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

EDWARD WALTER ALLARIE

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
April 4, 2017

BEFORE:

CHAIRPERSON:	**B. Walter**
MEMBERS:	**Dr. S. Iskander, psychiatrist**
	A. Markwart

APPEARANCES:

ACCUSED/PATIENT: Edward Walter Allarie
ACCUSED/PATIENT ADVOCATE: T. Reyes
DIRECTOR AFPS: K. Field/Dr. M. Riley
ATTORNEY GENERAL:

INTRODUCTION AND BACKGROUND

[1] CHAIRPERSON: On April 4, 2017, the BC Review Board convened an annual hearing to review the disposition of Edward Walter Allarie, the accused in this matter, who is now 56 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. Allarie has been under the Board's jurisdiction since August 1999, some 18 or more years now. Mr. Allarie suffers from an organic brain disorder. He demonstrates cognitive impairment due to a significant brain injury. This has considerable impact on his overall functioning. In earlier times he was also diagnosed with schizophrenia and antisocial personality traits, however, the diagnostic picture has changed over time. His organic brain disorder is accompanied by a progressive dementing process which has rendered him impulsive and irritable in hospital and in care settings, where he has demonstrated repeated aggressive and threatening behaviour. His index offence, which occurred in July of 1999 was threatening pursuant to s. 264.1(1)(a) of the *Criminal Code*. His threats were of a verbal nature and directed at a care worker at a residential facility where Mr. Allarie was residing. As a result of that offence, the accused was given a verdict of NCRMD on August 20, 1999 and he has, until recent times, been almost consistently detained at the Forensic Psychiatric Hospital (FPH). Mr. Allarie also has a history of convictions including assaults.

[4] Mr. Allarie also has longstanding alcohol and substance abuse addictions. Following his verdict and while at the Forensic Psychiatric Hospital, Mr. Allarie has presented as consistently and chronically drug-seeking. In earlier times, he continuously used marijuana which produced transient psychotic symptoms, and which increased his impulsivity and likelihood to act out without thinking. Despite the remission in psychotic symptoms under treatment, he was considered unable to live or function independently, especially given the additional needs occasioned by his HIV positivity and other physical ailments. The consistent evidence was that, if discharged prematurely, he would be at high risk to reoffend.

[5] In October of 2006, after six years in hospital, Mr. Allarie was accepted into the Hillside facility in Kamloops and he was placed there on conditional discharge. Unfortunately, that attempt to discharge and to reintegrate Mr. Allarie into the community was unsuccessful. Quite quickly his behaviour deteriorated, he became threatening towards staff and was returned to FPH under an Enforcement Order, where he remained until 2015.

[6] In January of 2007, Dr. Widajewicz, who was then Mr. Allarie's treating psychiatrist, indicated at Exhibit 43 that most of Mr. Allarie's behaviour was due to or stemmed from a combination of severe brain damage and an underlying antisocial personality disorder, both compounded by substance abuse. Dr. Widajewicz opined that those conditions were not likely to respond to psychiatric treatment. He also said that Mr. Allarie was additionally seriously compromised due to his co-morbid HIV infection. However, even at that time, Dr. Widajewicz withdrew Mr. Allarie's diagnosis of schizophrenia due to the lack of any evidence of an active psychotic disorder. He also indicated that in his opinion, Mr. Allarie's prognosis was poor, as he would likely continue to become even more disoriented, secondary to the negative effects of his HIV infection and diabetes. Dr. Widajewicz did not anticipate any significant improvement in Mr. Allarie's overall functioning. The main focus of treatment was to maintain a degree of control over him so that he could be prevented from intoxication and subsequent violent behaviour.

[7] In the intervening years, Mr. Allarie almost continuously sought and used marijuana which may have contributed to a noted and continuing deterioration in his cognitive abilities. Although he could present as irritable, impulsive, labile and verbally aggressive, his behaviour in hospital has essentially consisted of throwing coffee at co-patients or staff as, for example, he did in 2013. He did engage in an altercation with a co-patient in or about 2014, but that, in addition to the index offence, has been the extent of his aggressive, albeit unpleasant behaviour.

[8] In or around 2014, Mr. Allarie established a relationship with a female former co-patient. The Review Board was presented with the option of placing Mr. Allarie on 28-day visit leaves to the home of his girlfriend. This was seen as perhaps a last opportunity for Mr. Allarie's community reintegration. Accordingly, in the year between 2014 and 2015, he was permitted visit leaves, during which he was able to demonstrate that he could remain both abstinent and non-aggressive. Finally, on March 5, 2015, just over two years ago, on the basis of his successful behaviour on visit leaves, Mr. Allarie was conditionally

discharged. He has since resided with Ms. S., who has her own considerable physical needs, in a number of different settings. He has, in the main, been able to remain abstinent and, according to his treating outpatient psychiatrist, demonstrated "remarkable" stability.

