Case Name:

Mazzei (Re)

IN THE MATTER OF Part XX.1 (Mental Disorder) of
the Criminal Code R.S.C. 1985 c. C-46,
as amended 1991, c. 43
AND IN THE MATTER OF the Disposition Hearing of
Vernon Roy Mazzei

[2006] B.C.R.B.D. No. 93

British Columbia Review Board
B. Long (Chairperson), H. Parfitt and
L. Chow (Members)

Decision: April 11, 2006.
(70 paras.)

Appearances:

Accused/patient: Vernon Roy Mazzei

Accused/patient/counsel: D.Nielsen, G. Barrière

Hospital/clinic: D. Lovett, Q.C.

Attorney General: L. Hillaby

SUPPLEMENTARY REASONS

Introduction

¶ 1 CHAIRPERSON:-- On April 11, 2006 the B.C. Review Board conducted an annual disposition review in the matter of Vernon Roy Mazzei. This review involved a number of contentious legal issues. During the course of the hearing Ms. Nielsen, one of Mr. Mazzei's counsel, requested an adjournment in order to provide written argument with respect to two additional issues. These were whether the Board should:

1 Order an independent risk assessment; and,

2 In the event the Board made a custodial disposition, specify conditions that would require the Director to move and then keep the accused on a minimum security ward (Hawthorne).

¶ 2 The Director, represented by Ms. Lovett, and the Crown, represented by Mr. Hillaby, did not oppose Ms. Nielsen's request. They also wanted an opportunity to provide written argument on these issues. However the delay that would have been introduced by this adjournment would have made it impossible for the Board to provide reasons by May 9, 2006. That was the date for a hearing in the Court of Appeal related to matters raised by the other issues before the Board. In order to meet that deadline the Board and the parties agreed that these two additional issues could be severed from the other matters before the Board, and be separately considered as a discretionary disposition review under s. 672.82(1) of the Code. The parties subsequently provided written submissions as agreed upon, although the Board did not receive the final submission until May 29, 2006.

¶ 3 On May 5, 2006, the Board made a custodial disposition, reviewable by July 31, 2006, and released accompanying reasons. These reasons should therefore be considered in conjunction with that decision. We will therefore not further review the accused's background, forensic history, and new evidence, except as is necessary for these reasons.

1. Independent risk assessment

¶ 4 Mr. Mazzei seeks an order for an "independent risk assessment". The origin of this request is rooted in the Board's order of April 3, 2002 [See Note 1 below], which included the following conditions:

Note 1: Exhibit 105

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8. That for the accused's next hearing the Director undertake a comprehensive global review of Mr. Mazzei's diagnostic formulations, medications and programs with a view to developing an integrated treatment approach which considers the current treatment impasse and the accused's reluctance to become an active participant in his rehabilitation;)
9. That for the next hearing the Board be provided with an independent assessment of the accused's risk to the public in consideration of the above refocused treatment plan.

¶ 5 The reasons for these conditions were explained by the Board as follows [See Note 2 below]:

Note 2: supra, footnote 1, p. 4

> ... However, it is equally clear that after 16 years of programs, treatment and medication his current program is meeting neither his nor the public's needs. It is our serious concern that if the status quo persists for an extended period of time Mr. Mazzei will become more institutionalized, more angry, more reactive, more oppositional, and indeed no less attracted to substances.
>
> For those reasons we believe that it is both appropriate and just that we impose a further order of custody, however for no more than four months. Our thinking is that to make a 12-month order would be to simply acquiesce to the status quo.
>
> Our objective between now and the time that we reconvene is to require the Director to undertake a global review of Mr. Mazzei's case history with a view to reconsidering and reintegrating his various and complex diagnoses, as well as his history of medication trials and programs with the intention of resolving the current treatment impasse and Mr. Mazzei's own ambivalence or reluctance to becoming an active participant in his treatment and reintegration. We would also request that for his next hearing, and as part of the aforementioned case review, the production of a revised and preferably independent assessment of the accused's risk in light of a reformulated treatment plan. ...

¶ 6 The Director appealed the Board's order. The Court of Appeal allowed the appeal, concluding, inter alia, that the Board did not have the jurisdiction to make conditions #8 and #9. The Court found that the role of the Board was restricted to the management of the accused, while the Director was responsible for the accused's medical treatment. This division of roles and responsibilities made the Board's request that FPH consider and deliver medical treatment redundant. Furthermore, the Board could not make conditions binding on anyone other than the accused.

¶ 7 Mr. Mazzei appealed to the Supreme Court of Canada. On March 16, 2006, the court released its reasons in Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Service). [See Note 3 below] This decision represents the latest Supreme Court of Canada interpretation of the provisions of Part XX.1. The court unanimously allowed the accused's appeal. The court found that although the Board did not have the power to prescribe treatment, the scope of the Board's power to make, in a supervisory capacity, orders and conditions related to or regarding an accused's medical treatment included anything short of actually prescribing treatment. In order for the Board to be able to form its own independent opinion of an accused's treatment, prospects for rehabilitation, reintegration, and risk to public safety, the Board was entitled to order a re-evaluation of treatment approaches and exploration of alternative treatment where necessary. Conditions #8 and #9 constituted a valid exercise of the of the Board's powers and jurisdiction, and fell squarely within the Board's authority to question the accused's treatment plan, explore new treatment possibilities, supervise his rehabilitation, and assess his risk to public safety.

