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

Z.S.

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
May 18, 2017

BEFORE: **ALTERNATE CHAIRPERSON:** **S. Boorne**
MEMBERS: **Dr. P. Constance, psychiatrist**
Dr. L. Murdoch *(dissenting)*

APPEARANCES: **ACCUSED/PATIENT: Z.S.**
ACCUSED/PATIENT COUNSEL: D. Nielson
DIRECTOR AFPS: Dr. C. Kerr D. Bernier
DIRECTOR'S COUNSEL:
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION AND BACKGROUND

[1] On May 18, 2017 the British Columbia Review Board (the Board) convened a hearing in the matter of Z.S. (the accused). We subsequently granted the accused an absolute discharge. These are our reasons.

[2] The accused is before the Board as the result of a verdict of not guilty by reason of insanity (NGRI) dated June 10, 1987 on a charge of second degree murder. The index offence was committed on January 23, 1987 when the accused fatally stabbed a fellow graduate student in the Department of Chemistry at the University of British Columbia. The accused committed the index offence in response to severe paranoid delusional beliefs that the victim was a member of a conspiracy that intended to kill him.

[3] The accused is 62 years old. This is his 30th appearance before the Review Board. He was born in Eritrea and both of his parents were killed during the conflict with Ethiopia. He came to Canada on a student visa in 1986 to pursue graduate studies in chemistry at UBC. He had no psychiatric history prior to coming to Canada. Following the index offence he was diagnosed with paranoid schizophrenia from which he continues to suffer. He has been living in the community since 2003 except for brief period when he was returned to hospital in 2009 following significant mental deterioration. While his illness is controlled by medication, he continues to suffer from paranoid delusional beliefs involving the Canadian immigration service and the risk he will be deported.

[4] There is a basis for Mr. S's concerns regarding his immigration status and for many years he was subject to a deportation order. In 2014 he was declared a protected person and therefore could not be returned to Eritrea or Ethiopia. He is currently applying to obtain permanent resident status in Canada. At his most recent hearing on May 31, 2016, the accused expressed plans to visit his sisters who live in Sweden. In its reasons, the Review Board commented:

> [19] Mr. S appears to appreciate the importance of medications to his mental health, and would be pleased to be connected with civil mental health services. He has established an extremely positive lifestyle, with his participation in a variety of support groups. He gets satisfaction from helping others and he also gets a small income to supplement his PWD benefits. He does not drink or use drugs. With the support of MPA he has moved to another apartment in a senior's complex that appears to meet his needs very well.
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> [20] At the same time, he continues to experience paranoid delusions, including his belief that the Immigration Service is still out to get him in some

> way. He is committed to visiting his sisters in Sweden, and would do so if granted an absolute discharge. Dr. Kerr agreed that this is extremely important for him and entirely reasonable, particularly given their advancing age. At the same time, international travel is extremely stressful at the best of times, and is particularly concerning in light of Mr. S's continued delusions that the immigration service is out to get him in some way.
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> [21] We are of the view that it is reasonable for Mr. S to visit his sisters in Sweden but are of the view that his continued jurisdiction under the Review Board is critical to manage any risk he may pose to the public in the context of such travel. *(Par 19-21)*

EVIDENCE AT THE HEARING

[5] To prepare for the current hearing we received a report from Dr. Kerr the accused's community psychiatrist and from Mr. Bernier his community mental health nurse. In addition we received *viva voce* evidence from Dr. Kerr, Mr. Bernier and the accused. Although we have considered all of the information on record, we only refer to that necessary to render our decision.

[6] Dr. Kerr testified that the risk presented by the accused is manageable in the community through the forensic service. Prior to advocating for an absolute discharge he would like to comfortably know that the accused is no longer paranoid although he conceded there is no way to measure this. Dr. Kerr testified the accused's paranoia is pervasive and he has felt that many in the community were monitoring him. As recently as April 2017, he approached a member of the public on the street who he was suspicious about asking him "who are you?" Last year, Mr. Bernier and the accused travelled to Vancouver International Airport for a "dry run" in preparation of his anticipated trip to Sweden to visit his sisters. While everything appeared normal, later the accused mentioned to Mr. Bernier he was surprised he had not noticed the man in the food court who he believed was an immigration official watching them. The accused also continues to fear he could be deported from Canada despite his immigration status as a protected person.