[9] Prior to Mr. Allarie's last scheduled hearing, Dr. Riley offered a diagnosis of major neurocognitive disorder due to brain injury, complicated by substance use; HIV; vascular disease; diabetes, and on a secondary axis, he raised the possibility of antisocial personality traits, short of a disorder. Dr. Riley made it clear that his diagnosis does not include a freestanding psychotic disorder.

EVIDENCE AT HEARING

[10] In his report, and orally, Dr. Riley's evidence is that Mr. Allarie has now been conditionally discharged for two years. He has met the accused on eight occasions in the past 12 months in the company of his partner, Ms. S. His diagnosis is unchanged. Dr. Riley's view on the secondary diagnosis of antisocial personality traits is that these may be historic, but they may just as readily be explained in terms of impulsivity, frustration tolerance and lability, due to Mr. Allarie's extensive brain injury. In any event, these traits are not currently an active focus of treatment or, for that matter, of concern.

[11] Despite his general abstinence and lack of physical aggression, Mr. Allarie's circumstances are not stable. His partner has considerable medical needs of her own. When she requires periodic hospitalization or respite, Mr. Allarie is unable to care for himself. The couple has recently located to more affordable housing in Langley. But because of Mr. Allarie's impulsivity, which includes public urination and exposure, he has been warned that they may be evicted if this behaviour is repeated. It has also been requested that his outings be accompanied. The couple is also provided with outreach services. Clearly the relationship is under stress by the extent of his and his partner's needs. On one occasion Mr. Allarie confessed to having used a single beer, which he says he did not enjoy and will not repeat. His potential to relapse to alcohol is considered his primary risk factor.

[12] Mr. Allarie remains on a reviewed and adjusted, but still complex regime of medications, which he has demonstrated he is unable to self-administer. These are a prescribed combination by his forensic psychiatrist, Dr. Riley, his personal practitioner and from St. Paul's Hospital, for the treatment of his HIV condition.

[13] Clearly, taking into account the narrative in Ms. Field's report, which chronicles a somewhat tumultuous year, Mr. Allarie's extensive and multi-faceted needs will, at some point, exhaust his partner's capabilities. At that point, he may have to be placed into a far more supervised and supported setting, approximating a hospital. At this time no referral to such a setting has been made, but the Fraser Valley Brain Injury program has been highly involved. Failing that, Mr. Allarie would have, at some point, to be returned to the confines of the Forensic Psychiatric Hospital.

[14] Dr. Riley indicates that, despite one episode of ingesting a suspicious pill, Mr. Allarie has been true to his commitment to abstinence, although he has obviously had access to alcohol on at least one occasion, in the form of a beer in or around his residence during this past year. That episode precipitated no change in Mr. Allarie's mental state and he appears to have insight into the risk posed by his alcohol use.

[15] Focusing on the threshold issue of significant threat, Dr. Riley was unable to recall any incidents of harm to others, aside from one episode in 2016, when Mr. Allarie kicked out at his partner, who was not within striking distance. That said, Dr. Riley cannot conclude that Mr. Allarie could not be harmful to others and considers him still capable of lashing out, even though his mobility is restricted to the use of a walker. That is, of course, not the legal test or definition of significant threat. Beyond his, at times, irritable presentation and his public urination, Mr. Allarie is otherwise directable. Dr. Riley voices a residual concern about the impact of destabilizing stressors if Mr. Allarie’s placement disrupts, but he admits that even under that scenario, the risk of serious harm to others is in the realm of speculation. Moving forward, Dr. Riley plans to continue to review and reduce Mr. Allarie’s regime of medications in order to reduce their potential to cause his patient physical harm. Certainly, Mr. Allarie is unable to self-administer his complex regime of medications. They are, as indicated, prescribed and administered via a number of sources.

[16] Currently, Mr. Allarie gets support from Ms. S. He is also provided with outreach programming through the auspices of the Fraser Health Brain Injury Program. He gets support in the form of service coordination, advocacy and supervision from his FPS team, and from his residential care provider. Ideally, the treatment team would like to see Mr. Allarie more socially engaged or activated in the community, but he tends to lack motivation to get out and attend programs. He does on occasion, attend an ALANO club.

[17] Under questioning, Dr. Riley said that the current array of services would continue if Mr. Allarie were absolutely discharged, as he requests, and that FPS would remain involved for at least three months, or as long as needed, in order to bridge Mr. Allarie to other sources of support in the community. In that vein, Dr. Riley says that, in fact, the psychiatric component of Mr. Allarie's care is quite limited, and FPS remains involved by "default". Mr. Allarie is probably not eligible for community mental health service supervision as he does not carry a diagnosis of an active psychotic disorder.