Note 3: 2006 SCC 7

¶ 8 The hearing of April 11, 2006 was the first review of the accused's disposition following the Supreme Court of Canada decision. Ms. Nielsen submits that now that the Supreme Court of Canada has upheld the Board's jurisdiction to order an independent risk assessment, the Board should give effect to the original order. She argues that although nearly four years have elapsed since the Board's original order, little has changed. She submits that the treatment impasse identified in the April 3, 2002 reasons persists. Ms. Nielsen further submits that the independent risk assessment should be "done by a psychiatrist who is not on staff of the Forensic Psychiatric Services Commission, who is chosen by Mr. Mazzei, and funded by the Director ... or the Attorney General ...".

¶ 9 Ms. Lovett, on behalf of the Director, submits that there is no need for another risk assessment. She argues that if there is a treatment impasse, it does not logically follow that the Board needs a new risk assessment. She submits that the concerns of the Board resulting in the April 3, 2002 order had been subsequently addressed. The accused's care was transferred to a new psychiatrist, Dr. Brink. She argues that he has tried a number of different or fresh treatment approaches. She submits that if the accused is unable to establish a therapeutic relationship with his treatment team, it is due to his personality disorder. The Board should therefore not order another risk assessment simply because the accused is unhappy with his latest treatment team. In terms of formulating the precise meaning of an independent risk assessment, she submits that it should be construed to mean independent of the treating psychiatrist, but still conducted by the Forensic Psychiatric Services Commission (FPSC). She submits that FPSC is the service created by statute to provide expert advice to the courts and administrative tribunals. She argues that a court or tribunal has no jurisdiction to make an order that would cause the government to expend funds, absent explicit statutory authority.

¶ 10 Mr. Hillaby, on behalf of the Crown, supports the Director's position. He also submits that the mandate of FPSC is to provide expert forensic psychiatric evidence to this tribunal. He argues that expert evidence requested by the Board from FPSC is "independent" of the litigants. He submitted that if the Board found that FPSC was unable to meet the Board's needs, it should retain its own expert. He agrees with the Director's submission that the Board has no power to order the Director or the Crown to expend funds.

a. Need for Independent Assessment

¶ 11 The evidence discloses that the treatment impasse that concerned the April 3, 2002 panel continued following the hearing. The accused's relationship with his treatment team deteriorated to the point that he refused to attend meetings with the treatment team. In October 2003 a "decision was taken, in consultation with the other psychiatrists, to have another psychiatrist accept care of Mr. Mazzei". [See

Note 4 below] Dr. Brink then assumed care of the accused. Significantly, the treatment relationship improved markedly. This was described in Dr. Brink's first report [See Note 5 below] of December 16, 2003 in the following terms:

Note 4: Exhibit 114, report from Dr. Murphy, December 16, 2003, p. 2

Note 5: Exhibit 113, p. 4

> At interview, Mr. Mazzei is cordial and cooperative, presenting in a relaxed manner. ... He appears to have navigated his initial resistance to a new treatment team, and appears to engage enthusiastically in discussions regarding attainable goals and objectives.

¶ 12 Dr. Brink's report then continued with this assessment:

> In terms of diagnostic formulation, his difficulties are best conceptualized in terms of Schizophrenia complicated by poly-substance use. These difficulties are pre-imposed on personality structure best characterized as antisocial in nature. His psychotic symptoms, which emerged during periods of non-compliance and acute intoxication, are well-controlled on his current regime of Clopixol 50 mgm intramuscularly every three weeks.

¶ 13 We conclude that by December 2003, the treatment impasse described in the April 3, 2002 reasons had ended, and the accused was fully engaged with his new treatment team.

¶ 14 The improvement in the treatment relationship was short lived. In Dr. Brink's next report [See Note 6 below], dated May 5, 2004, he summarized as follows:

Note 6: Exhibit 119, p. 4

> Diagnostic formulation remains unchanged as does my assessment of the risk that he poses to others. In my opinion his difficulties stem primarily from personality disturbance characterized by denial, minimization and externalization of responsibility. Mr. Mazzei seems to hold quite a grand perception of himself and is quite demeaning towards fellow patients in this hospital. His attitude towards the treatment team has changed and he has now again requested a change in psychiatrist, presumably because we explored with him his thinking and reasoning behind the recent unauthorized absence and use of illicit substances.

¶ 15 Despite resumption of a conflicted treatment relationship, Dr. Brink remained willing to reconsider the nature of the accused's illness. This had been a deep-seated ground of contention since the accused first began to receive involuntary forensic treatment. Mr. Mazzei has consistently maintained that he does not have an underlying psychotic illness. He insists that the index offences were the product of a drug-induced psychosis, superimposed upon pre-existing drug-induced brain damage.

