. A variation in the conditions of a conditional discharge, or the conditions under which an NCR accused is detained in a mental hospital, can also have serious ramifications for his or her liberty interest, as will be seen.” par.27 (see also **Winko**, supra at paras.148,165).

[174] In particular and relevant to the current proceeding, the Court went on to define with greater precision the types of conditions it had in mind:

“Apart from hospital selection, there are other conditions routinely considered by Review Boards that also affect the liberty interest having regard to “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”. The disposition order may specify that the detainee is (or is not) to have access to the grounds of the hospital, or to the community within a defined radius (including a weekend or overnight pass), and, if so, the level of accompanying supervision, if any. The Review Board may specify the purposes for which community access is authorized (such as medical or dental treatment, education, employment, recreation, or social activities). Equally, the conditions may place particular restrictions on a detainee’s liberty. In a conditional discharge under s. 672.54(b) for example, such restrictions may include a prohibition against consuming alcohol or drugs, using or possessing firearms, associating with particular persons or classes of persons, and reporting requirements”.: par.32 (emphasis added).

[175] Binnie SCJ, for the Court, went on to conclude:

*“My reading of s. 672.54 as a whole is that Parliament intended the Review Board to consider at every step of s. 672.54 “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 there is no textual or contextual reason to isolate the governing requirement of s. 672.54 (“the least onerous and least restrictive”) from the preceding list and hold that it alone does not apply to the formulation of conditions that constitute part of the *décision or disposition order*.”: par.45.*

Delegation of Authority from BCRB to the Director

[176] Having concluded that the conditions imposed by the BCRB as part of any disposition must also conform with the “least onerous and least restrictive” dictum does not, however, shed much light upon the practical implementation of such conditions. The vehicle which Parliament has provided to the BCRB for fine tuning the implementation of its conditions is the mechanism of delegation contemplated under s.672.56:

“672.56 (1) A Review Board that makes a disposition in respect of an accused under paragraph 672.54(b) or (c) may delegate to the person in charge of the hospital authority to direct that the restrictions on the liberty of the accused be increased or decreased within any limits and subject to any conditions set out in that disposition, and any direction so made is deemed for the purposes of this Act to be a disposition made by the Review Boards.” RS C, 1991 c.43.

[177] This “code” of delegation of authorities was discussed in detail in **Johnson** (BCCA #620369, Oct 31/95, paras.50,51-54). Importantly, the BCCA in that decision also discussed the matter of any residual or implied discretion in the Director, absent any explicit delegation from the Board:

“Whatever may have been the extent of the Director’s discretion to alter the accused’s liberty restrictions prior to the 1991 amendments, I am of the view that such discretion is now confined to that which

must be explicitly delegated by the Review Board pursuant to s.672.56.” **Johnson**, supra at par.58; (see also **Winko**, supra at par.123 and **Wiebe**, infra at par 80,84).

[178] Despite the clarity of the language of **Johnson**, since reinforced in **Tulikorpi** (supra), the practice which has evolved in BC has been to generally delegate an extremely broad discretion, similar to that being sought by the director in the current case, e.g.:

“That, at the Director’s discretion, he may have unescorted or unsupervised access to the community depending on his mental condition, having regard to the risk the accused then poses to himself or others”

[179] Since **Tulikorpi** (supra), the Manitoba Court of Appeal has undertaken a further detailed analysis of s.672.56 in **Manitoba (Attorney General) v. Wiebe**, [2006] MBCA 87. That decision (at par.84) affirms that all discretion flows from the Review Board to the director under the mechanism of s.672.56, whether or not that section is referenced explicitly. The MBCA goes on to state:

*“Obviously, there are certain matters that cannot be delegated either expressly or impliedly, and to do so would be an error in law. For example, the Review Board cannot delegate such fundamental decisions as the NCR accused’s core level of security. In provinces where there are different psychiatric hospitals at different levels of security, the choice of hospital and level of security can be crucial to the NCR accused. Even in provinces where those choices are not available, the conditions of detention are just as crucial. See **Tulikorpi**, at paras.29-34, and **Johnson**, where the British Columbia Court of Appeal held that the Review Board erred when it ordered a conditional discharge subject to conditions that delegated to the director the discretion to confine the NCR accused to the hospital.”: Par.81*

[180] Having said that however the Court went on to say that the Review Board cannot delegate to the director its paramount responsibility for ensuring the accused’s liberty interests are protected:

“While a Review Board cannot delegate to the director its paramount responsibility for ensuring that the proper balance is maintained between these interests, there is a power to delegate certain decisions within the parameters of the Review Board’s “outer envelope” that allows the hospital to respond to changing circumstances” Par.84

[181] Finally, lest there be any residual or lingering doubt on the matter, the SCC has made it clear that the Director is a party and, as such, bound by the orders and conditions of the Review Board: **Mazzie v. BC(DIR AFPS)**, 2006, SCC 7, par.18.

