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

SHAINA LEIGH INKSTER

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
December 13, 2016

BEFORE:

ALTERNATE CHAIRPERSON:	**F. Hansford, QC**
MEMBERS:	**Dr. P. Constance, psychiatrist**
	B. Walter
	Dr. S. Iskandar, *ex officio*

APPEARANCES:

ACCUSED/PATIENT:	**Shaina Leigh Inkster**
ACCUSED/PATIENT COUNSEL:	**D. Abbey**
DIRECTOR AFPS:	**Dr. A. Kolchak, M. Byer**
ATTORNEY GENERAL:	

INTRODUCTION AND BACKGROUND

[1] ALTERNATE CHAIRPERSON: On December 13, 2016, the British Columbia Review Board (the Board) convened a mandatory hearing pursuant to s. 672.94 of the *Criminal Code* in respect of Shaina Leigh Inkster, a 28-year-old woman who was found not criminally responsible on account of mental disorder (NCRMD) on July 6, 2016 in respect of charges of assault and assaulting a police officer on March 30, 2016 and one count of assault of a nurse employed at the Royal Inland Hospital in Kamloops on April 1, 2016. Disposition was deferred to the Review Board. Ms. Inkster first appeared before the Board on September 27, 2016. She received a conditional discharge.

[2] Although we have considered all the evidence on record, for the purpose of these Reasons we only recite that which is necessary to our decision.

[3] The first offences occurred when members of the RCMP were called to a residence in 100 Mile House as a result of the complaint that Ms. Inkster had assaulted another occupant of the house. Upon arrest, and without warning and provocation, Ms. Inkster started yelling at the attending police officers and punched a female officer. She then attempted to kick her in the chest. Ms. Inkster was subdued and placed in the police car, where she made comments about committing suicide or otherwise harming herself. She was apprehended and taken to hospital in 100 Mile House, where she was held under the *Mental Health Act*. She was transferred to the Royal Inland Hospital in Kamloops. On admission, she exhibited disorganized thinking and appeared to be in a manic phase of a serious mental illness, although attending physicians could not rule out substance-induced psychosis.

[4] On April 1, 2016, Ms. Inkster was agitated, wandering restlessly around her ward and yelling out her door. Her nurse, RM felt that she had established a good rapport with Ms. Inkster, who appeared to respond to compassionate nursing care. RM attempted to administer a PRN medication, placing herself in a position of vulnerability to Ms. Inkster. Without warning or provocation, Ms. Inkster punched her in the face. RM and another staff member were unable to contain Ms. Inkster in her room. Additional staff members attended and were able to secure Ms. Inkster and admit her to a seclusion room. Ms. Inkster later complained that RM was “in my personal space, touching me”. She hoped that “maybe next time she will not get in another’s personal space”. RM suffered some physical injuries, but her main injury was psychological. She described herself as having been in shock because

only minutes earlier, she was providing care, support, comfort and reassurance and Ms. Inkster had stated that she trusted RM. This assault had a significant impact upon RM both personally and professionally.

[5] Ms. Inkster also attempted to trip another Royal Inland Hospital nurse who was merely walking by her, with whom she had had no previous contact. This attempt was unprovoked and random.

[6] Ms. Inkster was subsequently discharged from Royal Inland Hospital pursuant to the extended leave provisions of the *Mental Health Act*. Pending her initial hearing before the Board, she was managed by a community based treatment team.

[7] Ms. Inkster has a history of admission to psychiatric facilities in various hospitals, commencing in or about 2009 in New Westminster. Since 2011, when she was admitted to Queen Victoria Hospital in Revelstoke, she has been admitted to psychiatric wards in that hospital and in hospitals in Trail and Vernon on at least eight further occasions up until 2014. At that time, she moved to Calgary, where she was apparently hospitalized in a psychiatric ward on at least one further occasion. Details of her medical management in Alberta were not provided. While in British Columbia, she was managed under the extended leave provisions of the *Mental Health Act*. She was on such leave at the time she committed the index offences.

