CML 3193 - Forensic Science

Forensic Psychiatry References

Criminal Code

Defence of mental disorder

16. (1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

Presumption

(2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.

Burden of proof

(3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.

Definitions

2. In this Act,

"mental disorder" « troubles mentaux »

"mental disorder" means a disease of the mind;

"unfit to stand trial" « inaptitude à subir son procès »

"unfit to stand trial" means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to

(*a*) understand the nature or object of the proceedings,

(*b*) understand the possible consequences of the proceedings, or

(*c*) communicate with counsel;

PART XX.1

MENTAL DISORDER

INTERPRETATION

Definitions

672.1 (1) In this Part,

"accused" « accusé »

"accused" includes a defendant in summary conviction proceedings and an accused in respect of whom a verdict of not criminally responsible on account of mental disorder has been rendered;

"assessment" « évaluation »

"assessment" means an assessment by a medical practitioner or any other person who has been designated by the Attorney General as being qualified to conduct an assessment of the mental condition of the accused under an assessment order made under section 672.11 or 672.121, and any incidental observation or examination of the accused;

"disposition" « décision »

"disposition" means an order made by a court or Review Board under section 672.54 or an order made by a court under section 672.58;

"dual status offender" « contrevenant à double statut »

"dual status offender" means an offender who is subject to a sentence of imprisonment in respect of one offence and a custodial disposition under paragraph 672.54(*c*) in respect of another offence;

ASSESSMENT ORDERS

Assessment order

672.11 A court having jurisdiction over an accused in respect of an offence may order an assessment of the mental condition of the accused, if it has reasonable grounds to believe that such evidence is necessary to determine

(*a*) whether the accused is unfit to stand trial;

(*b*) whether the accused was, at the time of the commission of the alleged offence, suffering from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1);

(*c*) whether the balance of the mind of the accused was disturbed at the time of commission of the alleged offence, where the accused is a female person charged with an offence arising out of the death of her newly-born child;

(*d*) the appropriate disposition to be made, where a verdict of not criminally responsible on account of mental disorder or unfit to stand trial has been rendered in respect of the accused; or

(*e*) whether an order should be made under section 672.851 for a stay of proceedings, where a verdict of unfit to stand trial has been rendered against the accused.

1991, c. 43, s. 4; 1995, c. 22, s. 10; 2005, c. 22, s. 2.

Where court may order assessment

672.12 (1) The court may make an assessment order at any stage of proceedings against the accused of its own motion, on application of the accused

or, subject to subsections (2) and (3), on application of the prosecutor.

Limitation on prosecutor's application for assessment of fitness

(2) Where the prosecutor applies for an assessment in order to determine whether the accused is unfit to stand trial for an offence that is prosecuted by way of summary conviction, the court may only order the assessment if

(*a*) the accused raised the issue of fitness; or

(*b*) the prosecutor satisfies the court that there are reasonable grounds to doubt that the accused is fit to stand trial.

Limitation on prosecutor's application for assessment

(3) Where the prosecutor applies for an assessment in order to determine whether the accused was suffering from a mental disorder at the time of the offence so as to be exempt from criminal responsibility, the court may only order the assessment if

(*a*) the accused puts his or her mental capacity for criminal intent into issue; or

(*b*) the prosecutor satisfies the court that there are reasonable grounds to doubt that the accused is criminally responsible for the alleged offence, on account of mental disorder.

1991, c. 43, s. 4.

FITNESS TO STAND TRIAL

Presumption of fitness

672.22 An accused is presumed fit to stand trial unless the court is satisfied on the balance of probabilities that the accused is unfit to stand trial.

1991, c. 43, s. 4.

VERDICT OF NOT CRIMINALLY RESPONSIBLE ON ACCOUNT OF MENTAL DISORDER

Verdict of not criminally responsible on account of mental disorder

672.34 Where the jury, or the judge or provincial court judge where there is no jury, finds that an accused committed the act or made the omission that formed the basis of the offence charged, but was at the time suffering from mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1), the jury or the judge shall render a verdict that the accused committed the act or made the omission but is not criminally responsible on account of mental disorder.

1991, c. 43, s. 4.