[7] Dr. Kerr agrees the accused has not engaged in any recent aggressive or violent behaviour despite his ongoing paranoid beliefs. He referred to an incident which occurred at Coast Cottages in 2009 involving a potential threat to kill a staff member who he believed was accusing him of theft of a set of car keys. Dr. Kerr testified that while the accused never engaged in violence, the incident was a threat and it was serious.

[8] The accused is compliant with his medication which has dampened his paranoia but has not been a total cure. He has stable housing which is subsidized through a community organization called the Motivation Power and Achievement Society and he works closely with a one on one worker provided by that organization. He has strong support through close friends including one named Q who accompanied him to the hearing and a long-term friendship with one of his former university professors and his wife who he sees for dinner monthly. He is actively involved in his church and maintains other friendships with current and former forensic patients and members of the Eritrean community.

[9] Mr. Bernier reports that the accused supports himself through a disability pension and part-time work. He is employed as a peer support worker with the Vancouver Coastal Health Authority's (VCH) mental health housing services. He is also employed as a facilitator leading a therapy group called the Hearing Voices group which meets three times per month also through VCH. The accused attends a Baptist church for weekly Sunday service and participates in bible study. His involvement with the church provides him with social connection and spiritual fulfilment.

[10] The accused is visited weekly by an outreach worker provided by the MPA Society who helps him with shopping and various recreational activities. He has a good rapport with this outreach worker who he has known for over 10 years. In 2015 he acquired a BC driver's license and has gained some experience driving with the pastor of this church.

[11] The accused is a self-published author and has a recently published his third book called "Am I Still Crazy? Mental Illness and the Canadian Justice System". He has no history of substance use issues and occasionally uses alcohol in moderation. Mr. Bernier testified that he sees the accused every two weeks and believes they have a very good rapport. He believes that the accused has partial insight into his illness but this insight fluctuates. He understands that some of his perceptions are based on his thoughts. However, at other times he believes that these perceptions are actual events. The accused told him that he mitigates his reactions to situations where he believes he is being monitored by immigration officials because he does not want to make his situation any worse. He referred to an incident where the accused told him that if someone came up to him and slapped him he would not react as he believed this would provoke a reaction from immigration Canada.

[12] The accused testified that his paranoia is well-managed and the medication helps. He takes all of his prescribed medication and would follow-up with civil mental health services

if granted an absolute discharge. He is a peer support worker and helps with people transitioning from hospital to the community. He believes that once he is granted permanent resident status his paranoia regarding immigration officials will dissipate. He loves his new accommodation and has no plans to move.

[13] He testified that he is no longer hoping to travel to Sweden because his sister is coming to visit in June of this year from Sweden. He has located rental accommodation for her and her two children through his church.

[14] The accused testified that he came to Canada in September 1986 and committed the index offence a few months later in January 1987. He said that he was renting a room in a house and was feeling very lonely and homesick. His days were filled with long demanding work from his studies and his additional teaching assistant duties. In addition, he had never had to cook before and didn't know how so he was hungry all the time. He usually ate in the cafeteria at the University but came to believe that they were poisoning his food. He related an incident when he went to pay for a cup of tea and was carrying several packets of sugar. The cashier told him that he did not need that much sugar, perhaps believing he would steal it. He then became suspicious the tea was being poisoned. This led to concerns he was being followed.

[15] Mr. S testified about the index offence. He had become paranoid that the victim who was a fellow researcher, was poisoning the tea in the laboratory with potassium chloride, a highly toxic substance. He confronted his advisor about his beliefs and was referred to counselling services. He was not sleeping and started to hear the voices of two of his friends from Ethiopia telling him he needed to do something about the lab worker who was poisoning him which led him to commit the index offence.

[16] The accused testified that, looking back on the incident he understands that he was behaving irrationally and was paranoid. He knows that no one was trying to poison him. Under questioning, the accused testified that he believes immigration Canada is monitoring his cell phone and Internet but also believes they will no longer follow him if he obtains permanent residency. When asked about approaching someone in April 2017 asking who they were, the accused had no recollection of approaching anyone.

[17] The Director and the Crown sought a continued conditional discharge. The accused asked to be discharged absolutely.

ANALYSIS AND DISPOSITION

[18] We must first determine if the accused represents a significant threat to the safety of the public. If he does not pose such a threat, he is entitled to an absolute discharge. If he poses a significant threat to the safety of the public, we must then determine what disposition ought to be made. We are not bound by the recommendations of the parties.