EVALUATING THE EXPERT EVIDENCE

[182] JPH's psychiatric presentation renders this an exceedingly complex proceeding. Rather than simplifying matters, the involvement of three credible experts, including two who are presumably entirely independent, geometrically increases the complexity of the matter. To the extent that the BCRB is being asked to accept the expert evidence in its decision making, some parsing of that evidence is required.

[183] Clearly the Crown's witness, Dr. O'Shaughnessy, enjoys enormous stature and credibility, academically and as a forensic witness, before the courts. He is in all respects an "expert's expert", with acknowledged expertise in the area of sexual offenders.

[184] Dr. O'Shaughnessy, in his written (Ex.57) and his viva voce evidence, made it clear that JPH's unique combination of diagnoses renders risk assessment, in his case, exceedingly complicated, indeed or an "anomaly", for a psychiatric hospital (as opposed to a correctional) setting: Ex.60, pg.47. This rarity, according to Dr. O'Shaughnessy, means that generalized, empirical academic data or studies, and population-based risk assessment instruments, are of limited, if any, value in their application to JPH's case.

[185] At best, Dr. O'Shaughnessy's assessment relies upon "general clinical maxims" and his own personal past experience in assessing and "treating a few sexual sadistic murderers": Ex.57. In his viva voce evidence, Dr. O'Shaughnessy also states that the majority of sexually sadistic offenders generally also carry prominent personality or psychopathic traits and impulsivity, rendering them a high risk to re-offend. JPH has been assessed with no such features: Ex.60, pgs.42-45; see also par.124, supra.

[186] As to the risk-exacerbating implications of "stress", Dr. O'Shaughnessy discusses at a general level, the differences in terms of stressors affecting sexual sadism, verses schizophrenia, but fairly concludes:

"I don't know that much about him, I'd be -- just to be (sic) cautious, I mean what I'm learning is -- from seeing this, I think there's a clear risk. How -- how to quantify that is the issue, and I'm not so sure we can do that very well": Ex.60, pgs.47,48.

[187] Nevertheless, despite these limitations, Dr. O'Shaughnessy determined that an actual personal interview would not have been productive. His altogether appropriate concerns that an in-person interview might open the door to deception heightens the concern that the authors of the reports he reviewed might also have been deceived; or that reports perpetuate, by repetition, potentially critical inaccuracies, a phenomenon we encounter not infrequently.

[188] Moreover, Dr. O'Shaughnessy goes on to comment on such non-clinical areas as "institutionalization", "quality of life", prospects for integration and the accused's credibility, all without ever meeting the accused. With the greatest of respect, these areas are not properly the purview of expert evidence. Further, Dr. O'Shaughnessy was not a qualified expert in these areas. His evidence on these topics is of little weight and, in any event, inadmissible: see generally **R.v. Mohan**, [1994] SCC 9, quoting **R.v.Abbey**, [1982] 2 S.C.R. 24

[189] Given JPH's uniqueness and the Board's statutory requirement to impose the least onerous and least restrictive regime, on the basis always of an "individualized assessment", we conclude that even a comprehensive documentary review and assessment, is of lesser reliability and an in-person process gains in importance.

[190] According to Dr. O'Shaughnessy's analysis, information regarding outcomes with individuals like JPH is lacking as they are rarely discharged. He therefore concludes we should detain JPH indefinitely because we are unable to predict what will happen. His circular reasoning, with respect to JPH's risk, is speculation based on generalities. It does not amount to an individualized assessment. Under the circumstances, Dr. O'Shaughnessy's highly general evidence and his decision not to conduct an in-person clinical psychiatric interview, renders his evidence, overall, of limited utility.