¶ 16 In an effort to try and conclusively determine the existence or nature of any underlying major mental illness, Dr. Brink agreed to a trial discontinuation of all antipsychotic medication in July 2004. Over the next several months, the accused's mental state gradually deteriorated. By September 2004 he was exhibiting frank psychotic features. This was accompanied by a marked increase in aggression. The accused had threatened to kill another patient at FPH. Dr. Brink decided to recommence antipsychotic medication, and thereafter the accused's psychosis gradually resolved. [See Note 7 below] In Dr. Brink's opinion, this trial conclusively established that the accused had an underlying major mental illness. Significantly, Mr. Mazzei remained unconvinced.

Note 7: Exhibit 122, report of Dr. Brink, April 9, 2005, pp. 2-3

¶ 17 In some senses there have been real changes since April 2002. There was a change in psychiatrist, a notable, albeit short-lived, improvement in the treatment relationship, and a major diagnostic experiment that yielded a clear result. Conversely, Mr. Mazzei's conflict with his treatment has not changed. However the persistence of this difficulty does not necessarily imply that the cause is rooted in the members of the treatment team or a narrow minded or inflexible approach to the accused's treatment. The evidence is that the accused has a consistent history of conflict with treatment. That has been an enduring feature of his presentation.

¶ 18 In Dr. Brink's opinion, the likely cause of the continuing conflict between the accused and his treatment team is the accused's antisocial personality disorder. Dr. Brink commented at some length on the significance of this disorder, and the consequent difficulties in establishing a therapeutic treatment relationship with the accused. This opinion is consistent with substantial Board experience that confirms

the enormous treatment challenges posed by personality disordered accused. Having the benefit of four additional years of treatment experience since the April 3, 2002 hearing, we conclude that the continuing conflicted treatment relationship is rooted in the accused's personality disorder.

¶ 19 We conclude that the need for an independent risk assessment has been overtaken by the events of the last four years. In that time there has been a change in psychiatrist, an improved, although short-lived, treatment relationship, and a major clinical trial. The Board now has the benefit of another and detailed risk assessment. There would be no practical purpose served from the Board's perspective to obtain a further risk assessment.

¶ 20 We wish to acknowledge that the Board seriously considered ordering an independent risk assessment for entirely different reasons. The Director's appeal of the April 3, 2002 decision stayed the original order. The Court of Appeal allowed the Director's appeal. The accused's appeal to the Supreme Court of Canada was entirely reasonable, and indeed he ultimately succeeded. We do not know why the appellate process took four years to complete, however that period of delay is not unusual. We were concerned about the perception of unfairness in finding that the benefit of intervening experience has obviated the need for the information sought by the Board four years ago. Nevertheless after careful reflection, our firm conclusion is that there is no practical utility from the Board's perspective in obtaining another risk assessment. An order for an independent risk assessment should only be made when there is a real and genuine need for that information. As the evidence does not support the need at this time, we concluded that the order should not be made.

b. Nature of the Independent Risk Assessment

¶ 21 Although we have decided that we do not require an independent risk assessment, we concluded that the marked disagreement between the parties as to the nature of such an order required further comment. The parties have expended considerable effort in their submissions in support of their respective views. Now that the Supreme Court of Canada has unequivocally affirmed the Board's power to make such an order, the issue is likely to arise again. We therefore concluded that the Board should address the issues raised by the parties for future reference. [See Note 8 below]

Note 8: See discussion under "Mootness" in Mazzei, supra, footnote 3, at paragraph 15

¶ 22 The reasons for the April 3, 2002 decision plainly state that the Board was seeking a global case review, which was to be supplemented with "a revised and preferably independent assessment of the accused's risk" [See Note 9 below] in light of a reformulated treatment plan. However the decision is silent with respect to who would prepare the assessment. Similarly the Supreme Court of Canada reasons also did not address who provides an independent risk assessment. The decision focused on

whether the Board had the jurisdiction to order an independent risk assessment.

Note 9: Exhibit 105, p. 4

¶ 23 The Board's reasons [See Note 10 below] at the next disposition review following the April 3, 2002 hearing are of some assistance. They explain that the basis of the Board's concern with the existing risk assessment related to the lack of information in that opinion. As the Board stated:

Note 10: Exhibit 109, Reasons for Disposition, July 19, 2002, pp. 13-15

> Nothing amounting to a risk assessment was provided at the April 3 hearing. Mindful of its legal obligation, the Board ordered such information. After 10 years of operation under the current legal framework the Director should, whether it agrees with it or not, be able to understand and accept this legal requirement. What was called for was not the mechanical act of filling out an HCR 20 checklist but an actual, balanced, critical analysis/assessment of the instrumental risk factors.

¶ 24 The risk assessment [See Note 11 below] that the Board found unsatisfactory was remarkably brief. The reasons for disposition of April 3, 2002 and July 19, 2002, when read in entirety, do not disclose any concern with respect to the source of the information, i.e. the Director, but rather a concern about the paucity of information.