[19] What constitutes a “significant threat to the safety of the public”?

[20] In ***R. v. Carrick***, 2015 ONCA 866, the Court specifically adopted the formulation from ***Winko*** and added:

> In short, the “significant threat” standard is an onerous one. An NCR accused is not to be detained on the basis of mere speculation. The Board must be satisfied as to both the existence and gravity of the risk of physical or psychological harm posed by the appellant in order to deny him an absolute discharge *(Par. 17)*

[21] Recently the B.C. Court of Appeal in ***Calles v. British Columbia (Adult Forensic Psychiatric Services)***, 2016 BCCA 318, stated that:

> A significant threat to public safety is defined in s. 672.5401 of the *Criminal Code* to mean “a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent”. The threat posed must be more than speculative and be supported by the evidence. It must be significant “both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of grave harm will not suffice”, nor will a high risk of trivial harm: *Winko*, at para. 57. (*para. 15)*

[22] A finding of significant threat must be based on evidence rather than speculation. It must be significant in the sense that there must be a real risk of physical or psychological harm to individuals in the community that is serious, in the sense of going beyond the merely trivial or annoying. The conduct of concern must be criminal in nature. There must be a foreseeable and substantial risk that the accused would, or is likely to commit a serious criminal offence if discharged absolutely. Both the probability of the harm and the severity of the harm must be significant. In making these determinations, we must have regard both to the interests of individual liberty and to the paramount consideration of public protection.

[23] We find that the evidence in this case does not meet this high threshold.

[24] The accused continues to suffer from some paranoid delusions related primarily to concerns about his immigration status. Based on the evidence, despite medication, this paranoia will remain. The accused has not acted on his paranoid beliefs despite being open about them in letters, in previous Board hearings and during his evidence before us.

[25] This is a far different situation from that which existed at the time of the index offence when the accused was a new immigrant, isolated, homesick and hungry. The accused is a thirty year resident of Canada, has stable housing, is prosocial, and does not use substances. He has extensive social support from an outreach worker who he has known for over 10 years, and several close friends many of whom have experience with the mental health system. He is actively involved in his church and is employed as a peer support worker and a group facilitator for mental health patients.

[26] It is impossible to state unequivocally that an individual will never be a risk. We have to make a positive finding based on the evidence before us both to the existence and gravity of the risk of physical or psychological harm posed by the appellant to deny him an absolute discharge. We find the risk does not meet this high threshold. Therefore, the accused is entitled to an absolute discharge.

Reasons written by S. Boorne, in concurrence with Dr. P. Constance

DR. L. MURDOCH, DISSENTING:

[27] In my opinion, the evidence establishes that Mr. S remains a significant threat to the public and requires the involvement of the Review Board in order to manage his risk.

[28] Mr. S was raised in Eritrea. Due to the violence and danger created by armed conflict with Ethiopia, Mr. S left Africa to pursue graduate studies in chemistry at UBC. He arrived in Canada on Sept. 18, 1986 at the age of 32. Approximately 4 ½ months later, Mr. S fatally stabbed a fellow graduate student. He was immediately taken into custody and, on June 10, 1987, Mr. S was found not guilty by reason of insanity (NGRI). He remained in custody at the Forensic Psychiatric Hospital (FPH) until his first conditional discharge in 1991. Since then, he has lived either in supported housing (during periods of relative wellness) or at FPH (during periods of psychiatric decompensation). He currently resides in an apartment supported by staff of MPA, an organization that assists individuals with mental illness. He enjoys this apartment and intends to remain there for the long term. His last return to FPH occurred in 2009.

[29] The evidence indicates that Mr. S did not suffer symptoms of his psychiatric illness, now diagnosed to be paranoid schizophrenia, prior to his arrival in Canada. He stated that his symptoms began two to three months prior to the index offence. He attributed the onset of illness to feeling homesick and lonely, his excessive workload as both a student and a teaching assistant, and frequent hunger due to not knowing how to cook. He began having thoughts that people were slandering him by calling him a communist or a thief, laughing and talking about him, and following him everywhere. He became convinced that people were planning to kill him, and saw extreme threat in everyday innocuous events. He came to believe the victim was poisoning him via sugar cubes in his tea. His paranoia was not restricted to the victim and included both people known to him, such as his landlord and other students, and individuals unknown to him, such as people on the bus and a cashier at the student cafeteria. He was unable to sleep and developed auditory hallucinations, asking him, “What he was waiting for”, telling him he needed to defend himself and that he would be called a “hero” for avenging himself for being “dishonoured”. He took a knife from home to the university and, in a state of psychotic panic and fear, stabbed his fellow graduate student with tragic results. Although this occurred thirty years ago, I have briefly summarized these events in order to illustrate several key points about Mr. S’s illness.