[191] Though equally qualified, Dr. Riar's written and oral evidence admittedly lacked the academic sophistication of Dr. O'Shaughnessy's. Dr. Riar did, however, assess JPH in 1997, in 2003 (Ex.35), and again for the current proceeding in 2009, three times in all. He stated that on both latter occasions he also reviewed collateral documents beyond those he lists in Ex.59. This combination of interview and documentary review enables independent, observable, and longitudinal comparisons of JPH's clinical presentation over time.

[192] Again Dr. Riar's observations, with respect to JPH's credibility, institutionalization and quality of life issues, though they differ markedly from Dr. O'Shaughnessy's, are of limited assistance as their determination falls to the Tribunal: see par.128, 188, supra.

[193] Ultimately, we find no compelling rationale in this case for overvaluing Dr. O'Shaughnessy's evidence; indeed, under the circumstances, Dr. Riar's personal familiarity with this accused over thirteen years, renders it far more helpful and persuasive, and deserving of greater weight, on such critical issues as mental state assessment and risk prediction.

[194] Dr. Meldrum is known to this Tribunal as a competent, highly skilled, caring, thorough and ethical clinician. Her expertise is entirely the equal of the independent assessors tendered.

[195] It is clear that Dr. Meldrum cleaves to a very different view of JPH's risk and prospects. Despite being granted a broad discretion since 2002, Dr. Meldrum has not permitted JPH unescorted outings. The fact that the accused has successfully exercised escorted outings since November 2001, apparently does not sway her. She couches her concern about the consequences of failure of such outings in "catastrophic" terms: Ex.56, par.13. The totality of her own extensive testimony in this proceeding, despite the additional evidence of the two independent experts, makes it clear that she will not do so unless ordered.

[196] Mindful of our earlier discussion regarding the SCC's admonition to base decisions affecting an accused's *Charter* protected liberty interests on an "individualized assessment", it

is of some concern that Dr. Meldrum appeared to acknowledge that her approach toward JPH, was at least influenced by her experience with another patient who is well known to us:

“... a young man who I’d worked with since 1993, who had had many visits home to his family, 21 to be precise. They all went well. Nonetheless, we were vigilant every – every time he went out, assessed his mental state within a day or two of going. And on the 22nd visit he killed a family member, and that really brought home that risk is not static. What we see when we assess is not what’s present two hours later or two days later”: Transcript of Proceeding, Sep. 15, 2009, pg.44.

[197] For the record, the accused in that case, BP is considered by a leading expert in treatment-resistant illness as one of the most challenging and severely ill individuals in the province. His illness has been non-responsive to medication. He has been continuously, profoundly psychotic, including negative, homicidal auditory commands. He has been persistently non-compliant and abusing marijuana and cocaine. He was also repeatedly assaultive and sexually inappropriate in hospital. The tragedy of that case, and the caution it understandably inspires, does not justify its generalization to the current case to which it bears no similarity whatsoever.

ANALYSIS OF THE EVIDENCE AND DISPOSITION

[198] It has not to date been argued by any party, nor seriously entertained by the BCRB that JPH is no longer a significant threat, so as to require his absolute discharge.

[199] Irrespective of the positions of the parties, and absent a presumption of dangerousness, the BCRB must independently and impartially inquire into and consider the evidence and determine whether the individual accused before it is a significant threat warranting its ongoing jurisdiction: **Winko**, supra par.70,71,88.

[200] In the case before us, the Board has once again reminded itself of the following:

- The index offence which brings JPH before us was a serious and extremely dangerous event.

- On assessment JPH disclosed that in early to mid 1996 he began to experience psychotic delusions and ideas of reference (par 3, supra) and that his intent was to rape and kill the victim of the index offence.
- JPH was, on the basis of extensive diagnostic exploration, assigned diagnoses of sexual sadism as well as schizophrenia, which was active and florid at the time of the index offence.
- JPH's active schizophrenia, specifically its symptoms influencing his behaviour at the time of the index offence, formed the foundation of his NCR verdict.
- Despite consistent treatment with a number of medications, in a custodial environment, over more than 12 years, JPH has demonstrated ongoing symptoms including delusions and auditory hallucinations, with intermittent episodes of clear and overt decompensation (Aug-Dec 1998; early 2007)(paras.29,85,86 supra).
- JPH has no Axis II diagnosis of Antisocial Personality Disorder.
- JPH has, inter alia, and despite treatment with Lupron since 2003, continued, from time to time, to disclose or acknowledge episodes of coercive sexual fantasies, albeit at a much reduced frequency.
- Expert evidence holds that JPH is somewhat fragile and that social and environmental stressors can exacerbate his symptoms and serve to decompensate his mental stability.
- JPH has demonstrated complete abstinence from intoxicating, destabilizing intoxicants while at FPH.
- JPH has never demonstrated any aggression or sexually inappropriate behaviour or gestures while detained at FPH

[201] Under the circumstances, and on the available evidence as well as in consideration of the historic evidence and findings, the BCRB concludes that the accused continues to satisfy the threshold of finding “significant threat” required to sustain our jurisdiction over him.