Note 11: Exhibit 104, report of Dr. Murphy, March 29, 2002

¶ 25 We begin our analysis by first considering whether the Board has the jurisdiction to make an order that would require an entity other than FPSC to prepare the assessment. This is of considerable importance since such an order would require the Director or the Crown to pay for the assessment. There is a fundamental constitutional principle that no court (or tribunal) may make an order that would compel the government to expend funds in the absence of statutory authority to do so. This principle was stated in Auckland Harbour Board v. The King [See Note 12 below] as follows:

Note 12: [1924] A.C. 318 (P.C.), at p. 326

> For it has been a principle of the British Constitution now for more than two centuries, a principle which their Lordships understand to have been inherited in the Constitution of New Zealand with the same stringency, that no money can be taken out of the consolidated Fund into which the revenues of the State have been paid, excepting under a distinct authorization from Parliament itself. The days are long gone by in which the Crown, or its servants, apart from Parliament, could give such an authorization or ratify an improper payment. Any payment out of the consolidated fund made without Parliamentary authority is simply illegal and ultra vires, and may be recovered by the Government if it can, as here, be traced.

¶ 26 The rationale underlying the rule that a court cannot make an order that would require the government to expend funds was explained by Alberta Court of Appeal in R. v. R.J.H. [See Note 13 below] as follows:

Note 13: [2000] A.J. No. 396, at paragraph 36

> Governments control public spending by allocating a finite number of budgeted dollars among competing programs. If judges were empowered to order the government to make specific additional expenditures, they too would have their hand in taxpayers' pockets, for ultimately governments would have to raise taxes to pay the extra costs.

¶ 27 The Board found the reasoning in R. v. Gray [See Note 14 below] particularly useful. This was a B.C. Supreme Court decision that reviewed whether a judge of the Provincial Court could order the preparation of an expert assessment from a third-party. In this case a provincial court judge found that the court needed a specialized FAS assessment of an accused prior to sentencing. Legal aid refused to pay for such a report. Although the Crown suggested an assessment by FPSC, the accused would not agree. The sentencing judge consequently made an order for an assessment from a specialized private clinic or hospital, to be paid for by the Crown, under the authority of sections 672.11 - 672.14 of the Code (the sections in Part XX.1 authorizing court ordered assessments to determine criminal responsibility and fitness to stand trial). The Supreme Court quashed the order, finding that sections 672.11 - 672.14 did not apply to sentencing. The court also considered the rule in Auckland Harbour Board and firmly concluded that the sentencing judge did not have the jurisdiction to make the order. The reasons emphasize that no court has the jurisdiction to compel the government to expend funds, unless giving a Charter remedy.

Note 14: [2002] B.C.J. No. 1989

¶ 28 The authority of Auckland Harbour Board has been applied by the Board. In Phillips(Re) [See Note 15 below] the Board was confronted by a provincial government decision to withdraw funding for the care of a developmentally disabled man. The government had historically assumed the cost of his care in the community. He was subsequently charged with a criminal offence, found unfit to stand trial, and with no hope of becoming fit, he was left detained at FPH because the government refused to restore funding for his care. The Board found that it had no alternative to continuing detention at FPH, as it had no jurisdiction to compel the Director or the Crown to expend funds to cover the cost of the accused's care in the community.

Note 15: [2001] B.C.R.B.D. No. 66, at paragraph 37, and the next unreported decision of the Board in this proceeding of February 6, 2002, at p. 7

¶ 29 We therefore conclude that the law firmly establishes that an order that would require the Crown or the Director to pay for an independent risk assessment is beyond the jurisdiction of the Board. Where then can the Board obtain the evidence that it may need to discharge its inquisitorial mandate to determine whether the accused is a significant threat to public safety? The answer is found in the Forensic Psychiatry Act. [See Note 16 below] Section 5 reads as follows:

Note 16: R.S.B.C. 1996, c. 156, as amended

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5 The functions of the commission are:

(a) to provide forensic psychiatric services to the courts in British Columbia and to give expert forensic psychiatric evidence;
(b) to provide forensic psychiatric services for

(i) accused persons remanded for psychiatric examination,
(ii) persons held at the direction of the Lieutenant Governor in Council under the Criminal Code or the Mental Health Act,

(iii) persons in need of psychiatric care or assessment while in custody, and
(iv) persons held under a court order;

(c) to provide inpatient and outpatient treatment for persons referred to in paragraph (b) and other persons the minister may designate;
(d) to plan, organize and conduct, either alone or with other persons and organizations,

(i) research respecting the diagnosis, treatment and care of forensic psychiatric cases, and
(ii) educational programs respecting the diagnosis, treatment and care of forensic psychiatric cases;

(e) to consult with ministries, departments and agencies of the federal and provincial governments, and municipal departments or agencies, mental health centres and other persons or organizations about the advancement of the objectives set out in this section;
(f) to perform other duties, responsibilities, research and educational programs respecting forensic psychiatry as directed by the Lieutenant Governor in Council.