[30] Firstly, although the severity of Mr. S’s illness fluctuates, the paranoia he experiences is an ongoing chronic problem even with decades of intensive treatment and support. In its Reasons dated August 20, 2007, the Review Board noted:

> The established tendency of the accused’s illness to periodic, fluctuating exacerbation and breakthroughs of psychotic symptoms, including suspiciousness, paranoia and irritability, suicidal and homicidal ideations and odd beliefs, despite fastidious supervision and follow up and the accused’s compliance with treatment [Paragraph 9].

[31] At our most recent hearing, Dr. Kerr, who has been Mr. S’s outpatient psychiatrist for fourteen years, gave evidence that although antipsychotic medication has helped to dampen Mr. S’s paranoia, they have not resulted in a cure of his illness and the paranoia remains always in the background. Dr. Kerr gave a recent example of Mr. S experiencing paranoia in the community and approaching a stranger whom he believed was spying on him in April of this year. When interviewed on May 2, 2017, Mr. S advised Dr. Kerr that he believed he was being monitored 24/7 by Immigration Services. Before us, Mr. S acknowledged that he felt suspicious of the individual he encountered in April, but was unable to explain his suspicions, other than noting that paranoia has its “advantages”. He described being at a

missionary festival at Canada Place and becoming suspicious of a woman who struck up a conversation and asked him about a cat, stating, “Why would she do that unless she was following me?” Mr. Bernier, who is Mr. S’s community mental health nurse, described Mr. S in his most recent report as “particularly susceptible to relapse into psychosis with symptoms of paranoid thoughts and hallucinations” and noted that Mr. S is “covertly vigilant of his environment and appears to require very little evidence to support the paranoid thoughts”. Mr. Bernier detailed multiple incidents over the past year in which Mr. S has believed certain individuals were spying on him on behalf of Immigration Services, including a neighbor (June 2016), a man at the airport (sometime after May 2016), a customer behind him in line at a Dollar Store (September 2016), the woman at the Church convention (January 2017), and the individual he approached in April 2017. He also believes he is being continuously monitored via his home computer and telephone, and followed on the streets throughout the day by “clever” agents who change at major intersections and transit junctions.

[32] Secondly, Mr. S’s deterioration into paranoia typically occurs over the course of months, but is not obvious to those with whom he interacts until his symptoms are quite severe because Mr. S does not disclose their onset. The examples of this are numerous in the evidence, but his return to hospital on August 13, 2009 provides an apt illustration. On July 26, 2009, the Review Board granted Mr. S a conditional discharge. Less than a month later, he was returned to FPH because his symptoms had become outwardly manifest. In its reasons dated September 29, 2009, the Review Board stated that Mr. S had been meeting with his treatment team at least every two weeks for the previous year. Dr. Kerr in his “extremely comprehensive and fastidious report” remarked that the accused’s mental state had been normal and free of active symptoms for over three years. In paragraph 13, the Board stated:

> On further examination and exploration it turned out that, notwithstanding Dr. Kerr’s confidence in the remission of the accused’s symptoms for three years, the accused was actually experiencing symptoms as early as December 2008.

[33] Although Mr. S testified that he now tells his treatment team “everything”, in my view the evidence indicates that he continues to be non-disclosive about his symptoms. Mr. Bernier notes in his May 2, 2017 report that Mr. S is non-disclosive of paranoid thoughts related to being monitored by immigration officials unless specifically asked and will often wait several days or weeks before sharing that information. He did not advise Mr. Bernier of his suspicions about the man in the airport during their outing, but disclosed his beliefs two weeks later during a conversation about the airport visit. He only just, in January 2017, disclosed to Mr. Bernier a

serious suicide attempt that occurred seven years ago. The reason given by Mr. S for not disclosing it earlier was that he thought he would be returned to FPH. Before us, although Mr. S stated he would tell his treatment team "everything", he also added that "it could go against me", suggesting he continues to believe it is not in his interests to be fully honest with his treatment providers.

