BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1991 c. 43, as amended S.C. 2005 c. 22, S.C. 2014 c. 6

REASONS FOR DISPOSITION
IN THE MATTER OF

WILLIAM CHARLES ROXBOROUGH

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
March 5, 2019

BEFORE:
CHAIRPERSON: **B. Walter**
MEMBERS: **Dr. S. Iskander, psychiatrist**
Dr. L. Murdoch

APPEARANCES:
ACCUSED/PATIENT: William Charles Roxborough
ACCUSED/PATIENT COUNSEL: D. Nielsen
DIRECTOR AFPS: P. Gummerson, Dr. C. Kerr
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION AND BACKGROUND

[1] On March 5, 2019, the British Columbia Review Board convened an annual hearing to review the disposition of William Charles Roxborough, the accused, who is 69 years of age.

[2] We are entitled to accept some, none or all of the evidence before us. While we have considered all of the evidence on record in this case, we only recite that which is necessary to our decision.

[3] Mr. Roxborough's index offence occurred on November 10, 2010. It consisted of the aggravated assault of a peace officer, contrary to s. 268(2) of the *Criminal Code*. The charge was initially attempt murder and was reduced to aggravated assault. The victim, a peace officer, responded to a report of a suspicious male in a vehicle in North Vancouver. He approached the vehicle and when he began to question the occupant, the accused attacked him with a three-inch folding knife. The attack was quite vicious. It caused much damage to his victim's body armour and the officer was seriously injured. The accused was tasered and arrested. According to Exhibit 8, an agreed upon Statement of Fact which outlines the serious injuries suffered by the victim, Mr. Roxborough was, at the time, experiencing delusional beliefs that the victim was some sort of alien and deceiving him about his true identity.

[4] On April 20, 2011, Mr. Roxborough was given a verdict of NCRMD and released on a recognizance of bail requiring him to report and comply with treatment. Since his first contact with Dr. Kerr, his forensic community psychiatrist, his insight has been termed excellent.

[5] Despite a 40-year history of serious mental illness, including in excess of 20 hospital admissions even prior to the index offence, the accused has no other history of violence or criminal convictions. He has not behaved in a violent manner in the nine years since the index offence. Relevant facts are set out in more detail at Exhibit 8 and have been commented upon repeatedly.

[6] The accused is a sophisticated, educated and high functioning individual. He has a post graduate university degree in fine arts and has worked in the film industry. He has been a moderate user of alcohol with a history of binge drinking in the 1990s but has

not used much in the way of illicit substances. He says that he intends to remain entirely abstinent as alcohol does not mix well with his current medication regime.

[7] Mr. Roxborough has a consistent diagnosis of schizoaffective disorder, which fluctuates between hypomanic or manic and depressive states, at times accompanied by psychosis. Currently he is non-psychotic and appears to have foresworn episodes of elevated mood in favour of what is referred to as a chronic low mood.

[8] Mr. Roxborough has a more than 20-year history with a family psychiatrist. That relationship is of such consistency that the doctor sees Mr. Roxborough at his home on a weekly basis. He has, according to his treatment team, been entirely medication compliant and there has been no evidence of psychosis in recent years.

[9] The accused has a highly robust, informed and capable support system. He continues to see friends he knew as far back as university. He is in consistent contact with family and extended family members. He is physically active and free of financial stressors. He is very engaged with supports. Everyone involved appears to have a very informed, thorough understanding of Mr. Roxborough's illness and its presentation and they appear vigilant and ready to seek help when they believe it is needed.

[10] Mr. Roxborough was able to remain in the community until November 20, 2013. According to his community psychiatrist he stopped taking his medication, became unstable, and experienced paranoid thoughts regarding his safety. He admitted non-compliance, became psychotic and was admitted to FPH under a Restriction of Liberties for a period of one month before again being conditionally discharged. He admitted that he had ceased his medication without informing anyone and he said that his symptoms were similar to those he was experiencing at the time of the index offence.

[11] Between December 2013 and October 2014, the accused's brother reported some elevation of mood. During that period, Mr. Roxborough was also seeing Dr. Ryder four to five times per week. He acknowledged suicidal ideation in February of 2014, again occasioning a brief admission to FPH.

[12] In July of 2016, the accused was once more admitted to FPH, this time under an Enforcement Order of the court. On this occasion, the accused had, despite the prohibition in his disposition, obtained a knife, he says for camping purposes. He was using

alcohol and was experiencing elevation of mood. He was also experiencing psychotic features and communicating with a delusional entity which he has since put into the past. He was also depressed and suicidal. He was detained at FPH under a six-month disposition of custody. By November of 2016, the accused had restabilized and he was again discharged in January of 2017.

[13] Mr. Roxborough's loss of judgment during a hypomanic phase was the subject of considerable examination and scrutiny at his January 2017 hearing. The Review Board determined that obtaining a knife, contrary to his Review Board disposition, was for no nefarious purposes. He said he obtained it for camping. He acknowledged his poor judgment or mistake, and agreed to ongoing close monitoring.