¶ 30 This section unequivocally establishes that the function of FPSC includes providing expert forensic psychiatric evidence to the courts (and this tribunal). We conclude that FPSC is the legislative solution to the limitation posed by the rule in Auckland Harbour Board.

¶ 31 The accused is entitled to an "independent" risk assessment. Can another risk assessment, prepared by FPSC, be considered legally independent?

¶ 32 Black's Law Dictionary [See Note 17 below] defines independent as:

Note 17: Eighth Edition

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1. Not subject to the control or influence of another ... 2. Not associated with another (often larger) entity ... 3. Not dependent or contingent on something else.

¶ 33 A risk assessment is an expert opinion provided by a forensic psychiatrist, or other qualified professional, as to likelihood or risk of dangerous behaviour in the future.

¶ 34 Opinion evidence is defined [See Note 18 below] as:

Note 18: Black's Law Dictionary, supra, footnote 17

A witness's belief, thought, inference, or conclusion considering a fact or facts.

¶ 35 A risk assessment is by definition the opinion of an individual witness. There was no suggestion that a risk assessment prepared by a psychiatrist in the employ of FPSC constituted anything other than the expert's own opinion. A psychiatrist is bound by the professional obligations associated with medical practice. The opinion is presumptively neutral. While this presumption is capable of being rebutted, there was no evidence before the Board that another psychiatrist at FPH would be unduly influenced by an earlier assessment.

¶ 36 Finally from a practical perspective we note that FPSC is the entity that the Legislature has created to supply courts and tribunals with expert psychiatric evidence. If it was not considered presumptively neutral, the Board would be required to seek out an independent risk assessment at every disposition review.

¶ 37 Ms. Nielsen submits that the risk assessment should be prepared by a non-FPSC psychiatrist, to be chosen by the accused. This suggests an adversarial approach designed to elicit evidence favourable to the accused's interests, and is consistent with the accused's right to present evidence in support of his position. This is what has been referred to as the tactical burden that was explained in Winko [See Note 19 below] in the following terms:

Note 19: Winko v. British Columbia (Forensic Psychiatric Institute), [1999] 2 S.C.R. 625, at paragraph 53

However, this tactical incentive to adduce evidence is not properly described as a shifting of the legal or evidentiary burden to the accused. "It is not strictly accurate to speak of the burden shifting to the defendant when what is meant is that evidence adduced by the plaintiff may result in an inference being drawn adverse to the defendant": Snell v. Farrell, [1990] 2 S.C.R. 311, at pp. 329-30, per Sopinka J. See also J. Sopinka, S.N. Lederman and A.W. Bryant, The Law of Evidence in Canada (1992), at pp. 77-78. This tactical burden exists in every legal proceeding and does not violate the presumption of innocence guaranteed by the Charter: see R. v. Osolin, [1993] 4 S.C. R. 595.

¶ 38 This passage repeats the common sense proposition that every party to any legal proceeding

bears the burden of proof with respect to any matter that the party believes is advantageous to its legal position. The Board's duty to search out and obtain evidence does not include discharging the tactical burden of the accused.

¶ 39 In conclusion we find that an independent risk assessment means an opinion provided by FPSC from another expert. This flows from the limitation on Board power to order the government to expend funds, the function of FPSC, and the definition of independent as it applies to legal proceedings.

2. Conditions specifying level of security and placement FPH

¶ 40 Ms. Nielsen submits that Mr. Mazzei's liberties have been unreasonably restricted by the Director's authority to determine the security level of his living unit, and level of privilege. These decisions are currently beyond Board review. She submits that a custodial disposition should include conditions that require that:

1 The accused be moved to Hawthorne as soon as a bed becomes available, with the condition that he be provided with regular access to the community to attend culturally appropriate drug and alcohol counseling;

2 FPH keep a bed reserved for the accused at Hawthorne after he is transferred there; and,

3 If the accused is moved to a more secure unit for more than seven days, the Director must give notice to the Board, which shall then hold a disposition review.

¶ 41 Ms. Nielsen argues that the Board has the authority to specify the level of privilege and living unit at FPH under the authority of the Supreme Court of Canada decision in Penetanguishene Mental Health Centre v. Ontario (Attorney General) ("Tulikorpi"). [See Note 20 below]

Note 20: [2004] 1 S.C.R. 498

¶ 42 Ms. Lovett, on behalf of the Director, submits that Tulikorpi only establishes that the Board may choose the hospital of detention. She submits that in British Columbia there is only one hospital of detention, namely FPH, and the Board should not go beyond specifying this institution.

¶ 43 Mr. Hillaby, on behalf of the Crown, submits that criminal courts invariably do not interfere with correctional decisions that set security levels for convicted persons. Although he concedes that a

Review Board disposition is somewhat different from a court imposing a sentence, he submits that the Board should not interfere with the internal management of security at FPH.