[8] Ms. Inkster carries a diagnosis of bipolar disorder type 1, characterized by frequent periods of mania during which she displays extreme irritability and excitability, demonstrates poor impulse control and poor judgment, and acts out aggressively. Prior to the index offence, she was insightless into her illness and the risk she posed to others. Her manic episodes frequently occurred in the context of noncompliance with her medication regimen and are complicated by a history of stimulant and cannabis abuse. She has an established pattern of doing well when certified and compliant with medication, but of frequently and quickly decompensating to mania when she does not comply and when she engages in use of illicit substances. Management under the *Mental Health Act* in the community has not been adequate to prevent frequent relapses.

[9] Ms. Inkster is noted to have a history of becoming extremely aggressive, assaultive, of throwing things, and of spitting at caregivers and first responders when she becomes ill. She is noted to act aggressively and unpredictably. When hospitalized, she is dismissive towards nursing staff, endorses the use of marijuana, and has stated that she wished to

“follow the rules on my own terms”. Contact with the police is generally initiated by bizarre behaviour and disorganized thinking. Previous incidents include exposing herself in public, shouting at traffic and passersby, sitting in the middle of the road in an attempt to end her life, hypersexuality and expressions of suicidal intent. When ill, she is disorganized, agitated, and responsive to internal stimuli.

[10] Prior to the index offence, Ms. Inkster engaged in significant cocaine, marijuana and alcohol use over a period of two days while en route to 100 Mile House from New Westminster with her brothers and then boyfriend. Her behaviour during the index offences was consistent with her behaviour during prior relapses.

[11] In granting Ms. Inkster a conditional discharge despite her apparent limited insight, repeated non-compliance with medications in the community and a pattern of repeated decompensations, the Board placed particular emphasis on Ms. Inkster receiving the support of DH, described as her aunt, a retired RCMP member with whom she was then residing, and of her grandmother, who resided in Revelstoke. Ms. Inkster testified that she intended to continue to reside with Ms. H and expressed gratitude for her guidance and assistance. The Board stated as follows (Exhibit 13b, paragraph 29):

> “Ms. Inkster presented as calm and cooperative with her treatment team. There are protective factors in her environment and in particular, her aunt and grandmother are very supportive. Her aunt has provided shelter and guidance and offers a stable environment to Ms. Inkster … She appears to have developed a reasonable therapeutic alliance with her community and forensic treatment teams, who are in a position to offer her necessary psycho-education, counselling, treatment and rehabilitation in Kamloops. She has been compliant with her medication regimen, although additional counselling and education will be required to address ongoing concerns respecting her marijuana use and to assist her in developing increased insight.”

[12] The Board rejected Ms. Inkster’s request that her disposition accommodate ongoing use of marijuana, considering that consumption of controlled substances remained a significant feature of her risk profile. Provision was made for urinalysis where the Director had reasonable grounds to suspect that the condition preventing consumption or possession of controlled substances had been breached.

[13] Ms. Inkster’s life in the community after her discharge did not, in the Director’s opinion, conform to the expectations of the parties or the Board. The court felt it necessary to issue an Enforcement Order pursuant to s. 672.93 of the *Criminal Code*. Ms. Inkster was

subsequently arrested, appeared before a judge, and returned to the Forensic Psychiatric Hospital. These events triggered a mandatory hearing pursuant to s 672.94 of the *Code*.

EVIDENCE AT THE HEARING

[14] Additional disposition information circulated in preparation for this hearing included the Enforcement Order of October 26, 2016 (Exhibit 14a), a letter from Crown Counsel to the RCMP, Kamloops Detachment, respecting Ms. Inkster's arrest (Exhibit 14b) and updated Case Management Report prepared by Ms. C. Harkies, R.N. (Exhibit 15), a psychiatric report prepared by Dr. S. Lessing, dated December 1, 2016 (Exhibit 16), a psychiatric report prepared by Dr. A. Kolchak (Exhibit 17a) and a report prepared by M. Byer, Director's Review Board Representative (Exhibit 17b). Appended to Ms. Harkies' report was a Pharmanet printout covering Ms. Inkster's prescription history from July 2016 through October 2016 and an Official Prescription Receipt respecting a prescription for lithium, dated October 27, 2016. Dr. A. Kolchak, Ms. Harkies, Ms. Inkster and Mr. U testified orally. Mr. U is the father of Ms. Inkster's boyfriend.

