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

CHRISTOPHER LEE FARRELL

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
March 22, 2017

BEFORE:

CHAIRPERSON:	**B. Walter**
MEMBERS:	**Dr. J. Smith, psychiatrist**
	K. Polowek

APPEARANCES:

ACCUSED/PATIENT: Christopher Lee Farrell
ACCUSED/PATIENT COUNSEL: D. Mossop, QC
DIRECTOR AFPS: B. Lohmann/Dr. B. Singh
ATTORNEY GENERAL:

INTRODUCTION AND BACKGROUND

[1] CHAIRPERSON: On March 22, 2017, the British Columbia Review Board convened an annual hearing to review the disposition of Christopher Lee Farrell, the accused in this matter, who is now 53 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. Farrell was charged in January of 1997 with the attempted murder of his father, who was then aged 66 and confined to a wheelchair. While that distant offence was quite serious, over time Mr. Farrell was forgiven by his father; the two reconciled and became friends. On December 8, 1997, Mr. Farrell was given a verdict of NCRMD for a lesser charge of assault, carrying, using or threatening to use a weapon.

[4] Mr. Farrell had a criminal record, in the main property offences. There was a sexual assault in 1993, the details of which are not known. We assume that it was at the less egregious end of such offences as he received a two-month suspended sentence and a two-year order of probation.

[5] The accused has a history of head injuries and significantly impaired cognition, as well as multiple drug and alcohol use. The current diagnosis is one of schizoaffective disorder, borderline intelligence, with an IQ of less than 70, antisocial personality traits, marijuana use disorder, and stimulant abuse disorder (in remission). Despite this history, cocaine abuse has not been an issue since shortly after Mr. Farrell’s verdict and admission to FPH.

[6] The major impediment to Mr. Farrell's progress in the forensic system has been his repeated and almost uninterrupted relapse to marijuana use. He has never been able to say no to the offer of drugs. His inability to abstain from substances was considered a function of his intellectual impairment. Marijuana use was considered a potent factor in his potential risk to others. Early evidence appeared resigned to the notion that he would likely never be able to abstain.

[7] Another factor impeding Mr. Farrell's progress has been his impulsivity and lack of social judgment, again, the product of his cognitive impairment. This has left him with an inability to learn from experience and has rendered him a considerable behavioural challenge in the hospital setting, as well as on an outpatient basis.

[8] A third factor, which has affected Mr. Farrell's progress has been a by-product of his nomadic, highly mobile family. He has repeatedly eloped to Ontario where, in 1999, he was charged and convicted of threats directed at his ex-wife, who resides in British Columbia. It has been Mr. Farrell's pattern that, once returned to BC, he again, after a period of time elopes to Ontario where his surviving siblings and extended family members reside. On one such occasion, between February 2002 and June 2003, the accused was actually AWOL for more than a year.

[9] After another four-month elopement in 2007, the accused was readmitted to FPH in an acutely psychotic condition. His behaviour was disordered, disorganized and disinhibited. He demonstrated numerous sexually inappropriate behaviours, and was unable to comply with expectations. Once his psychotic symptoms abated, so did his inappropriate sexual behaviour. There has been no repetition since 2008, from which time he has been continuously in custody at this hospital.

[10] Despite Mr. Farrell's difficulties and challenges, and despite his persistent relapse to marijuana use, he has actually been non-psychotic for some time. He has been maintained on injectable medication. Needless to say, given his afflictions and his behaviour, attempts to reintegrate him into the community, have been markedly unsuccessful. Looking at matters longitudinally, Mr. Farrell's opportunities or chances for anything in the way of a durable reintegration to community are receding and becoming more tenuous.

[11] According to the evidence, Mr. Farrell's psychosis has been in remission for eight or nine years. Although he has rendered hundreds of positive urine screens, there has been no assaultive or violent behaviour, even in the enhanced structure, security and behavioural expectations of this hospital.