[202] Having concluded that the accused continues to satisfy the threshold finding of potential significant threat, the BCRB is required to reconsider the criteria in s.672.54, and the evidence, in order to identify and impose the least onerous and least restrictive available order.

[203] Our analysis takes into account in particular that JPH has no community or financial supports or accommodation available to him in Canada. He has not been given opportunities to try to function in less restrictive circumstances. His capacity to so function after 12 years in an institution therefore remains un-assessed and unexplored.

[204] Absent evidence of JPH's capacity to function safely in less onerous or less restrictive circumstances and absent evidence of even the availability of less onerous and less restrictive yet adequately protective resources, we have no option but to continue his detention under s.672.54(c).

[205] Our task does not end here. We are next required to craft and impose appropriate conditions as part of the accused's disposition which, again, conflate with the least onerous/least restrictive rubric: see paras.172-175, supra.

[206] This brings us squarely to a reconsideration of the singular outstanding issue in this hearing, that of determining whether the impugned condition is appropriate and reasonable in the sense of being supported by the evidence and the BCRB's reasons: see **R. v. Owen**, [2003] 1 S.C.R. 779.

[207] Dr. Meldrum's opinion is consistent that, despite the passage of 12 years, JPH, for a variety of clinical reasons, remains an un-assumable risk for even brief periods of access to the community on an unescorted basis.

[208] In her most recent assessment she cites, in support of her thesis, such factors as:

Insight

[209] Dr. Meldrum has endorsed this factor without reservation or amelioration since JPH's admission to FPH: par.106, supra.

[210] The evidence suggests that, in fact, the accused freely and early on acknowledged his single episode of non-compliance due to genuine side effects. This does not, in our estimation, illustrate an absence of insight.

[211] We do not see how an accused's overall embracing of treatment and perfect compliance since, could be characterized in obviously pejorative terms as "self-serving".

[212] The evidence on record further suggests the accused has always been painfully candid in terms of his disclosure of his sexual history (Ex.17) and ongoing thoughts, though for much of the time this has not been a target of treatment at FPH. Despite what might be considered entirely justified fears of entering a correctional facility and despite his vulnerability to stress, JPH willingly agreed to a transfer to RTC to attend an ITPSO. Not surprisingly he became more overtly ill.

[213] At his June 1999 hearing and throughout the following year, JPH fully disclosed his fantasies as well as his visual and auditory symptoms, despite the fact that he considered his religious experiences as separate from his illness.

[214] Following his June 2000 hearing he remained disclosive and forthcoming of his fantasies and delusions. He willingly participated in psychotherapy, pastoral counseling and drug and alcohol counseling.

[215] In September 2001, after disclosing an escalation in coercive fantasies, JPH expressed interest in and consented to anti-androgen treatment.

[216] JPH's reports with respect to the variations in his sexual fantasies have been specific and quantified: Ex.32, par.60, supra.

[217] On an independent assessment performed by Dr. Riar in 2003, his insight into his illness and his sexual issues was termed “reasonable”: Ex.35.

[218] A further psychological assessment documented as indicators of positive progress, a reduction in the accused’s positive symptoms, his continuing abstinence, a “significant” reduction in libido and fantasies, which he acknowledged would pose an ongoing problem: Ex.56.

[219] A treatment summary of JPH’s progress in psychotherapy (January to March 2004) indicated, inter alia, significant clinical gains and motivation; an absence of manipulative behaviour; insight into his personality style and behaviours; modest increase in insight into his mental health; increased insight into the triggers of his sexual fantasies and their consequences; significant motivation for further sex offender treatment: Ex.40; see par.66 supra.

[220] In 2005, JPH attended the North Star Program at RTC for nine months. He was described as refreshingly candid and disclosive. His participation was deemed excellent.

[221] Nevertheless, Dr. Meldrum’s risk assessment tabled for JPH’s February 2006 hearing was described by the Board as “unaltered or unabated”. Ex.46, par.10.