[15] Difficulties quickly arose in maintaining a reasonable therapeutic alliance as described to the Board at Ms. Inkster's original hearing. Ms. Harkies testified that initially, Ms. Inkster presented as pleasant and cooperative. Her affect and mood were blunt. She denied experiencing delusional thinking, paranoia or hallucinations and none were noted. However, she was unhappy with the involvement of the Board in her life, particularly with the conditions of her discharge and the reasons for being under Review Board jurisdiction. She expressed frustration at having to attend at the Forensic Psychiatric Services Clinic (hereafter "FPSC") after her discharge. She stated that she had "chosen" to be under Board jurisdiction only because she felt she would receive greater services through the FPSC than in the civil mental health system. She had difficulty understanding the Board's role and was frustrated at being required to obtain permission to travel out of town. She also wished her lithium prescription to be discontinued, or in the alternative, prescribed monthly instead of weekly. Dr. Lessing declined both requests for clinical reasons. This was a significant concern because lithium levels prior to her initial Board hearing were below therapeutic levels.

[16] Subsequently, Ms. Inkster began to present with animated mood and affect, which she attributed to finding a new love interest, with whom she was spending most of her time. She was adamant that she was taking medication as prescribed even though the history of

her prescriptions indicated that she would not have on hand sufficient medication to comply with her regimen. Her response was to assert that she had extra medication at home, but she could not explain how she had obtained it. When concerns were expressed about medication noncompliance and the rapid decompensation which generally followed, she became tearful at the thought of being away from her boyfriend.

[17] On October 11, 2016, Ms. H reported that Ms. Inkster had not been seen since October 6, 2016. She believed that Ms. Inkster was residing with her boyfriend and advised that phone and text messages were not being returned. Ms. Inkster replied only on one occasion, stating that she would be back, but giving no date or time frame. Ms. H felt that this behaviour was unusual as Ms. Inkster had kept in touch up to that date. Ms. Inkster attributed this situation to some “personal problems” with her aunt, about which she refused to elaborate. Ms. Inkster provided her boyfriend’s contact information to Ms. Harkies and was reminded of her obligation to reside at her aunt’s residence.

[18] In her report of December 1, 2016 (Exhibit 16), Dr. Lessing advised that she met Ms. Inkster to assess her mental state on October 13, 2016. This meeting occurred in the context of concerns respecting changes in Ms. Inkster’s behaviour, relationships and housing. There were additional concerns that she had not been compliant with oral medication consumption and may be relapsing into drug use. Ms. Inkster advised that she felt subjectively “okay and in love with Jared” (her new boyfriend). Ms. Inkster was surprised by the intrusive nature of the Review Board process and stated that she would not have pursued an NCRMD defence had she known about it. The meeting concluded with an apparent agreement by Ms. Inkster that she would comply with medication, attend for bloodwork and maintain herself in the community responsibly and in accordance with the Review Board’s conditions

[19] Ms. Inkster’ relationship with her treatment team and her aunt continued to deteriorate rapidly. Ms. Inkster continued to request a change in her prescription, which was refused on clinical grounds. She was again advised of the discrepancy in her prescription records that was consistent with non-compliance with her medication regimen. Ms. Inkster was highly critical of Ms. Harkies. She advised that she had not gone for blood work because the requisition conflicted with advice she had received from her father and step-mother, who were both bipolar. She had also been busy with her new boyfriend. At their meeting on October 18, Ms. Inkster renewed her objection to picking up her medication every week and again asserted that it was her choice whether to attend FPSC or not.

[20] On October 19, Ms. H reported that she had been away from Kamloops for a few days. Upon her return, she found Ms. Inkster and her boyfriend in her home, sleeping. The house was, in her words “a disaster”, there had clearly been a party, and that she found an empty rye whiskey bottle on the floor as well as a “baggie” of marijuana. All the spoons in her house had been stolen. When confronted, Ms. Inkster said that she would replace the spoons from a thrift store and denied knowledge of how they went missing. In a subsequent telephone call to Ms. Harkies, Ms. Inkster dismissed Ms. H’s concerns about the drugs, claiming that Ms. H would not know drugs if she saw them. In the background, Ms. Harkies heard the boyfriend saying that Ms. H was delusional and had Alzheimer’s. Ms. Harkies reminded Ms. Inkster of her conditions and of her liability to be returned to hospital either under the *Criminal Code* or the *Mental Health Act*. A follow-up appointment was arranged.