Relevant Cases

Admissibility of Psychiatric Opinions

R. v. Abbey, [1982] 2 S.C.R. 24

DICKSON J.:-- Robert Mark Abbey was tried by a judge sitting alone on two charges (i) importing cocaine into Canada and (ii) unlawful possession of cocaine for the purpose of trafficking. His sole defence was that he was insane at the material time. The trial judge gave effect to that defence. He found Abbey not guilty on account of insanity and the Court of Appeal of British Columbia dismissed a Crown appeal. The matter has now, by leave, reached this Court. […]

Dr. Vallance testified that he first saw Abbey approximately 10 weeks after the commission of the offence. Dr. Vallance's testimony was based on his interviews with Abbey, his interviews with Abbey's mother, his review of a medical report prepared by another psychiatrist, and his discussions with other doctors who were involved in treating Abbey. In particular, Dr. Vallance relied on Abbey's description of the events surrounding his trip to South America as indicative of his mental state at the material time. Dr. Vallance's opinion was that Abbey, at all material times, was suffering from a disease of the mind, a manic illness, known as hypomania. While Abbey appreciated that he was bringing cocaine into Canada and knew that what he was doing was wrong, he believed that, if caught, he would not be punished. Dr. Vallance said:

> He had a considerable disturbance of mood. He had delusional ideas. He had hallucinatory experiences. It's difficult under circumstances like that to fully appreciate what you are doing, particularly when the feelings and delusional ideas are tangled up with what you are doing. If you feel that you are for some delusional idea inordinately powerful or safe then that impairs good judgment. I am sure he had some appreciation of what he was doing.

Dr. Vallance further testified that, while Abbey was not rendered totally incapable of appreciating the nature and quality of his acts by reason of the disease of mind from which he suffered, there was a degree of impairment of judgment. He had the feeling that he was being looked after by some outside force that was feeding him strength and that no harm would come to him and even if he did get caught it did not matter because somehow he would be looked after. Dr. Vallance made reference to Abbey's delusional belief that he was committed to a particular path of action which he could not change and his further delusional idea, while in Lima, Peru, that he had "astro-travelled" back to Vancouver already and that in getting on the plane in Lima to fly home he was simply having the body follow where the "rest" had already gone.

Dr. Eaves, in rebuttal, was of the opinion that the disease of the mind experienced by Abbey, hypomania, would "not be substantially enough to render him incapable of appreciating the nature and quality of his actions ... not to know that his actions were wrong".

[…]

An expert witness, like any other witness, may testify as to the veracity of facts of which he has first-hand experience, but this is not the main purpose of his or her testimony. An expert is there to give an opinion. And the opinion more often than not will be based on second-hand evidence. This is especially true of the opinions of psychiatrists.

As stated by Fauteux J. in Wilband v. The Queen, [1967] S.C.R. 14 at p. 21:

> The value of psychiatrist's opinion may be affected to the extent to which it may rest on second-hand source material; but that goes to the weight and not to the receivability in evidence of the opinion, which opinion is no evidence of the truth of the information but evidence of the opinion formed on the basis of that information.

[…]

In the present case Abbey did not testify. Dr. Vallance testified, in the course of his opinion, as to many events and experiences related to him during several interviews. This testimony, while admissible in the context of the opinion, was not in any way evidence of the factual basis of these events and experiences. The trial judge in his decision fell into the error of accepting as evidence of these facts, testimony which if taken to be evidence of their existence would violate the hearsay rule. There was no admissible evidence properly before

the Court with respect to: the delusions experienced by the accused; the accused having described the symptoms of his disease to his mother some six months prior to the commission of the offence; the accused having seen a psychiatrist before leaving for Peru; the accused's unstable conduct at the airport some days prior to leaving for Peru or his bizarre behaviour in Peru.

R. v. Innocent, [2008] O.J. No. 312 (S.C.J.)

2 The principal issue in this trial is whether the accused had the requisite intent to kill police officer Umer Khan in relation to the charge of attempted murder. It was not contested by the defence that all three of the weapons charges (counts 1, 2 and 3 of the indictment) arising from the May 16, 2005 incident were proven, as was the charge of carrying a concealed weapon (count 8) at the time of the May 21, 2005 incident. There was no issue with respect to the accused's identity.