[12] In recent years, again, Mr. Farrell has consistently asked to be transferred to Ontario. Between 2009 and 2011, he was sufficiently stable and symptom free that he was able to attend a supported work program for a period of time. Mr. Farrell's brother and his extended family in Toronto recently again have offered to accommodate him. The Board

has consistently rejected that option because of fears that he would elope, relapse to more significant substance abuse, cease taking his medication and become psychotic to a point where violence would be a predictable outcome. Nevertheless, and despite those concerns, the Board has for some time now endorsed the recommendation that Mr. Farrell be transferred to Ontario under the *Code*. However, no consents from the respective provincial Attorneys General have been forthcoming.

[13] At his last hearing, in April of 2016, the Review Board noticed that the accused had actually had a more positive year compared to previous reporting periods. His schizoaffective disorder, or symptoms thereof, remained in complete remission. He was on injectable medication, ensuring compliance. Mr. Farrell's use of substances, or at least his positive urinalysis tests, confirming marijuana use, had decreased significantly. Despite this overall improvement, problematic episodes highlighting the accused's impulsivity and lack of self-control continued. However, while these episodes required monitoring and management, and while they at times involved verbal altercations, there were no episodes of overt violence.

[14] At his last hearing, the Board again detained Mr. Farrell on the basis of risk assessment evidence that suggested he would, under an absolute discharge, experience psychosis associated with potential or even probable violence. The Board detained Mr. Farrell on the basis that his plan for absolute discharge lacked the safety elements necessary to render it viable. It also found that Mr. Farrell's brother's offer to accommodate him was questionable in terms of his capacity to appropriately care for and supervise the accused.

EVIDENCE

[15] At the current hearing, we learn that the accused's relatively positive progress has continued as has his baseline non-psychotic presentation. As of June of 2016, Mr. Farrell was able to adhere to expectations sufficiently that he moved to the Hawthorne Unit with level 3 privileges but without staff escorted community outings. He declined to participate in programs. He continued to test positive for cannabis and to breach rules by smoking tobacco on hospital grounds. His current psychiatrist, Dr. Singh, indicates that he has not yielded a positive urinalysis test since February 10, just over a month. His behaviour tends not to change when he uses marijuana, and he has, as already noted, remained non-psychotic for several years.

[16] In terms of his progress toward reintegration, Mr. Farrell has been referred to the Fraser Health Region to be placed in a tertiary care setting where there is significant supervision and support, and where his injectable medication would continue to be administered. While some of the necessary paperwork has been submitted, the process is not yet complete. No actual placement is contemplated or expected within the next six months or more.

[17] Dr. Singh was asked to predict Mr. Farrell's progress under absolute discharge. In her estimation, Mr. Farrell would relapse to more consistent marijuana use as he has been manifestly unable to ever abstain. If more disorganized or intoxicated, he would then likely cease consuming his medications, and his risk of harm to others would increase. Dr. Singh noted that, despite his advancing age Mr. Farrell is large and he remains strong. He could readily cause physical harm if he were psychotic. She has reapplied for, and Mr. Farrell has been provided with an assessment outing during which he was able to maintain his behaviour. He has remained free of verbal or temper outbursts in the last year. If he were placed in an outpatient setting, the treatment team would continue to endorse his interprovincial transfer to Ontario, which has not proceeded on an in custody basis due to bed shortages in the destination province.

[18] The Review Board heard from RF, the accused's brother. In contrast to previous years, he now resides in a four-bedroom house with two nephews and a sister. The family invites Mr. Farrell to live with them. RF says he would take his brother to appointments. He said that there were no substances in the house but he did not give a clear answer regarding the nature of his response if he found his brother using marijuana, beyond saying he would make him stop and, if he saw symptoms, he would rush him to a hospital or a doctor. RF was not able to provide much persuasive evidence regarding the signs and symptoms of his brother's relapse to psychosis. He said that if his behaviour changed he would take him to a doctor. I note that the family has in the past, indeed two weeks prior to the index offence, on the basis of behavioural signs, sought to hospitalize the accused. In the course of RF's questioning, it was also noted that during the accused's previous AWOLs to Ontario, in particular in or about 2002, the accused was actually seen by a psychiatrist at the Centre for Addiction and Mental Health (CAMH), in Toronto for almost two years. RF is convinced that he could re-connect his brother to a psychiatrist there.