[21] On October 20, Ms. H telephoned to report that she had received a telephone call from Ms. Inkster and her boyfriend, during which the boyfriend presented as threatening. She had decided that she could no longer house Ms. Inkster. She also reported that she had found additional drugs in the house and delivered them to the local RCMP detachment. The Board was not provided with the details of this find.

[22] When Ms. Harkies telephoned Ms. Inkster to make arrangements for return of her property from Ms. H’s residence and to make arrangements to find an alternate address, Ms. Inkster was upset and blamed her aunt for their conflict. Ms. Inkster denied she had symptoms of concern even though her behaviour was consistent with her pattern of past relapses. Ms. Inkster again asserted that it was her choice whether she attended FPSC or not. Ms. Harkies refused to review clinical decisions with Jared, Ms. Inkster’s boyfriend or discuss the case with him, as demanded. Ms. Inkster was requested to attend the FPSC on October 21, 2016 to review her situation.

[23] Ms. Inkster attended at FPSC on October 21 as arranged. Unexpectedly, she brought with her three male friends and one female friend whom she identified as her “support people”. She wished them to attend her conference with Ms. Harkies. Ms. Harkies described this group as loud and boisterous. They were drinking liquid out of brown bottles that resembled beer bottles, hiding the labels from the clinic staff. (It was later determined to that they were labelled as root beer). One of the males had a knife strapped to his belt. In consultation with her regional manager, Ms. Harkies determined that it was necessary to make arrangements to return Ms. Inkster to hospital and elected to do so under the *Mental Health Act*. Her friends reacted in a rude and hostile manner, asserting that Ms. Inkster did

not have a mental illness, that she would not hurt a fly and that Ms. Harkies was heartless and without empathy. They wished to advocate for Ms. Inkster as “she needs it with you [i.e., Ms. Harkies]”.

[24] Ms. Inkster was assessed at and subsequently released from hospital. Her blood work indicated that her lithium level had only increased by .1 mmol/L since the index offence. The hospital did not conduct blood work to determine whether Ms. Inkster had consumed illicit drugs.

[25] Neither Ms. Inkster nor the hospital contacted FPSC about Ms. Inkster’s discharge. Ms. Harkies did not know where Ms. Inkster was living and had not had the opportunity to assess changes in her discharge plan. Ms. Harkies managed to contact Ms. Inkster, who advised only that she was not residing with Ms. H. She did not make any appointment to attend FPSC.

[26] Ms. Harkies testified that Ms. Inkster continued throughout to minimize the use of marijuana, which she viewed as medication. She displayed poor insight into her substance misuse history, was not content with her medication regimen, did not follow it assiduously, and in fact asserted, contrary to fact, that Dr. Lessing had decreased her medication dosage. Her treatment team was specifically concerned with her position that compliance with the conditions of her discharge was voluntary and with her presence in environments where drugs and alcohol were being used. Ms. Inkster was also evicted from her aunt’s residence and was unwilling to engage with her treatment team respecting her residence. She did not accept her diagnosis and, when taken to the Royal Inland Hospital, demanded a second opinion from a different psychiatrist, which she was convinced, would free her of any need to attend FPSC or abide by the terms of her conditional discharge.

[27] As a result, the Director instituted an enforcement proceeding.