¶ 44 The evidence is that the accused was residing on the medium security Elm unit with Level 4 privileges prior to his first AWOL on July 30, 2005. Upon his return on August 5, 2005, he was moved to the high-security Ashworth unit, and his privileges were restricted. He remained on Ashworth until November 30, 2005, a period of almost 4 months. He was then moved to Hawthorne, which is a minimum security unit. By this time the accused had been granted Level 5 privileges.

¶ 45 These freedoms were short-lived, as the accused absconded about one week later on December 6, 2005. Upon his return on December 9, 2005, his privileges were once again restricted and he was transferred to the Ashworth unit. The accused was still living on the Ashworth unit when the Board held the oral hearing on April 11, 2006. [See Note 21 below] The net result is that as of this date, the accused was confined to the Ashworth unit for approximately 8 of the preceding 11 months.

Note 21: The Director's written submission of May 3, 2006 states hat the accused was transferred to Hawthorne House shortly after April 11, 2006. As no issue was taken with this assertion in the accused's subsequent reply submission, we have proceeded on the basis that the parties were content that the Board have this information.

¶ 46 Dr. Brink explained that after the accused returned from his each of the last two AWOL's, his mental state was unsettled, and his behaviour unpredictable and aggressive. In both instances the accused had admitted to polysubstance use, which was subsequently confirmed by urinalysis. Dr. Brink said that the combination of these circumstances required that the accused be temporarily transferred to the higher security Ashworth unit for both his own and other patients' safety. Unfortunately, by the time the accused was ready to return to his previous living unit (Elm at the first AWOL and Hawthorne at the second AWOL), a bed was no longer available. Dr. Brink said that this was caused by an acute shortage of bed space at FPH. He said that this was quite unusual and in fact the worst that he had ever observed.

a. Discussion

¶ 47 In Tulikorpi, the Ontario Review Board held that the obligation to make the least onerous and least restrictive disposition was not restricted to the bare choice between the three classes of disposition (detention order, conditional discharge, or absolute discharge), but also applied to the individual conditions of a disposition. Although the accused was ordered detained in hospital, the Board found that the least onerous and least restrictive requirement applied to the individual conditions of the disposition, and included the choice of hospital of detention. The Board ordered the accused be transferred from a maximum security hospital to a medium security hospital. The Administrators of the affected hospitals appealed the Board's decision.

¶ 48 The Ontario Court of Appeal disagreed, and found that the least onerous and least restrictive requirement only applied to the choice between the three classes of disposition. Although the Board's power to choose a particular hospital detention was not disputed, that determination did not have to meet the least onerous and least restrictive requirement.

¶ 49 Upon further appeal to the Supreme Court of Canada, the court unanimously restored the Board's decision that the requirement to make the least onerous and restrictive disposition included the individual conditions of a disposition.

¶ 50 The court described the Ontario hospital system as follows [See Note 22 below]:

Note 22: Supra, footnote 20, at paragraphs 29-31

> There are 10 hospitals in Ontario designated by the provincial Minister of Health for the custodial treatment of NCR accused. These hospitals operate out of 12 locations around the province. Oak Ridge is the only facility designated "maximum" security. The rooms are cell-like, with barred or solid steel doors, barred windows and attached steel fixtures (sink, toilet, bed). ...
>
> The Ontario hospital system provides three levels of security below the Oak Ridge "maximum", namely, double-lock medium (high medium), single-lock medium (regular medium) and minimum. These levels permit detainees what is called "a cascade" of increasingly greater levels of liberty. ... The importance of these lower level security hospitals is that they can facilitate the gradual reintegration of detainees into the community as the twin goals of public safety and treatment permit, with progressively greater access to family, community facilities and outward-looking programming, and their attendant therapeutic effect.
>
> It is obvious that once the Review Board has made the disposition to "a hospital" under s. 672.54(c), choice of the type of hospital and level of security and conditions of detention will have a vital impact on the liberty interest of the detainee. Confinement to a cell-like room at Oak Ridge is a long way from a life of liberal access to the community at the Royal Ottawa Health Care Group facility at Brockville. (emphasis added)

¶ 51 The judgment then continued as follows:

> 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. ...

¶ 52 The situation in British Columbia is quite different from Ontario. For all practical purposes, FPH is the only hospital detention. [See Note 23 below] Within the FPH campus, the wards or living units have different security levels that range from maximum-security (Ashworth), through medium security (Elm, Dogwood), to minimum security (Hawthorne). The practice that has evolved in British Columbia leaves the determination to the Director of where an accused will be placed within FPH. This decision is made based on the Director's assessment of the accused's risk and clinical needs, and is subject to available resources. Although the range of differing security levels associated with the different wards at FPH is roughly analogous to the Ontario system, the B.C. Review Board has never specified the security level (maximum, medium, or minimum) or ward in its orders.

Note 23: The federal Regional Health Center at Matsqui prison is also designated as a hospital of detention. However the Board does not consider this facility as an available option, unless the accused is a dual status offender, or is otherwise under consideration for specialized sex offender programming that is only available at this facility.