[222] Dr. Riar has now seen JPH on three occasions, spanning more than the 12 years the accused has been under our jurisdiction, providing him with a unique longitudinal perspective. Dr. Riar found JPH had gained the ability to recognize his symptoms as part of his illness and that JPH still considers himself (insightfully) high risk for potential aggressive acts, all suggestive of an appreciable increase in insight.

[223] Insight relates to an understanding of one’s own mental process, illness and as well, a degree of self-knowledge. Simply put, it includes appreciation or acceptance of the index offence and the harm done; an appreciation of one’s illness and the signs and symptoms

thereof; an understanding of the role and benefits of treatment on mental and behavioural stability; and presumably of one's own risk potential. The presence of ongoing symptoms does not eliminate or exclude the possibility of insight.

[224] JPH expresses considerable remorse about the harm he inflicted at the index offence and he has, over time, expressed an understanding that it was wrong, as well as the desire to not see a recurrence.

[225] Despite his religious beliefs, which Dr. Riar and other assessors believe are protective and separate from his illness, JPH has never denied his schizophrenia or paraphilia. He has embraced and accepted every form of treatment that has been recommended, including treatment amongst and involving actual sex offenders. We would observe, without diminishing the seriousness of the index offence or the tenaciousness of his diagnosis, that JPH has never actually been convicted of a sexual offence and has no documented history of either consensual or non-consensual sexual violence.

[226] Finally, this case may also be illustrative of the uniquely double-edged nature of "insight" which ironically can work against an accused. On the one hand, if JPH denied his illness or his need for, or refused, pharmaceutical or psychotherapeutic treatment, he would be considered at a dangerously impaired level of insight. On the other hand, his manifest acceptance of his diagnoses and his almost perfect compliance, total abstinence, acceptance of treatment, and his cooperative presentation, are interpreted as self-serving and manipulative impression-management, evidencing a continuing and acutely escalated level of risk.

[227] This conundrum places JPH in an untenable Catch-22 situation. It is difficult to foresee what behavioural changes he would have to demonstrate to persuade Dr. Meldrum to alter her perspective or her decision making.

[228] As has Dr. Riar, this Tribunal has had the opportunity to hear from and interact with JPH at least annually for 12 years. On the basis of the evidence and our own observations over time, we conclude that JPH has significant insight in the various dimensions described above. In our view at least, JPH does not suffer from such an impairment of insight that brief unescorted outings would unacceptably and imminently escalate his risk to offend.

Ongoing Symptoms

[229] JPH suffers from a rare, indeed unique, combination of diagnoses. His schizophrenia, which the court found was the defining precipitating factor in the index offence, has been deemed refractory or treatment-resistant. This characterization arises because JPH's symptoms have never remitted entirely, despite trials of a variety of medications.

[230] In the main, his schizophrenic symptoms consist of the traditional components of psychosis: delusions, auditory, visual and, in JPH's case, tactile hallucinations. Though these symptoms may at one time have been informed in terms of content by JPH's pre-existing sexual interests, the established evidence is clear that his psychosis, not primarily his sexual interests, dominated his behaviour during the index offence. It is those symptoms which have, in recent times, been the focus of treatment, except for the anti-libidinal impacts of the administration of antiandrogens targeting his sexuality.

[231] Since his detention and treatment, JPH's symptoms have consisted of bothersome auditory symptoms or clv's (which have over time, decreased in intensity). While we have little difficulty in concluding that JPH's communications with, or from, God might also be defined as psychosis, Dr. Riar was far more willing to accept that these exist separate from JPH's schizophrenic symptoms, and that they are predominantly benign and, indeed, "protective". The nature of JPH's ongoing participation in pastoral counseling might be instructive in understanding this aspect of JPH's presentation.

[232] As early as 2003, FPH psychologists documented a reduction in psychotic symptoms, possibly in response to medication, as well as reduced libido and sexual ideation (paras.56,60-65, supra). Importantly, these assessors also characterized JPH's religious beliefs or even delusions as generally pro-social and "protective" in nature, during periods of stress or anxiety and in relation to both sexual and non-sexual impulses: Ex.40, par.66, supra. While no party

seriously contends that JPH's psychosis is in remission, certainly any longitudinal review of JPH's symptomology would conclude that their frequency and intensity has diminished over time and that, despite their residual influence on his behaviour, they recently appear to be benign and free of anti-social content.