The Psychiatric Evidence

28 Dr. John Bradford, a forensic psychiatrist, was called on behalf of the defence. He diagnosed the accused with substance abuse disorder, anti-social personality disorder and with schizophrenia. There was a great deal of discussion as to whether or not schizophrenia was an accurate diagnosis in this case. However, Dr. Pallandi, the Crown's psychiatrist, conceded that this was likely an accurate diagnosis and I therefore am content to accept that the accused does suffer from schizophrenia. Having said that, the question for the Court is what affect the schizophrenia and indeed the substance abuse disorder have had on the accused's ability to form the specific intent to kill and whether this intent is proven in the context of the assault on officer Khan. Dr. Bradford conceded that any differentiation between a psychotic condition induced by consumption of street drugs (such as ecstasy) and the typical effects of schizophrenia may be of no more than academic interest in that both conditions can cause the same degree of impairment. Dr. Bradford was of the view that the accused exhibited "erratic impulsive behaviour" due to a disturbed mental status.

29 An important part of Dr. Bradford's analysis and diagnostic reasoning arose from the fact that the accused told Dr. Bradford that he exhibited a generalized amnesia with respect to these events. However, there is no admissible evidence before the Court with respect to the accused's professed amnesia and this detracts from the weight to be accorded to and the assistance to be derived from this psychiatric opinion. It is Dr. Bradford's view that at the time of the offence, the accused was likely in a disturbed mental state due to a combination of factors including schizophrenia and a substance-induced condition that affected his operating mind, judgment and impulse control. This condition would affect his ability to think coherently, impair his decision-making capacity, his ability to interpret events and his volitional control over his behaviour, all of which, in Dr. Bradford's opinion, would call into question the accused's ability to form the requisite intent.

30 Dr. Derrick Pallandi, a forensic psychiatrist, testified on behalf of the Crown. He diagnosed the accused as suffering from anti-social personality disorder and from polysubstance abuse and/or dependence. As for the diagnosis of schizophrenia offered by Dr. Bradford, Dr. Pallandi was of the view that this diagnosis was less clear although on balance he was prepared to accept that the accused probably did suffer from schizophrenia. He was unable to assess the impact of these diagnoses on the accused concerning the events of May 21, 2005 because the accused professed a general and

profound amnesia for these events. As noted previously, there was in fact no evidence before the Court that the accused suffered from amnesia with respect to either of the incidents giving rise to the charges before the Court.

31 It was, however, Dr. Pallandi's opinion that a review of the events which occurred demonstrated a good deal of purposeful behaviour. He felt there was an absence of evidence of bizarre or erratic behaviour leading up to the incident. He also felt that the use of the gun to facilitate an escape and the escape attempt itself seemed to evidence purposeful goal-oriented behaviour. Dr. Pallandi observed that the accused was to some degree intoxicated by alcohol or drugs during the incident involving Cst. Khan but that the accused was nevertheless capable of purposeful behaviour as the events demonstrated. In Dr. Pallandi's view there was no indication that the accused was responding to psychotic experiences such as delusions or command auditory hallucinations in relation to his actions.

32 The question was pursued in cross-examination as to whether the accused's amnesia might be evidence of the type of episodic memory deficits which are a feature of schizophrenia or were blackouts which can be a feature of excessive alcohol consumption. This was of limited value to the Court because there was no admissible evidence of either blackouts or amnesia on the part of the accused. Dr. Pallandi did concede in cross-examination that impulsivity could be a feature of schizophrenia with some individuals. He acknowledged that when this occurs a schizophrenic's impulsive acts are not preceded by appreciable thought, although they are nevertheless voluntary. He also accepted that schizophrenics have an impairment of the executive functions of the brain which can manifest itself in difficulty spontaneously processing information as they encounter it, resulting in a slowed down thought process. He stressed, however, that it is highly variable as to how impaired a schizophrenic might be. Some are highly functional and others show significant deficits manifested by episodic memory deficits and a compromise of executive control processes.

44 The question is therefore whether the evidence discloses a particularly advanced degree of intoxication or of mental impairment so as to raise a reasonable doubt as to the accused's ability to appreciate the probable consequences of his acts. If this question is answered in the negative, then the normal inference will be drawn, i.e. that the accused intended the probable results of his actions. In this case, the act of pointing a revolver at the officer's head from close range and pulling the trigger would lead to an inescapable inference of an intent to kill.

45 I am unable to conclude on the evidence that there was a sufficient degree of impairment through consumption of drugs or alcohol by itself or in combination with possible symptoms of the accused's schizophrenia, to displace the presumption that the accused intended the probable consequences of his acts.