[14] In January of 2018 the accused applied to the Review Board to permit him international travel. Following the evidence given at that special hearing and the accused's excellent presentation of a highly developed monitoring plan while outside Canada, the Review Board approved his planned international travel.

EVIDENCE

[15] As we convene for Mr. Roxborough's annual hearing, we learn from Dr. Kerr and from Ms. Gummerson that, in fact, the international travel to Europe which Mr. Roxborough had planned to undertake in March 2018, was postponed due to mutual concerns about his mood, registered both by his personal psychiatrist, as well as in discussions with his forensic treatment team. His postponement of his travel plans is seen as an indicator of his concern, cooperation and insight. Mr. Roxborough continues to be seen at the forensic clinic every two weeks. His injectable medications are administered on a monthly basis. He has not disclosed, nor has there been any evidence of psychotic symptoms since 2016. He continues to function independently and at a high level.

[16] The accused continues to reside in an apartment which he owns, and which is fully paid for. He has adequate financial means, including a disability pension. He continues to see his personal psychiatrist, Dr. Ryder, at least weekly and they have even more frequent phone and email contact. She monitors his mental state closely and freely communicates with the forensic treatment team. The accused's brother and his family see

Mr. Roxborough at least weekly. Members of that family are highly vigilant and not hesitant to communicate about Mr. Roxborough's mental state.

[17] At Dr. Kerr's most recent assessment, the accused was non-psychotic, organized and mood appropriate. He tends to suffer from chronically low mood. His medication has recently been reduced, yet remains at an effective dosage. According to Dr. Kerr's risk assessment, the accused is considered as a very low risk of significant harm. Dr. Kerr says that the accused has been ill for many, many years. Other than the index offence, he committed no violence before or since 2010. He has been in the community again since 2017. He is doing well. He remains well supported by a family and social network, as well as by his personal psychiatrist. If forensic services are withdrawn, Mr. Roxborough will continue to see Dr. Ryder on a weekly basis. She remains in touch with his family and friends, as has the treatment team.

[18] Dr. Kerr believes that the accused has a high level of quality, stable, and informed relationships, as well as such other protective factors as stability of mood, insight and adherence to treatment, all of which support his absolute discharge at this time. He has demonstrated that, even when his mood is less than fully normal, he remains sufficiently insightful and persuadable by members of his support system to seek help when he needs it. He has also given up activities which, in the past, have caused him to feel more creative and have elevated his mood beyond what he feels is healthy.

[19] Mr. Roxborough testified that he would under no circumstances discontinue his treatment without medical advice. He will continue to see Dr. Ryder and rely on the support he gets from his lay network which provides vigilant and intense oversight. Mr. Roxborough will continue to see his treatment team pending the full transfer of his care to Dr. Ryder. He was able to describe concerning symptoms marking the onset of instability, including escalation of mood, starting to smoke and drink, and concerns expressed by friends, neighbours and family. He remains active. He skis, attends gym, plays tennis, and goes to movies with friends. He is willing to accept his medications from Dr. Ryder. The index offence has had a chastening effect and caused everyone in his support system to be much more vigilant. He has benefited from his involvement with FPS which according to Mr. Roxborough has been both helpful, beneficial, educative, and compassionate. He described in detail his memory of the index offence and his actions at the time. As indicated, he says

he will in the future desist from the use of alcohol due to concerns about its interaction with his medication, and will resist activities which would escalate his moods, in favour of remaining at a level of somewhat low mood.

ANALYSIS AND DISPOSITION

[20] The Board's decision making is governed by s. 672.54 and s. 672.5401 of the *Criminal Code* which provide:

> **672.54** When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:
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> > **(a)** where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;
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> > **(b)** by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
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> > **(c)** by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.
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> **672.5401** For the purposes of section 672.54, a significant threat to the safety of the public means 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.

[21] As confirmed in ***Calles v. British Columbia (Adult Forensic Psychiatric Services),*** 2016 BCCA 318, the codification of the definition of significant threat in s. 672.5401, has not changed its interpretation:

> 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] ***Re Sokal***, 2018 ONCA 113, at paragraph 15:

> The threat posed must be more than speculative in nature; it must be supported by evidence. The threat must also be "significant", both in the sense that there must be a real, foreseeable risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must itself be serious: *R. v. Ferguson*, 2010 ONCA 810, at para. 8. The likelihood of a risk materializing and the seriousness of the harm that might occur must be considered together: *Re Carrick*, 2015 ONCA 866, at para. 16.

[23] In this case, having considered the totality of the historic evidence, as well as that of the accused and the expert risk assessment provided for this hearing we no longer have a basis to make a positive finding of significant threat justifying our ongoing jurisdiction over Mr. Roxborough.

[24] Uniquely, Mr. Roxborough has the benefit of an extensive, vigilant, informed and disclosive support network, which also includes a professional component.

[25] Under these circumstances Mr. Roxborough does not pose a reasonably foreseeable threat of serious harm and he is discharged absolutely.

Reasons written by B. Walter in concurrence with Dr. S. Iskander and Dr. L. Murdoch.