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

THAMER HAMEED ALMESTADI

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
December 7, 2017

BEFORE:
CHAIRPERSON: **B. Walter *(for the majority)***
MEMBERS: **Dr. P. Constance, psychiatrist *(concurring)***
P. Cayley *(dissenting)*

APPEARANCES:
ACCUSED/PATIENT: Thamer Hameed Almestadi
ACCUSED/PATIENT COUNSEL: T. Duncan, C. Legget
DIRECTOR AFPS: Dr. C. Robertson, Dr. D. Toguri
B. Lohmann
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION AND BACKGROUND

[1] On December 7, 2017, the BCRB convened an initial hearing to make a disposition in the matter of Thamer Hameed Almestadi ("the accused").

[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.

THE ACCUSED

[3] Mr. Almestadi is 20 years of age. He was academically bright and a successful student in his youth. He came to Canada from Saudi Arabia just over two years ago, initially to study English.

[4] At the material time Mr. Almestadi was enrolled at UBC and was living in a student residence there. There is no evidence of historic mental health issues or treatment nor of violence. He had been using marijuana on a daily basis but stopped a month or more prior to the index offence so that it would not interfere with his studies. Marijuana is not considered to have influenced Mr. Almestadi's behaviour at the index offence or as a potent factor in predicting his risk to public safety in the future.

[5] By mid-September 2017, Mr. Almestadi was experiencing concentration and focus problems and was falling behind in his school performance. He was homesick for his family back in Saudi Arabia. He became worried and acutely stressed to a degree that he considered and even explored dropping out. He became socially withdrawn, lost weight and was sleeping excessively. He sought help and advice and pursued counselling but was unable to obtain an appointment before the date of the index offence. Perhaps two weeks before the offence, he began to harbour delusional thoughts, including in class. By September 22, 2017, he had stopped attending classes.

INDEX OFFENCE

[6] Mr. Almestadi and the victim lived in the same UBC residence complex. He had briefly encountered her two or three weeks before the index offence. She had invited him for a drink on her birthday which he declined.

[7] On October 4, 2016, after listening to a religious recording or reading, Mr. Almestadi attended at the victim's room in an acutely psychotic state. When she opened her door, he pushed his way in and began stabbing her neck with a knife. During the ensuing struggle she succeeded in breaking the knife and she tried to use it to defend herself. Her screams attracted the attention of other residents who eventually separated the two and subdued Mr. Almestadi until his arrest.

[8] On arrest, Mr. Almestadi said he felt badly about what he had done and asked about the victim. He said that he had not slept the night before and endorsed hallucinatory experiences. He was charged with attempted murder (s.239(1)(b) *CC*); assault with a weapon (s.267(a)), and aggravated assault (s.268(2)).

[9] Beyond the evidence of Mr. Almestadi's declining school performance, accompanied by abnormal, depressed and paranoid thinking and the psychotic beliefs arising while or after listening to a religious recording just before the offence, the motivation underlying the index offence, despite extensive psychiatric exploration as well as lengthy and intensive questioning at the hearing, remains poorly understood. Although the religious recording and its theme of sacrifice clearly played a role in Mr. Almestadi's behaviour, Dr. Robertson did not find that Mr. Almestadi was experiencing typical command hallucinations. Mr. Almestadi himself experienced events as a test from, or the wish of God. In Dr. Smith's opinion, the only motive for the attack was his psychosis. Lack of motivational clarity is not, in our experience, an unusual phenomenon among forensic patients. It is an issue which may indeed never fully resolve.

[10] Dr. J. Smith produced a psychiatric assessment at the request of Mr. Almestadi's counsel. In summary, she identified increasing stress, anxiety, impaired concentration, declining school performance, homesickness, excessive sleeping, nighttime insomnia, social withdrawal, confusion, paranoid ideation, ideas of reference, and misinterpretation of events by Mr. Almestadi, two to three weeks before the index offence.

[11] The evidence suggests that Mr. Almestadi's psychosis cleared in a matter of weeks or no later than November 7, 2016. None has been identified since.

[12] Dr. Smith diagnosed a Brief Psychotic Disorder in contrast with Schizophrenia, a diagnosis which requires a degree of chronicity or persistence of symptoms lasting six months. She did not believe Mr. Almestadi's symptoms were triggered by intoxication or by his earlier use of marijuana. She was unable to identify any anger or anti-social attitudes in Mr. Almestadi. The RCMP conducted forensic examinations of Mr. Almestadi's electronic devices and social media which identified no evidence of extremist, sadistic or misogynistic views, or interests. Dr. Smith considered Mr. Almestadi to present a low risk of future violence, subject to a further episode of psychosis, and to be manageable on an outpatient basis.