46 There is no question that the accused drank significant amounts of alcohol on the day of the offence. Ms. Rukima observed the accused order several rounds of liquor in the bar before the altercation. The arresting officers smelled alcohol and were of the opinion that the accused was intoxicated. On the other hand, the accused was clearly capable of considerable physical dexterity and goal-oriented behaviour. He was not observed to exhibit any unusual behaviour in the bar prior to the altercation. He was not acting out or staggering. He was able to manoeuvre physically in the struggle with the police to the point that they were unable to effectively subdue him. He was able to quickly and skillfully draw his revolver, aim it at Cst. Khan's head and pull the trigger. He was able to run down the

stairs and run an evasive pattern around several blocks in the market area and then hide behind a cement planter on Rideau Street, all in a conscious effort to avoid arrest. Upon arrest he was heard to say, "OK, you got me, you got me." During the ride to the police station following his arrest, he seemed agitated and told the officers, "I'm a loser, why don't you kill me?" but seemed to understand the standard warnings read to him. He seemed to be oriented to time and place and to appreciate his predicament. This was not an individual too intoxicated to be unable to appreciate the probable consequences of his actions in attempting to fire a gun at someone's head at close range.

47 The essence of the defence based on the evidence of the defence psychiatrist, Dr. Bradford, was that as a schizophrenic, there was likely to have been some impairment of the accused's executive functions, that is to say his ability to process information appropriately and quickly and to make decisions. He would be inclined to act impulsively and inappropriately and to be hypervigilant. It is suggested that this is what occurred in this brief and unexpected altercation with the police. It was further suggested that alcohol and drugs combined with symptoms of schizophrenia made for a volatile combination. It was argued that all of this should raise a reasonable doubt as to the accused's capacity to form an intent to kill.

R. v. Parks, (1992) 75 C.C.C.(3d) 287 (S.C.C.)

From the headnote:

Respondent attacked his parents-in-law, killing one and seriously injuring the other. The incident occurred at their home, some 23 km. from respondent's residence, during the night while they were both asleep in bed. Respondent had driven there by car. Immediately after the incident, the respondent went to a nearby police station, again driving his own car, and told them what he had done.

Respondent claimed to have been sleepwalking throughout the incident. He had always been a deep sleeper and had a great deal of trouble waking up. The year prior to the incident was particularly stressful for the respondent and his personal life suffered. His parents-in-law were aware of his problems, supported him and had excellent relations with him. Additionally, several members of his family suffer or have suffered from sleep problems such as sleepwalking, adult enuresis, nightmares and sleeptalking.

The respondent was charged with first degree murder and attempted murder. At the trial respondent presented a defence of automatism. The testimony of five expert [page872] witnesses called by the defence was not contradicted by the Crown. This evidence was that respondent was sleepwalking and that sleepwalking is not a neurological, psychiatric or other illness. The trial judge put only the defence of automatism to the jury, which acquitted respondent of first degree murder and then of second degree murder. The judge then acquitted the respondent of the charge of attempted murder. The Court of Appeal unanimously upheld the acquittal. At issue here is whether sleepwalking should be classified as non-insane automatism resulting in an acquittal or as a "disease of the mind" (insane automatism), giving rise to the special verdict of not guilty by reason of insanity.

Defence of “Battered Woman Syndrome”

R. v. Lavallee (1990), 55 C.C.C.(3d) 97 (S.C.C.)

2 The appellant, who was 22 years old at the time, had been living with Kevin Rust for some three to four years. Their residence was the scene of a boisterous party on August 30, 1986. In the early hours of August 31 after most of the guests had departed the appellant and Rust had an argument in the upstairs bedroom which was used by the appellant. Rust was killed by a single shot in the back of the head from a .303 calibre rifle fired by the appellant as he was leaving the room.

4 The relationship between the appellant and Rust was volatile and punctuated by frequent arguments and violence. They would apparently fight for two or three days at a time or several times a week. Considerable evidence was led at trial indicating that the appellant was frequently a victim of physical abuse at the hands of Rust. Between 1983 and 1986 the appellant made several trips to hospital for injuries including severe bruises, a fractured nose, multiple contusions and a black eye. One of the attending physicians, Dr. Dirks, testified that he disbelieved the appellant's [page858] explanation on one such occasion that she had sustained her injuries by falling from a horse.