¶ 53 In addition to choice of ward, the Director employs a separate system of regulating privileges within FPH that can have a profound effect on an accused's liberty interests. There are six levels of privilege [See Note 24 below] that vary from strict custody, with highly limited movement within the hospital, to full grounds privileges on the FPH campus with liberal access to the community. Privilege level is determined by a Programming and Privileges Committee, upon application from the accused's treatment team. This decision is also not subject to Board scrutiny or legal review. According to the written submissions of the Director, privilege level is mostly independent from ward security level. The evidence in this proceeding shows that the accused's privilege level also varied over the last year, sometimes significantly, according to the accused's progress or regress. For example following the accused's unauthorized absences, his privilege levels were restricted in addition to transfer to higher security living unit.

Note 24: reproduced in entirety at Appendix "A"

¶ 54 This system of granting internal privileges at FPH was considered by Review Board Chair Walter in Gielzecki (Re). [See Note 25 below] This decision was not unanimous, and although Chair Walter's reasons were not adopted by the majority, they provided a thorough and helpful review of the Programming and Privileges Committee in light of Tulikorpi. He concluded that this committee operated as a second layer of authoritative decision-making that was beyond legal review. His analysis acknowledges the need for flexibility to permit the Director to increase or decrease privilege level in response to the waxing and waning accused's illness or behaviour. However his reasons emphasize that the Director's power to vary privileges must be explicitly delegated by the Board to the Director under s. 672.56(1) of the Code. This conclusion relies upon the B.C. Court of Appeal decision in British Columbia (Forensic Psychiatric Institute) v. Johnson [See Note 26 below], which stated:

Note 25: [2005] B.C.R.B.D. No. 83

Note 26: [1995] B.C.J. No. 2247, at paragraph 58

> 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. ...

¶ 55 Section 672.56 (1) provides as follows:

> 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 Board. (emphasis added)

¶ 56 We hasten to add that we fully agree with Chairperson Walter's observation in Gielzecki that the Director must have the flexibility to regulate an accused's security and privileges in response to changes in behaviour and symptoms of illness. For example the Director's decisions to move Mr. Mazzei to the Ashworth unit and restrict his privileges following his AWOL's were clearly not unreasonable. The

accused had violated the terms of this order and had abused his privileges when he absconded from FPH and used drugs. Upon return his mental state was irritable and his behaviour aggressive.

¶ 57 One implication flowing from Chair Walter's analysis in Gielzecki is that if the Board can delegate the discretion to alter the accused's liberty restrictions, it must have initially had the power to make those determinations. If it were otherwise, how could the Board delegate an authority that it did not initially possess? This view is further reinforced by the wording of s. 672.56(1) that any direction to increase or decrease an accused's liberties that is made pursuant delegated authority is deemed to be a disposition made by the Board. Furthermore, the authority of Tulikorpi would seem to suggest that if the Board can make such decisions, that these must conform to the least onerous and least restrictive standard.

¶ 58 Although delegating the authority to make these decisions might seem to be the obvious solution, there are significant procedural consequences associated with such an approach. That is because delegated authority to vary restrictions under s. 672.56(1) is subject to the provisions of s. 672.56(2). That section provides as follows:

> 672.56(2) A person who increases the restrictions on the liberty of the accused significantly pursuant to authority delegated to the person by a Review Board shall
>
> (a) make a record of the increased restrictions on the file of the accused; and
> (b) give notice of the increase as soon as is practicable to the accused and, if the increased restrictions remain in force for a period exceeding seven days, to the Review Board.

¶ 59 The effect of receiving notice under this section requires that the Board must hold a disposition review as soon as practicable. That is because of s. 672.81(2.1) which provides that:

> 672.81(2.1) The Review Board shall hold a hearing to review a decision to significantly increase the restrictions on the liberty of the accused, as soon as practicable after receiving the notice referred to in subsection 672.56(2).

¶ 60 It seems clear from these sections that Parliament intended that the Board have the flexibility to delegate authority to vary restrictions on the liberty of the accused, but, any significant restriction that lasts more than seven days, is considered sufficiently serious that the Board must hold a disposition review as soon as practicable in order to review that decision. This interpretation is consistent with the twin goals of Part XX.1 of protection of the public and fair treatment of the accused. [See Note 27 below] Fair treatment of the accused means an assurance of procedural fairness. [See Note 28 below] This requires that the Board review a decision that it indirectly authorized through its delegation powers.

Note 27: Supra, footnote 19, at paragraph 30

Note 28: Supra, footnote 3, at paragraph 28

¶ 61 Under current practice the only authority that the Board typically delegates to the Director under a detention order governs day leave (which authorizes the Director the discretion to give the accused unescorted access to the community) or visit leave (which authorizes the Director the discretion to give the accused overnight visits in the community, for periods usually up to 28 days).