Paraphilia

[233] There is no dispute that JPH meets the diagnostic criteria for sexual sadism (Ex.17) (see footnote 3). As stated above, while his interests may have given shape to or informed the content of his psychosis, his paraphilia did not appear to be the defining factor which precipitated the index offence (Court transcript, Ex.5,6)

[234] We acknowledge that this diagnostic condition tends to be chronic and subject to exacerbations due to stress or anxiety. Nevertheless, absent florid psychosis, the affliction has not independently caused JPH to pose an enormous risk to others.

[235] Indeed, after an initial psychological assessment in 1997, and until his brief admission to ITPSO (RTC) in 1998, and again after his discharge from that program, JPH's sexual disorder was not a primary target of treatment, despite disclosure of ongoing sadistic fantasies.

[236] Despite the lack of targeted treatment, Dr. Meldrum concluded that JPH's sexual sadism had failed to respond to treatment: Ex.31. On interview with Dr. Riar, JPH was fully and graphically disclosive of his paraphilic interests and of his desire for help. In light of Dr. Riar's assessment, JPH was initiated on Lupron in July 2003.

[237] FPH psychologists confirmed a significant reduction in JPH's libido and fantasies: Ex.36. A further supplementary report (Ex.40) documented overall positive progress and clinical gains, including improved control over his sexual impulses, and a readiness for treatment of his paraphilia.

[238] In addition, despite the stress it had occasioned in the past, JPH agreed to and attended the Northstar Program for Sex Offenders at RTC for 9 months in 2005. Despite reports of his excellent participation and performance, JPH has never been given any credit for the relapse prevention strategies he learned, or the consequent risk reduction occasioned by, his attendance at that program. He was denied further sex offender programming probably because it was offered in the community.

[239] Despite several assessments and reports of better symptom control and diminished sexual interests, suggestive of reduced risk, Dr. Meldrum, for JPH's January 2009 hearing, reported no significant improvement in symptomology or risk: Ex.53.

[240] Despite past assessments on the very point, Dr. O'Shaughnessy, without interviewing the accused and at what can only be understood as a level of generality, expressed reservations about "assuming" the impact of Lupron. Though when asked specifically, he acknowledged (again at an admittedly general level), that with the administration of antiandrogens the risk of re-offending is indeed diminished substantially.

[241] On further probing, Dr. O'Shaughnessy acknowledged that controlled unescorted outings for short periods of time of less than a day would not expose the community to undue risk.

[242] In contrast to Dr. O'Shaughnessy, Dr. Riar, again with the benefit of at least two previous interviews and a further in-person assessment, opined that JPH does not wish to relapse to intense sexual ideation or behaviour. Dr. Riar did not find the accused sexually preoccupied, though he has generally been readily forthcoming in this area. JPH's insight and judgment, combined with the effects of Lupron and absent florid psychosis have, in Dr. Riar's opinion, significantly reduced his risk of sexual offending. Dr. Riar also stated that even the

presence of fantasies per se, absent behaviour, are not necessarily indicative of elevated risk. JPH could therefore manage closely monitored unescorted outings of increasing duration.

[243] In the final analysis our task is rendered at least somewhat less protean. Both independent experts agree that JPH's risk of re-offending remains manageable under his current disposition and is in no way exacerbated or rendered un-assumable if he is afforded initially brief, but slow and incremental, unescorted access to the community for periods ranging from 20 minutes to two hours, at least twice per month.

[244] That directive is, in our view, sufficiently flexible in terms of frequency that it in no way negates a "pre-outing" assessment of JPH's mental state. Given its flexibility, we further do not envisage that the periodic or postponement of JPH's community access, due to brief or transient fluctuations in mental state, would necessarily trigger the notice contemplated by s.672.56 of the *Code*.

[245] After careful analysis of the evidence and due deliberation and irrespective of JPH's position herein, the Board has chosen to prefer the opinions and conclusions of Dr. Riar over those of Dr. O'Shaughnessy and Dr. Meldrum.

[246] Nevertheless, the concerns identified and counsel's request for clarification, have persuaded us to reconsider the wording of the impugned condition on the basis of the totality of the evidence now before us.

[247] Rather than using the using the language of the impugned condition, "brief, or incremental", we leave the matter of the duration of outings to the Director, within the overarching timeframes proposed by the experts. We assume the Director's discretion in this regard will be exercised in good faith.