9 The expert evidence which forms the subject matter of the appeal came from Dr. Fred Shane, a psychiatrist with extensive professional experience in the treatment of battered wives. At the request of defence counsel Dr. Shane prepared a psychiatric assessment of the appellant. The substance of Dr. Shane's opinion was that the appellant had been terrorized by Rust to the point of feeling trapped, vulnerable, worthless and unable to escape the relationship despite the violence. At the same time, the continuing pattern of abuse put her life in danger. In Dr. Shane's opinion the appellant's shooting of the deceased was a final desperate act by a woman who sincerely believed that she would be killed that night:

> ... I think she felt, she felt in the final tragic moment that her life was on the line, that unless she defended herself, unless she reacted in a violent way that she would die. I mean he made it very explicit to her, from what she told me and from the information I have from [page860] the material that you forwarded to me, that she had, I think, to defend herself against his violence.

11 The appellant was acquitted by a jury …

28 Where expert evidence is tendered in such fields as engineering or pathology, the paucity of the lay person's knowledge is uncontentious. The long-standing recognition that psychiatric or psychological testimony also falls within the realm of expert evidence is predicated on the realization that in some circumstances the average person may not have sufficient knowledge of or experience with [page871] human behaviour to draw an appropriate inference from the facts before him or her. An example may be found in R. v. Lyons, [1987] 2 S.C.R. 309, in which this Court approved the use of psychiatric testimony in dangerous offender applications. At p. 366, La Forest J. remarks that "psychiatric evidence is clearly relevant to the issue whether a person is likely to behave in a certain way and, indeed, is probably relatively superior in this regard to the evidence of other clinicians and lay persons".

75 On my reading of the record Dr. Shane had before him admissible evidence about the nature of the relationship between the appellant and Rust in the form of the appellant's

statement to the police and the hospital records. In addition, there was substantial corroborative evidence provided at trial by Ezako, the emergency room doctor who testified to doubting the appellant's explanation of her injuries. There was also the evidence of the witnesses on the night of the shooting who testified to the appellant's frightened appearance, tone of voice, and conduct in dealing with Rust. The evidence pointed to the image of a woman who was brutally abused, who lied about the cause of her [page897] injuries, and who was incapable of leaving her abuser. As Huband J.A. comments in dissent, if the trial judge erred at all, he was probably remiss in not mentioning the corroborative evidence of Ezako as buttressing the evidentiary foundation on which Dr. Shane premised his opinion.

78 I would accordingly allow the appeal, set aside the order of the Court of Appeal, and restore the acquittal.

The Law of Insanity/Not Criminally Responsible

R. v. Swain, [1991] 1 S.C.R. 933

[…] At trial, the Crown sought to adduce evidence with respect to insanity at the time of the offence, to which the appellant objected. After conducting a *voir dire*, the trial judge ruled that the Crown could adduce such evidence. At the conclusion of the trial, Mr. Swain was found not guilty by reason of insanity on all counts. Defence counsel then moved to have s. 542(2) of the *Code* (now s. 614), which provides for the automatic detention at the pleasure of the Lieutenant Governor of an insanity acquittee, declared inoperative on the basis that it violated the *Charter*. O'Connell Dist. Ct. J. reserved judgment and on June 10, 1985, held that Mr. Swain's constitutional rights were not infringed by s. 542(2) and ordered that the appellant be kept in strict custody at the Queen Street Mental Health Centre in Toronto until the Lieutenant Governor's pleasure was known. […]

The mere fact that the Crown is able to raise a defence which the accused does not wish to raise, and thereby to trigger a special verdict which the accused does not wish to trigger, means that the accused has lost a degree of control over the conduct of his or her defence. […]

Thus, it is my view that the common law rule which allows the Crown to raise evidence of insanity over and above the accused's wishes is a denial of liberty which is not in accordance with the principles of fundamental justice. Accordingly, the common law rule limits an accused's rights under s. 7 of the *Charter*.

Winko v. British Columbia (Forensic Psychiatric Institute), [1999] 2 S.C.R. 625

62 On this interpretation of Part XX.1 of the Code, the duties of a court or Review Board that is charged with interpreting s. 672.54 may, for practical purposes, be summarized as follows:

1. The court or Review Board must consider the need to protect the public from dangerous persons, the mental condition of the NCR accused, the reintegration of the NCR accused into society, and the other needs of the NCR accused. The court or Review Board is required in each case to answer the question: does the evidence disclose that the NCR accused is a "significant threat to the safety of the public"?