[13] In their assessment for the Court, Drs. Robertson and Toguri agreed with the diagnosis of Brief Psychotic Episode. They diagnose no personality disorder: (Ex. 5).

[14] On October 26, 2017, the accused was given a verdict of NCRMD on the basis of Admission of Fact (Ex. 6) and committed to FPH: (Ex. 8).

EVIDENCE FOR AND AT HEARING

[15] The Director filed the report of Drs. Robertson and Toguri (Ex. 10), and both physicians testified.

[16] All collateral background evidence gathered has been internally consistent. Mr. Almestadi has been co-operative and polite with no anti-social behaviours at FPH, though he was initially guarded in his presentation.

[17] Mr. Almestadi's physicians continue to endorse, and the brevity of his single episode is also consistent with, their preferred diagnosis of Brief Psychotic Episode or Disorder. This is a less frequent or common diagnosis than Schizophrenia for example, and its association with violence is even less prevalent. With this diagnosis there is a 60% chance of a further episode within 2 years and an 80% likelihood of relapse within 5 years. As Mr. Almestadi has been free of psychosis for over a year, the risk or likelihood of a further episode is now below 50%. If he experiences further episodes his diagnosis would

likely change to one of a Schizophreniform Disorder. In that event, a Brief Psychotic Episode could (retrospectively) be characterized or viewed as a precursor to Schizophrenia but this cannot be predicted definitively. In this case another episode would likely occur either spontaneously, or be precipitated by stress and its onset could be rapid.

[18] Mr. Almestadi is high functioning. The duration of his psychosis was four to six weeks and it remitted without medication. As he is apsychotic, he remains un-medicated though he has not declined medication. These factors, including the brevity of the episode, are positive signs that he may not relapse. Nevertheless, given the events of October 2016, a future episode, especially if the accused were to experience similar themes or beliefs, could involve violence.

[19] Mr. Almestadi's disclosiveness has improved and is now considered reasonable. He expressed remorse immediately after the offence and has done so since. The goal of treatment and supervision is to see him safely returned to Saudi Arabia.

ASSESSMENT OF RISK

[20] By history, Mr. Almestadi's risk to the safety of others is embedded, enmeshed in, and linked to, a future episode of psychosis. It is that experience or context which gave rise to his sole anti-social, albeit extremely violent, offence. He has no other history of violence, violent attitudes or ideation, anti-social behaviours or anger issues. There is no evidence of any animus toward women. Any frustration about the uncertainty of his current circumstances is not considered "abnormal".

[21] The risk of relapse, though significant, has, by the passage of time, declined to less than 50%. The passage of a year, symptom-free without treatment, including while detained in the highly stressful and alien environment of a pre-trial centre, all the while confronting serious criminal charges, and intensified by concern about the disappointment his behaviour and academic failure has caused his family, suggests that Mr. Almestadi's mental state is not particularly fragile currently.

[22] To the extent that stress was a central precipitating factor in his illness, and despite the rapidity of Mr. Almestadi's decompensation, that stress and its impacts were not unnoticed. There were alarms, intentions and steps planned or taken to respond. Mr. Almestadi himself, his peers, his teachers, and his family, were all aware of and concerned

by the changes they noticed. There is no compelling reason to assume that symptoms of a future relapse could not, in a vigilant, informed, consistent and motivated environment be discerned and responded to. That said, despite his pro-social and co-operative orientation and his stability, Mr. Almestadi's insight into the possibility of relapse remains incomplete.

ACCUSED'S PLAN FOR TREATMENT, SUPPORT & SUPERVISION

[23] Mr. Almestadi's parents have been living in BC during the past year since their son's legal problems. They visit him in hospital three times per week and have participated in treatment team meetings, usually with the assistance of a translator. His family wishes to repatriate him to live with them at home.

[24] The family has identified a psychiatrist who has reviewed Dr. Smith's assessment and who has agreed to provide treatment and monitoring. Dr. AlShimi is a Saudi psychiatrist in Jeddah with 16 years of practice experience including in the forensic area. Dr. AlShimi is prepared to accept the accused as a patient and to treat him. He has hospital admitting privileges. He proposes to engage in a program of psychoeducation with the family and the accused, including about the warning signs of relapse. He offers to remain in direct communication with the accused and family members and is willing to see the accused weekly. A home care program is available to attend at the family home. The accused could be hospitalized as needed.