[18] Dr. Riley is also of the opinion that, while it has not been quantified, Mr. Allarie is likely to continue to experience a gradual decline in his cognition over time. Dr. Riley also acknowledges that given his extensive mobility limitations, Mr. Allarie can likely only be a significant threat to anyone within striking distance or within arm's length, and that he would have difficulty inflicting serious harm on anyone. Serious harm is not realistically foreseeable given the accused's restricted mobility. He also agreed that Ms. S.'s support of Mr. Allarie was more prominent and more important than the coordination and support provided by FPS.

[19] Regarding Mr. Allarie's impulsivity and irritability, potentially due to his antisocial traits, Dr. Riley opines that these may decrease in intensity as his cognition declines further.

[20] Ms. Field's report at Exhibit 78 provides a detailed chronicle of Mr. Allarie's tumultuous progress over the past year, at times disrupted by his partner's needs, as well as his decreasing capacity for self-care. She reminds us that as recently as March 20, Mr. Allarie was given final notice that, if he did not curtail his public urination, he would be evicted from his current residence. She says that things have been going better since as he appears to have taken these warnings and those of his treatment team to heart.

ANALYSIS AND DISPOSITION

[21] The Board's decision making is governed by s.672.54, and s.672.5401 of the *Criminal Code* (as amended) 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:

> **(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;
>
> **(b)** by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
>
> **(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.
>
> **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.

[22] The Board must first determine whether Mr. Allarie poses a significant threat to public safety as defined in s.672.5401. Although it is considered an expert tribunal in respect of the subject matter within its jurisdiction, the Board is not required or entitled to conduct its own assessment of an accused's significant threat to public safety. As must any adjudicative body, the Board can only evaluate the evidence presented to us at a hearing to determine whether it meets that threshold.

[23] Despite the implementation of s.672.5401, in 2014, the Courts have held that this has not changed the interpretation of significant threat, in substance. The jurisdictional threshold test remains that articulated in **Winko v. British Columbia (Forensic Psychiatric Institute)**, [1999] 2 S.C.R. 625:

> [T]he threat posed must be more than speculative in nature; it must be supported by evidence: *D.H. v. British Columbia (Attorney General)*, [1994] B.C.J. No. 2011 (QL) (C.A.), at para 21. The threat must also 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 miniscule risk of grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. (Par. 57)

[24] In **R. v. Carrick**, 2015 ONCA 866, the Court specifically adopted the above 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)

[25] Even more recently in **Calles v. British Columbia (Adult Forensic Psychiatric Services)**, 2016 BCCA 318, the BC Court of Appeal confirmed 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)

[26] Both the probability of the harm and the severity of the harm must be significant. Prior to **Winko** it was sometimes argued that a miniscule risk of grave harm was significant. An alternate argument was that a high risk of trivial harm occurring could be significant. Both arguments are expressly rejected in **Winko**: there must be a significant risk of serious harm occurring.

[27] In summary, a finding of significant threat must be based on evidence rather than speculation. 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. In making these determinations, we must have regard both to the interests of individual liberty as well as to the paramount consideration of public protection.

[28] Mr. Allarie carries no diagnosis which involves psychosis. His progressive dementing disorder, complicated by historic alcohol and substance abuse make him irritable and impulsive. His disorder is not ameliorated by psychiatric treatment. These are the sources of his periodic acting out, mainly by expressing verbal threats. His convictions for assault, more than 20 years ago, pre-date his significant mobility limitations. He is also plagued by an array of physical ailments.

[29] Mr. Allarie's mobility limitations and physical decline, notwithstanding an extensive list of special care needs, make his ability to act on his threats or frustration and

to inflict serious harm speculation. Certainly even his current level of independence, such as it is, is tenuous.

[30] We are not entitled to maintain our jurisdiction over an accused out of an abundance of caution or in his or her best interests. The care and management of a medically frail NCR accused is not intended to fall solely on APFS: **LaJoie**. If an accused does not pose a significant threat, the Board must order absolute discharge: see **Re Marzec**, 2015, ONCA 658, par 28-33.

[31] Evidence of significant threat within a reasonably foreseeable time period must be beyond speculation: **D.H**. **v British Columbia** (Attorney General), [1994] BCJ No. 2011(C.A.).

[32] Mr. Allarie is not a significant threat to public safety. He is discharged absolutely.

Reasons written by B. Walter, in concurrence with Dr. S. Iskander and A. Markwart

[[[[[[[[[