2. A "significant threat to the safety of the public" means a real risk of physical or psychological harm to members of the public that is serious in the sense of going

beyond the merely trivial or annoying. The conduct giving rise to the harm must be criminal in nature.

[…]

Dangerous Offender

R. v. Innocent, [2009] O.J. No. 3663 (S.C.J.)

The Opinion of Dr. Pierre Gagné

29 The only expert medical evidence received in this sentencing hearing was that of Dr. Pierre Gagné, a forensic psychiatrist of over thirty-five years experience. He is currently head of forensic medicine at the University of Sherbrooke. Dr. Gagné filed the assessment report required by subsection 752.1(2) of the Criminal Code. He reviewed the extensive materials concerning Mr. Innocent's previous involvements with the law as well as the predicate offences and the custodial records concerning Mr. Innocent from various penal institutions. He interviewed Mr. Innocent on May 9, 2008 at the Regional Detention Centre in Ottawa and produced a report dated June 25, 2008.

30 Dr. Gagné noted that Mr. Innocent, now thirty-seven years of age, came to Canada from Haiti as a small child. His impression is that Mr. Innocent is of limited intelligence. Mr. Innocent was the product of a broken home and found himself in various juvenile facilities in Montreal during his youth. He appears to have completed his elementary education and is able to read but has difficulty writing. During his youth, Mr. Innocent began smoking marijuana and hash and developed an addition to alcohol. As a youth, he became immersed in the gang culture in Montreal and then engaged in pushing drugs as a means of support.

31 It is interesting to note that Mr. Innocent has apparently never received any specialized treatment for his drug and alcohol addictions, nor has he received therapy of any sustained nature in relation to his psychiatric problems.

32 In terms of psychiatric diagnosis, Dr. Gagné is of the view that Mr. Innocent has an Axis I diagnosis of substance abuse and dependence (in remission). This is accompanied by an Axis II diagnosis of anti-social personality disorder. I would note that this diagnosis is consistent with that offered by both of the psychiatrists who testified at trial on the issue of Mr. Innocent's ability to form the intention to kill, which issue arose in relation to the attempted murder charge in the predicate offence.

33 For sentencing purposes, I accept Dr. Gagné's diagnosis, including his observation that suggestions of possible schizophrenia in some of the medical reports and medical records tendered at trial are unlikely to be accurate and any psychotic behaviour thought to be observed in the past was likely the result of significant substance abuse or reaction to prescribed psychiatric medications. Dr. Gagné points out that if Mr. Innocent actually suffers from schizophrenia, he would have clinical symptoms after his drug and alcohol consumption had ended and yet there have been no such symptoms.

34 Dr. Gagné also observed that Mr. Innocent recognizes his past violence but has a tendency to blame others or to present intoxication as an excuse. Minimal earlier therapeutic interventions have failed and violence and alcohol and drug consumption has been a feature of his life. Dr. Gagné also observed that at the present time Mr. Innocent has no known personal

or community support and that the likelihood of a future sustained participation in psychological treatment and supervision in the community is "doubtful". He believes that there is a strong possibility of violent reactions to future stressful events due to Mr. Innocent's impulsive behaviour. I accept this evidence.

35 Dr. Gagné quoted in his report the following summary of Mr. Innocent's previous violent behaviour (from a National Parole Board document dated January 11, 1997):

> At the age of 25, you are presently detained for a second penitentiary term for very serious offences involving violence. You have relapsed hardly three months after the expiration of your first warrant and we notice that the releases on parole that you have obtained turned out to be failures either because of an escape or recidivism. The robbery happened with the help of an accomplice, but you were the instigator. You have taken out a truncated and charged weapon and you have pointed it on the victim, asking for the content of the cash register. Two days after committing the robbery, you have uttered death threats to the victim, telling the person that you would "have his shop blown up" if he was going to testify against you. Your criminal record started in 1990 and your criminality is persistent, repetitive, of polymorphous nature, and mainly directed against people. Your acting out is mingled with violence, and, for that matter, we find several sentences for violent offences. You have been accused of assault on an adolescent, you have threatened a guard in a juvenile centre with a truncated .22 rifle with no ammunition, as well as with a knife. During the intervention, two guards were injured with the knife. You have also been involved in several fights related to street gangs and, following verification with a liaison-agent, in regard to criminal groups, it shows that you were related to such groups, the Family and the CDP groups. You are described as a violent individual who shares the values of the gang.
>
> Moreover, at the occasion of an armed robbery in 1991, you and your accomplice have tied the employees to a chair; at another robbery, an imitation of a pellet gun was used, a salesman was hit on the jaw and fainted. At the occasion of another offence you had a pellet gun and a knife, you shot at a guy, hitting him in his leg. That incident was related to street gang's wars ... You have started this sentence in a maximum security prison, then you obtained a transfer to Drummondville. However in January 1998, you were identified as the instigator of an aggression on another inmate who had to be hospitalised. This incident led to your transfer to Cowansville where you have been unstable ... you were also placed in segregation twice for having smashed a window. Gas had to be used on one occasion ...