[25] Mr. Almestadi's mother has suffered from depression and the family has a demonstrated understanding of mental illness and the need for ongoing treatment adherence. If deemed necessary, Mr. Almestadi's family is prepared to relocate to Jeddah, which is 1.25 hours from their current residence. There are also public and private hospitals within a reasonably short distance of the Almestadis' home. The family undertakes to ensure the accused's compliance with medication if it is prescribed. They will provide him with a supportive, stress-free, vigilant and responsive family environment and take him to hospital forthwith if needed. The family is prominent in Saudi Arabia and motivated to preventing a recurrence of violence.

[26] Mr. Almestadi (the accused), wants to return home with his parents and to see Dr. AlShimi in Jeddah as directed. He agrees that there is a statistical likelihood of a future episode. He undertakes to be disclosive of his feelings and symptoms with his family

members and to seek treatment or admission to hospital. His family lives within 10 minutes of a hospital. He would consult with his psychiatrist concerning any future plans to continue his education. He is open to learning more about his illness through programs.

[27] Under intense questioning, Mr. Almestadi described the onset signs of his psychosis including paranoia, misinterpreting events, loss of focus and concentration, and listening to a religious broadcast ten minutes before the offence, the meaning of which he misinterpreted, as a test from God. He says his last symptoms resolved before November 7, 2016.

[28] Mr. Almestadi's immigration status, under an Exclusion Order dated November 29, 2017 (Ex. 14), means that if he is discharged from our jurisdiction, he will be deported under CBSA escort to Saudi Arabia.

[29] Mr. Almestadi's family must return to Saudi Arabia in December 2017. If detained, Mr. Almestadi would be entirely without support.

ANALYSIS AND DISPOSITION

Statutory framework

[30] 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;
> >
> > **(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.
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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.

[31] The Board must first determine whether, on the evidence, Mr. Almestadi poses a significant threat to public safety as defined in s.672.5401. The Board does not 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 admitted at a hearing to determine whether it meets that threshold.

Significant Threat

[32] Codification of the definition of significant threat in s.675.5401 has not changed its interpretation. The 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)*

[33] 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)*

[34] 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.

[35] 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.

[36] The process by which the Board determines whether or not the accused poses a significant threat is summarized in ***Winko*** at para 62 sub paragraph 1, paraphrasing s.672.54:

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

[37] The Review Board is tasked with forming an opinion as to an accused's significant threat in each and every matter before it. More often than not, in the case of an adult accused, professional risk assessment evidence is presented in the HCR.20 v.3 format. It falls to the Board to analyze and assign weight to the factors addressed, among others it considers relevant, in its determination of significant threat, which is a legal rather than a psychiatric concept.

[38] As discussed above, there is a significant likelihood that, under circumstances he experiences as highly stressful, Mr. Almestadi may experience a further episode of psychosis. Although it is somewhat unusual to provide a risk assessment in the context of an assessment of criminal responsibility, Dr. Smith does so in Ex. 4. Absent any significant historic factors such as past offences or violence, addictions, a lengthy history of mental illness, personality disorder or anti-social attitudes or behaviours, Dr. Smith says that: "[ ] it is likely that any risk posed to the public by Mr. Almestadi flows solely from the potential for him to experience a further psychotic episode" (par 124).

[39] Given Mr. Almestadi's overall presentation and history, the experts agree that only in that condition would it be reasonable to foresee him acting out in a violent manner.

[40] Dr. Smith says that the risk of relapse is exacerbated by stress or exposure to drug abuse. Mr. Almestadi has had no psychosis for over a year without treatment and has not been aggressive or assaultive. He accepts that he was suffering from an illness and is able to identify and respond to signs of onset.

[41] Despite the pace of onset of his acute symptoms, Mr. Almestadi himself was, according the evidence, keenly aware that his mental, social and academic functioning were deteriorating. He disclosed his fears and was assisted to try to access services. Individuals in his environment, including family members, friend and teachers, were aware of changes and were concerned. A resident advisor reported concerns of possible self-harm. The point is that the onset of his illness, signs of stress and worry, anxiety, declining performance and paranoia were both observable and observed.