¶ 62 Similarly, when the Board makes a conditional discharge, it usually includes a condition that delegates to the Director the authority to return an accused to FPH. In fact for all practical purposes, the only restriction of liberties hearings that the Board currently holds, are limited to when an accused is returned to FPH in excess of seven days while on conditional discharge.

b. Application to Facts

¶ 63 The order sought by Mr. Mazzei exposes two distinct problems. The first arises from the current practice that permits the Director the legally unfettered discretion to determine ward security and privilege level. The combination of these decisions can have a profound impact on an accused's liberty interests. Tulikorpi unequivocally establishes that the Board's duty to make the least onerous and least restrictive disposition applies to the conditions of an order, and requires that the Board apply that standard in choosing between hospitals of detention. British Columbia has only one de facto hospital of detention, but the range of liberties afforded by the Director within FPH varies as widely as in the differing hospitals of detention in Ontario. To adopt the phraseology of Tulikorpi, confinement on the Ashworth unit with level 1 privileges is a long way from a life on Hawthorne with liberal access to the community conferred by level 6 privileges.

¶ 64 The second problem relates to the present practice in which the Director makes these decisions in the absence of delegation by the Board. This results in the Director having the power to make significant decisions that impact the liberty interests of the accused without benefit of Board review.

¶ 65 We conclude that the combination of these two problems, which results in the current practice that allows the Director to determine both ward security and privilege level in the absence of any delegated authority to do so, is inconsistent with the principles established in Tulikorpi and Gielzecki.

¶ 66 This issue was presented by the parties by written submission following the conclusion of the oral hearing. The Board therefore did not have the benefit of any evidence that might illustrate practical difficulties that the Board might not be aware of, or other unintended consequences that could affect the Board's decision. For example on the matter of ward assignment, the Board knows nothing about the flexibility within FPH, or resource availability. All we know is that it was an acute bed shortage of FPH

over the last year that prevented the accused from returning to the ward that he had been assigned to prior to absconding. A review of several Ontario decisions shows that there have been real difficulties in some instances when Board orders specifying particular hospitals of detention could not be followed due to bed shortages. [See Note 29 below]

Note 29: See: Orru v. Penetanguishene Mental Health Centre, [2004] O.J. No. 5203 (application for Charter remedy after accused not transferred to lower security hospital due to lack of space); Pinet v. Penetanguishene Mental Health Centre, [2006] O.J. No. 678 (application for enforcement of transfer order to medium security hospital)

¶ 67 Another significant concern flows from the potential for a dramatic increase in mandatory restriction of liberties hearings should the Board begin to delegate authority to the Director to determine privilege and security level. Our own informal sense of the matter suggests that restrictions of this sort within FPH occur relatively often. This is illustrated by this proceeding, where there were at least two significant restrictions of liberties in excess of seven days over the last year that would have required mandatory disposition reviews.

¶ 68 After long and careful reflection, we have concluded that this decision should not be made in a vacuum, without reference to evidence, and without consideration to the practical consequences. We note that the court in Tulikorpi found it appropriate to consider whether the imposition of the least onerous and least restrictive requirement on the conditions of detention would result in unmanageable difficulty. [See Note 30 below] The potential for profound impact upon Board and party resources requires that the Board have whatever relevant evidence that may be available that might inform our decision.

Note 30: Supra, footnote 20, at paragraph 70

¶ 69 The Board's order of May 5, 2006 will result in a further disposition review prior to July 31, 2006. The accused was returned to the minimum security Hawthorne unit shortly after the oral hearing in this matter. His privileges have been restored to level 5. There is no practical difference from the accused's perspective on making the order sought in view of these developments. Even if the accused's liberties are subsequently restricted in excess of seven days, a mandatory disposition review is unlikely to be convened any sooner.

¶ 70 There will accordingly be no changes to the order of May 5, 2006. In preparation for the next disposition review, we request the parties consider presenting further evidence in keeping with the outstanding issues and concerns reflected in these reasons.

* * * * *

APPENDIX - A

LEVEL OF PRIVILEGES AND PROGRAMS

LEVEL 1

ESCORTED WITHIN A & B BUILDINGS ONLY:

* First Steps Program
* Occupational Therapy
* Act I/Act II
* Power Hour
* Native Brotherhood
* Dual Diagnostics/Substance Abuse Counselling in Ashworth Bldg.

LEVEL 2

ESCORTED:

* Psycho-Social Programs(specify)
* TSL Programs (specify)
* Vocational Programs (specify)
* SSCO
    - > Assessment Outing
    - > Small Structured Community Outing
    - > Large Structured Community Outing
    - > Single Escorted Outing
* Walking Club (inside security fence)
* Fir Hall (1 to 1 escort only)
* Supervised Grounds
* 1 to 1 Walks with Staff (inside fence)

LEVEL 3

* Unescorted attendance at programs within Hospital
* Full Grounds Privileges
* Accompanied D/Ls with a designated person, family or volunteer
* Fir Hall (unescorted)

* Walking Club (outside security fences)

LEVEL 4

* Unescorted and Structured Community Program D/L's (specify)

LEVEL 5

* Unescorted D/Ls for leisure purposes

LEVEL 6

* Overnight leaves
* Visit leaves
* Extended leaves

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