36 I accept this summary as a generally accurate review of Mr. Innocent's history and as supported by the documentation filed in this hearing.

37 In relation to the predicate offences, Mr. Innocent advised Dr. Gagné that he has no recollection whatsoever of the May 16 incident. In relation to the May 21 incident, he also professed to have no memory of his assault on Officer Khan. He explained his possession of the handgun as a method of self-protection and asserted that he always left an empty chamber in the revolver so that it would not fire accidentally. He told Dr. Gagné that he never intended to kill anybody except himself, when he was feeling suicidal.

38 Dr. Gagné concluded that on his assessment of the relevant facts, he was led to conclude that "there is an absence of foreseeable reasonable possibility of eventual control of the risk in the community".

39 I agree with Dr. Gagné's conclusions which are contained in the final two paragraphs of his report:

> From a clinical point of view, the prognosis is poor Mainly due to the association of antisocial personality with drug and alcohol abuse. Mr. Innocent's behaviour problems have existed since he was a child. Punishment (incarceration) and psychological therapy did not bring any change in his lifestyle or contribute to a reduction in his violent behaviour as demonstrated by the May 2005 incidents. At the present time, there is no known therapeutic approach, whether psychological or pharmaceutical that could bring significant changes in Mr. Innocent. Mr. Innocent lacks what we could call the substratum that one could work on to render him less at risk for others. In addition, his chronic low self-esteem makes him a danger to himself and as a way of consequence to others as well. This low self-esteem has been present since he was a teenager and has been accompanied with suicidal ideation. This contributes to worsening the prognosis when it comes to evaluating the risk that he represents for others.
>
> My assessment of this case leads me to conclude to the absence of foreseeable reasonable possibility of eventual control of the risk in the community. This opinion is based on the information available to me at the time of writing my report and on my 35 years experience as a forensic psychiatrist.

40 In Mr. Goldstein's capable cross-examination of Dr. Gagné, it was suggested that there would be a reduced chance of violent recidivism on Mr. Innocent's part by reason of the fact that pending his release in perhaps eight years of time, he would have reached his mid forties and would have had the opportunity to benefit from a prolonged abstinence from the use of alcohol and drugs and would have obtained the benefit of courses or therapeutic programs in the prison system. Dr. Gagné did agree that older offenders were subject to the phenomenon of "burnout" wherein there is often a significant drop off in violent behaviour as offenders get older.

41 In addition, it was suggested that it would be of benefit to Mr. Innocent if he could successfully pursue therapy in prison for his drug and alcohol addictions. Dr. Gagné agreed that these factors could occur and could accrue to Mr. Innocent's benefit, however Mr. Innocent's prognosis would only improve if there occurred a major change to his thinking patterns within the future incarceration period. Dr. Gagné was of the opinion that it was highly speculative as to whether that would occur.

42 I understood Dr. Gagné to agree with the suggestion offered in cross-examination that in theory, if Mr. Innocent could bring his Axis I diagnosis (poly-substance abuse) under control by a prolonged period of sobriety, presumably with the benefit of therapeutic interventions in prison, he might ultimately be supervised adequately in the community, particularly as he reaches his late forties, assuming the "burn out" phenomena took effect. Dr. Gagné agreed that there are many persons with anti-social personality disorder alone who are successfully supervised in the community. Dr. Gagné reiterated that on his review of the extensive prison records, Mr. Innocent had never apparently been offered or had attempted alcohol or drug abuse therapy in prison and whether he would accept such therapy or benefit from it was unknown.