[42] Drs. Robertson's and Toguri's assessment parallels Dr. Smith's. They recommend psychoeducation, monitoring, prescribing medication if signs of relapse occur, and ongoing abstinence.

[43] Dr. Smith assesses no relevant (so-called) clinical factors and considers Mr. Almestadi insightful in terms of acceptance and identification of his symptoms.

[44] ***Winko*** speaks at length about the difficulties inherent in predicting significant threat and says that:

> It follows that the inquiries conducted by the court or Review Board are necessarily broad. They will closely examine a range of evidence, including but not limited to the circumstances of the original offence, the past and expected course of the NCR accused's treatment if any, the present state of the NCR accused's medical condition, the NCR accused's own plans for the future, the support services existing for the NCR accused in the community and, perhaps most importantly, the recommendations provided by experts who have examined the NCR accused. The broad range of evidence that the court or Review Board may properly consider is aimed at ensuring that they are able to make the difficult yet critically important assessment of whether the NCR accused poses a significant threat to public safety: par 61.

[45] A past offence is not dispositive that the NCR accused continues to pose a significant threat: par 62.

[46] In this case, we have the benefit of assessments from three experts which are essentially at consensus on the issue.

[47] As to the accused's care and safety plan, in another case, the Crown actually acknowledged that a plan, similar to that offered by Mr. Almestadi, "might offer protective factors not available to the accused in Canada, to an extent which might legally support his absolute discharge". ***Re Sandhu***, [2006] BCRBD, NO. 17, par 17.

[48] In its analysis of the evidence in that case the Board said:

> In analyzing the evidence, the Review Board first approached its task from the perspective of the criteria contained in section 672.54 of the Code. The evidence, including the circumstances of the index offence; the accused's insight into his illness and his lack of remorse, giving rise to doubts about his future compliance; his ongoing use of potentially destabilizing substances and his apparent fragility would, in our view, continue to satisfy our significant threat jurisdictional threshold under current circumstances: ***Sandhu***, par 18.

[49] This brief synopsis describes a far more dire risk profile than the case before us.

[50] The Board went on to comment:

> It is however an unusual, indeed rare feature of this case that the accused has arranged to present a sufficiently developed alternative plan for his future care and treatment, which has within it a number of positive 'protective' factors which are simply not available under the status quo.
>
> Is it possible that an accused might satisfy the significant threat threshold under one set of circumstances but be entitled to be absolutely discharged under another plan? In an environment of scarce resources it would be

> unreasonable and unrealistic to impose upon the Director of Forensic Psychiatric Services the sole responsibility to marshall all of the resources an accused needs to ensure public safety: "the notion of danger must not be examined in the abstract outside of the context in which (the accused) will be living.": **Re Lajoie**, (PQ Court of Appeal #500-10-000600-99, Feb 18, 1994). **This panel agrees that the prediction or determination of significant threat is not absolute but rather must be approached on a pragmatic and contextual basis.** In other words it is not beyond possibility that an accused could, under one treatment plan be considered a significant threat but not under an alternative approach. The Board is entitled indeed it must, following ***Winko***, take into account all protective mechanisms available under alternative plans. Ideally every disposition hearing would routinely involve a comparative analysis of competing care treatment plans. Presumably, virtually any accused might be considered safe given a sufficient, relevant, responsive and available array of supervisory and treatment resources.: paras 19,20. **(emphasis added)**

[51] We are urged in our analysis to ignore the accused's immigration status. There is no legislative mandate for the Board to consider a deportation, except to the extent of its potential clinical and risk assessment implications: ***Re Seyoum*** [2007] BCRBD NO. 100, par 43. We consider it entirely appropriate, as part of our threshold inquiry, to consider not the accused's immigration status, but the proposed treatment plan set out at paras 23 to 26 above. ***Winko*** mandates that we do so.

[52] Drs. Robertson and Toguri consider Mr. Almestadi currently asymptomatic and stable. They appropriately and cautiously recommend steps to deepen the accused's insight. They acknowledge that this could occur in Saudi Arabia and they consider the plan to monitor and treat him there as reasonable. Similarly, Dr. Smith echoes that:

> "[ ] His family is now also very aware of his need for support and guidance … and is more than willing to ensure that he receives this": Ex. 4: par 126.

[53] Dr. Smith concludes that with ongoing care, monitoring and early access to treatment, Mr. Almestadi's risk is manageable in the community.