[34] Thirdly, the reasons for the exacerbation of Mr. S's symptoms over the years are not entirely understood. Some of the evidence points to reductions or changes in medication as underlying his decompensation. This appears to have been the case in 2002 and then 2005 when Mr. S was returned to FPH. The latter return required a long period of hospitalization and treatment. When recommending a conditional discharge in her April 30, 2007 report, Dr. Murphy, Mr. S's FPH psychiatrist, noted she would "recommend strongly against decreasing his medications in the future". He reportedly assured the treatment team that he would refrain from trying to have his community doctor reduce his medications (report of Jim Murden, April 25, 2007) and then requested, and obtained, a change in medication six months later. He experienced increasing paranoia over 2008 and 2009 with a return to hospital in August 2009. He was restarted on intramuscular medication in September 2009 with good results and released back into the community. However, according to the evidence before us, Mr. S again requested to have the intramuscular medication discontinued in favour of oral medications as recently as July 2015. Although Mr. Bernier stated he is confident that Mr. S takes his oral medication, he also acknowledged that he relies upon Mr. S's self-report in this regard. I am concerned that, if Mr. S is not legally mandated to attend appointments with his treatment providers, there will be insufficient oversight of his medication use and consequent inability to intervene in a timely way should Mr. S suffer another decompensation.

[35] Stress has also been suggested as a trigger for Mr. S's deterioration. A primary source of stress has been his immigration status over the years. Even if I were to accept that resolving his immigration status would cause his paranoia to abate, as Mr. S believes, the evidence shows that his immigration issues are not fully resolved. In any event, I agree with Dr. Kerr that, given the extent to which Mr. S's paranoia has continued even after being declared a protected person, it is unlikely that Mr. S's paranoia would abate even if his immigration proceedings were concluded. His paranoia is chronic and pervasive. He has expressed suspiciousness about neighbours, forensic services staff, and strangers in the community. As Dr. Kerr put it, Mr. S's paranoia "can include any person anywhere any time."

[36] Based on the evidence before us, including the evidence regarding Mr. S's illness pattern, continued pervasive paranoia, tendency to be non-disclosive about his symptoms, repeated attempts to change or discontinue medication against the advice of his treatment providers, and continued view that harbouring paranoid thinking can be advantageous whilst disclosing symptoms can be against his own interests, I find that Mr. S remains a significant threat to the public.

[37] With respect to the second branch of the jurisdictional question, i.e., whether the potential harm is serious and not merely trivial, I find there is a significant risk of serious harm. At the hearing, we discussed Mr. S's recent questioning of an individual he believed to be surveying him. Dr. Kerr noted that altercations involving those with mental illness arising from such confrontations are relatively common. I make no finding as to whether a physical confrontation might arise in that type of situation for Mr. S, or as to whether a push or shove qualifies as "serious harm". Although it might well constitute serious harm, in the present case the issue is irrelevant. We have ample evidence regarding the patterns of Mr. S's illness. He has never, to my knowledge, reacted with pushes, shoves or minor aggression towards individuals caught up in the net of his paranoia. Some individuals do become more disinhibited and impulsive as their illness worsens, leading to shouting, threatening, and relatively minor aggression that can be seen as part of an escalating pattern necessitating intervention to prevent more serious aggression and violence. That is not the pattern of Mr. S's illness. The evidence establishes that, as Mr. S's illness worsens, he becomes more fearful, withdrawn, and ruminative. His paranoia becomes more all-encompassing and he feels increasingly threatened and justified in his need to defend himself and his honour. This was the basis of his attack on the victim in the original offence. This was also the pattern involved in his 2002 decompensation when he advised Dr. Murphy he felt slandered by crying babies in the mall and felt like "booting them in the mouth" and his 2005 decompensation that resulted in a plan to kill a staff member whom Mr. S believed was slandering him. The Review Board noted in its Reasons dated December 15, 2005, that his "homicidal ideation was disturbingly similar to what he experienced prior to the index offence, with recurrent themes of injustice occasioned by slander".

[38] Lastly, I would give no weight to the argument that granting Mr. S an absolute discharge would eliminate his paranoia. In my view, that is highly speculative and not supported by the evidence.

[39]   In the result, I would impose a further conditional discharge on the same terms as his most recent order with the exception that I would remove the provision allowing travel outside Canada as Mr. S no longer plans any international travel, reviewable within 12 months. In my opinion, this is the necessary and appropriate disposition required to protect the public.

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