[19] The accused, testified that all of his family is back in Ontario, but he was not able to say much about his mental condition other than that he has a “little bit” of schizophrenia, including various thoughts.

ANALYSIS AND DISPOSITION

[20] 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.

[21] The Board must first determine whether Mr. Farrell 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 at a hearing to determine whether it meets that threshold.

[22] 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.:

> [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 minuscule risk of a 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)

[23] 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)

[24] 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)

[25] 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.

[26] In summary, 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. 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.

[27] We consider Dr. Singh's risk assessment. While we agree that the index offence was serious, we note that the parties reconciled, and aside from some veiled threats to his wife in 1999, Mr. Farrell has been violence free. His other offences have been in respect of property.

[28] Regarding Mr. Farrell's extensive alcohol and multi-substance abuse history, we note that there has been no evidence of any relapse to cocaine use since early on in his admission to hospital. He clearly remains highly attracted to marijuana. The evidence suggests that he will never be able to abstain. The question is to determine how robust a risk factor Mr. Farrell's inevitable and continuing marijuana use will be. Despite yielding literally hundreds of positive tests while under our jurisdiction and indeed in this hospital, the evidence of his psychiatrist is that marijuana use does not significantly negatively affect his behaviour. It has not resulted in relapse to symptoms of psychosis or violence. That said, we do not diminish his impulsive, poorly judged behaviour in hospital.

[29] As to Mr. Farrell’s schizoaffective disorder, we again note that illness is in remission and has been for close to ten years now. While he is chronically disorganized, the symptoms of the illness can certainly be kept at bay through the administration of injectable medication, which could occur outside of a hospital setting.

[30] As to his persistent supervision failures in the form of unauthorized absences involving cross country travel, while there have been numerous such elopements, the accused did not encounter any difficulties except on one occasion in August 1999 when he engaged in what were considered “veiled” threats towards his wife, albeit from a great distance.

[31] Mr. Farrell has not expressed any violence or violent ideation in recent times. While insight into his illness is lacking, he is generally settled and not deeply disorganized. While Mr. Farrell's relapse to substances is entirely predictable, we rely on evidence that it has not served to decompensate him. We also take into account that the treatment team supports his repatriation to Ontario, and would prefer that this happen sooner rather than

later. There is no reason to believe that Mr. Farrell could not continue, even with the assistance of the Director, to be connected to formal psychiatric services in Ontario, to maintain his regime of injectable medication. In our view, any history of violence is so remote that to predict a future significant incident is becoming speculative.

[32] Given Mr. Farrell's functional deficits, it would be inappropriate to place him in a position where the onus is upon him to demonstrate that he is no longer a significant threat: see **Marzec**, 2015 ONCA 658, par. 30, 33. Accordingly, we have determined that the time is right to absolutely discharge Mr. Farrell on the understanding that our disposition will be delayed its effect for a period of one month, during which we expect the Director to expend reasonable efforts to connect Mr. Farrell with treatment services in Ontario, which know him and which have treated him in the past. We would hope that prior to his departure, an appointment could be arranged and his family enlisted in ensuring that Mr. Farrell attends. Delaying the effective date of our order will also provide an opportunity for Mr. Farrell's treatment team or the hospital social work department to make contact with his host family and make arrangements to secure the funds necessary to transport Mr. Farrell to Ontario and to have him appropriately received on his arrival.

Reasons written by B. Walter, in concurrence with Dr. J. Smith and K. Polowek