[54] Drs. Robertson and Toguri note that Mr. Almestadi has no source of support in BC. They consider him a low overall risk of potentially serious violence and say that the plan proffered by his parents to manage him in his home country warrants consideration by the Board. Certainly living with his family in his home country would, in our view, expose Mr. Almestadi to far less stress which would, in turn, reduce the risk of relapse, and to public safety. Moreover, even the possibility of access to marijuana in Saudi Arabia would be close

to nil. That this plan also best meets the accused's needs is not in controversy. It represents as robust a safety and treatment plan as we have ever encountered and considered.

[55] In ***R. Campagna***, [1999] B.C.J. No. 2023, a judgement of the BCSC, shortly after ***Winko***, the Court had before it an NCR accused whom it found was high functioning; had insight into her conduct (dangerous driving causing death); was aware of her symptoms and prepared to respond; was abstinent; had been briefly acutely psychotic (due to a substance-induced psychosis); had no personality disorder, and had been off medication without any relapse to symptoms. There was no clear and highly developed treatment and safety plan such as was offered in the case before us.

[56] In that case, Singh, J., had the benefit of three psychiatric opinions and concluded:

> [..] the court has a solemn duty to uphold and apply the law. This is what I must do. I have reviewed in detail the law as it stands presently and as interpreted by the highest court of this land. Applying the law and in accordance with the guidelines by the Supreme Court of Canada, I can come to no other conclusion but to disagree with the Crown's position.
>
> I am satisfied that were I to accede to the Crown's submissions, I would be falling into the error that the Supreme Court of Canada cautioned against; namely, not to refuse to grant an absolute discharge based upon doubts or speculation or upon suspicions. I am satisfied on the whole of the evidence that this accused would not be a significant risk to the safety of the public: paras 42, 43.

[57] We paraphrase Singh, J. to say that we are satisfied, on the expert risk assessment evidence and under the plan for Mr. Almestadi's monitoring, supervision and treatment in Saudi Arabia, this accused is not a significant threat to public safety.

[58] Finally, we must add that we have, in compliance with s.672.541, also considered, as relevant, the eloquent and entirely appropriate Victim Impact Statement filed. We wish particularly to express our respect for and to commend the victim and her family for their attendance and the highly dignified demeanour they demonstrated throughout this hearing.

P. CAYLEY, DISSENTING:

[59] I have had the benefit of reading the reasons of the majority and must respectfully dissent from the disposition the Board is making in this case.

[60] I adopt the Chair's thorough account of the background leading up to the index offences, but wish to highlight the following:

1. The index offences were brutal, and targeted on a fellow female student. Mr. Almestadi was in a homicidal frenzy at the time of the attack. But for the will of the victim to survive and her fierce resistance, coupled with the fortunate intervention of the third parties, there can be no doubt that Mr. Almestadi would have accomplished what he understood to be his sacrificial goal;

2. The motivation for the attack is not well understood;

3. The motivation for the attack on this specific victim is not well understood;

4. Gaps in our understanding of what precipitated Mr. Almestadi's psychotic episode persist and are, in my view, likely in part to be attributable to only recently being found NCR on October 26, 2017.

5. The only explanation for the psychotic episode is that Mr. Almestadi succumbed to the stresses of everyday life – stresses that can be anticipated in the future.

6. Mr. Almestadi has had only one known psychotic episode, and it resulted in extreme violent life-threatening behaviour.

7. As the Chair notes in paragraph 38 and 39 of his reasons, "…there is a significant likelihood that, under circumstances he experiences as highly stressful, Mr. Almestadi may experience a further episode of psychosis . . . Given his overall presentation and history, the experts agree that only in that condition would it be reasonable to foresee him acting out in a violent manner.";

8. Drs. Robertson and Toguri noted in their joint report at Exhibit 10, page 12 that "The limited data on Mr. Almestadi's psychosis suggests that if he does have a second episode of psychosis, it could onset quickly and may result in severe violent behaviour";

9. As the Chair notes at paragraph 17 of his reasons, the onset of another psychotic episode would likely be rapid;

10. Dr. Robertson noted that Mr. Almestadi has at times been guarded since arriving at FPH. At this early stage, it is unclear to the treatment team if this is significant to understanding his current mental state or a simple lack of familiarity in his surroundings. Mr. Almestadi's delayed responses to questions, including at the hearing, and his restricted affect is not well understood. It is too soon for the treatment team to determine if such behaviours are evidence of the negative symptoms often associated with psychotic illness;

11. The psychoeducation that has been provided to Mr. Almestadi appears in my view to only have been superficially integrated into his thinking and understanding of his condition. Dr. Robertson's report at Exhibit 10 on page 9 states that Mr. Almestadi has demonstrated only partial insight into his situation. He notes that "my impression is that he lacks a full emotional conviction and that there is a real risk of having a relapse of psychosis . . . Treatment focused on increasing Mr. Almestadi's insight may decrease his risk of psychiatric relapse, which may in turn decrease his risk of violence". While it is not unusual for a newly diagnosed patient to lack insight, Mr. Almestadi and his parents have not had the full benefit of the psychoeducation necessary to effectively understand and manage his risk. There has been insufficient time for this to be accomplished. Given the critical role Mr. Almestadi's parents are likely to play in any future plan that involves identifying and managing future risk, it would seem to me to be essential for a co-ordinated, non-rushed and informed psychoeducation programme be in place and completed before consideration is given to a discharge. I note, as well, that in a meeting with Dr. Toguri, Mr. Almestadi's parents underestimated the risk of relapse, characterizing it as 20-25%. In fact, Dr. Toguri advised the parents that psychotic relapse rates were much higher and can be up to 60% or more;

12. Dr. Smith reported that Mr. Almestadi had expressed unusual paranoid thoughts during her interview of him on July 4, 2017. She said, he wondered whether a pain in his hand was being caused by an inmate that he did not like, but was able to examine such thoughts and conclude that they were not rational (Ex. 4, par 52). In my view, the fragility of the accused's mental state is evidenced by these accounts;

13. Drs. Toguri and Dr. Robertson agree that it is more likely than not Mr. Almestadi will become psychotic again and when ill, will be at a risk of severe violence. In terms of assessing the significance of that risk, what we do know is that Mr. Almestadi has been psychotic on only one prior occasion, just last year, and became homicidal.

[61] Given this background, it is my view that the ***Winko*** test has been met.

[62] Mr. Almestadi is likely to suffer another psychotic break. The risk of a future episode of violence seems very linked to the risk that Mr. Almestadi will experience another psychotic break. The risk is high – it is more likely than not that it will occur and that it will be rapid. The quick pace of the onset makes intervention and the prevention of another act of violence less certain and more complex

[63] While it is not certain whether such a future psychotic episode will result in an act of extreme violence as occurred on October 4, 2016.

[64] The evidence available to the Board, is that on the single occasion Mr. Almestadi experienced a psychotic episode he attempted to sacrifice a virtual stranger for reasons that remain largely unknown, other than he was experiencing stress.

[65] The risk assessment tools used by the experts in this case provide valuable insight and are useful but I would be inclined to give them more weight in a case of this kind when coupled with a period of observation, monitoring and supervision by a specialized forensic team. At this point he has only been evaluated in a highly secure environment, without the opportunity to be tested in the context of more freedoms.

[66] I am of the view that Mr. Almestadi has been shown to present a significant risk of serious harm.

[67] In order to comprehensively assess and manage Mr. Almestadi's risk, it is my view that a period of custody is required. This would allow for a more informed assessment of Mr. Almestadi's situation over time and an evaluation of his response to stresses associated with the granting of additional freedoms. It would also facilitate delivery of an intensive psychoeducational programme to assist Mr. Almestadi in managing his health and risk.

[68] The Director has advised that more freedoms would be granted by the hospital as Mr. Almestadi is evaluated. This will add further information to the risk assessment.

[69] I agree with the Crown that “reintegration is secondary to risk”. The discharge plan being proposed emphasizes close monitoring for public protection purposes. However once out of the Board’s jurisdiction there is no way of compelling Mr. Almestadi to comply with necessary follow-up. If he is unmotivated to pursue treatment while back in Saudi Arabia managing the risk to public safety is downloaded to his parents. In my view, the disposition proposed by the majority does not take sufficient account of this reality.

[70] Given the brutality of the index offences, the rapid onset of psychosis, the likelihood that Mr. Almestadi will experience another psychotic episode, the fact that he committed what appears to be a targeted act of extreme violence on a virtual stranger, the unexplored gaps in our knowledge as to what motivated or triggered the index, and the practical challenges of an early Saudi Arabia reintegration plan, I am of the view that the necessary and appropriate disposition at this time is custody.

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