[28] Ms. Inkster was admitted to the Forensic Psychiatric Hospital (FPH) on October 28, 2016. Nursing staff at FPH reported that since then, Ms. Inkster had received multiple visits from her boyfriend, parents, a friend and her brother while at FPH. She was initially pleasant, polite and followed staff direction. She had a full range of affect and was generally in a good mood on the Women’s Program unit. Despite this encouraging beginning, issues with FPH staff and her treatment team began to emerge fairly rapidly. Ms. Inkster became agitated when her requests for specific sleeping and anti-anxiety medications were denied. On another occasion, she insisted on being given medication for menstrual cramps which

would not be effective for that purpose. She responded in a hostile manner, stating that “you better note that you are denying my meds; you are a fucking joke”. She was offered alternate medication. On November 10, 2016, she stated that she was going through withdrawal and that she was “really wanting to hit my bong last night”. She reported that she had not slept the previous night, and was “drenched in sweat”. She stated that she was bored at FPH but “I take care of other patients in here; is not that what that’s all about; I want more drugs”. The next day she again requested medications for anxiety, although she showed no signs of distress or restlessness.

[29] In conversations with FPH staff, and particularly on October 30, 2016, Ms. Inkster stated that her “aunt” was really her second cousin. She complained that she should never have been arrested or held and blamed her situation entirely on Ms. H, describing her as a “68-year-old, retired RCMP officer” who was “vindictive and jealous” of her relationship with her boyfriend. She also accused her aunt of having taken money from her and somehow desiring to take an inheritance that Ms. Inkster though she should receive from a grandmother.

[30] At times, Ms. Inkster rambled, exhibiting disorganized thought and making very intense eye contact with staff. She acknowledged that she needed to get her housing sorted out before she could be conditionally discharged and that medications were necessary if she was to leave a good and productive life. Her attitude to her boyfriend was occasionally ambivalent, but generally she expressed her love for him and her desire to be with him. She complained about limits placed by staff on her contact with her boyfriend during visits, which included intimate kissing.

[31] Jared’s (Ms. Inkster’s boyfriend) concerns about Ms. Inkster’s management in the community and at FPH were reviewed with him by Dr. Kolchak. Although Dr. Kolchak felt that Jared’s intentions were good, he characterized Jared’s understanding of mental illness and its treatment as unconventional. He did not accept Dr. Kolchak’s diagnosis or opinion, preferring his own view that psychiatric issues are somehow related to quantum physics and that prescribed medications were of no use to Ms. Inkster. Jared did not approve of the treatment offered at FPH, and on several occasions, demanded explanations of clinical and nursing decisions and the names of treating staff members in order to lodge complaints of misconduct because she was distraught and was not speaking to him “properly”. He stated “I just want to know what you people did to her”. Ms. Inkster advised staff that he was being protective of her.

[32] At or about this time, Ms. Inkster's behaviour deteriorated and her thinking became disorganized. On November 14, she was observed to yell out, make loud noises vocally, but denied doing so when approached. She was found in a room naked and had to be reminded to put on clothing. Later that morning, she was observed to be wearing socks on her hands and her clothing inside out. Her moods shifted rapidly, and when talking to her boyfriend, she laughed erratically. She then laid down on the counter and appeared to fall to sleep. Staff noticed that she had apparently been incontinent of urine. She appeared unable to follow direction to take a shower and was disoriented. She was placed in seclusion, by which time her sweatpants were soaked in urine.

[33] During subsequent interviews, Ms. Inkster demanded to call her boyfriend, yelled at staff, complained of having been sexually assaulted in her youth, yelled nonsensical statements and talked over staff trying to calm her. Her boyfriend again telephoned to request clinical information. He claimed that staff were being "evil" and stated "I hope you can sleep well tonight and I hope you are happy with yourself".

[34] Dr. Kolchak testified that Ms. Inkster's behaviour and thinking became increasingly disorganized at FPH to a degree that he believed was significant. Her presentation worsened rapidly and she only began to improve approximately 2 weeks before the hearing. When at her worst, she endorsed seeing ghosts but denied experiencing any auditory hallucinations. She was unable to think clearly and it was very difficult for Dr. Kolchak to get a direct answer from her. Her presentation during their meeting was disjointed.

[35] In Dr. Kolchak's opinion, Ms. Inkster had no insight into her illness or the risk she poses. She advised that she would prefer to discontinue medications in the community. He was concerned as well that abuse of substances in the community could exacerbate and intensify her manic episodes, although substance abuse had no apparent role in her current presentation. She admitted to having used marijuana once while in the community on her discharge. She asserted that marijuana was useful to her. Dr. Kolchak could not be certain respecting the possible effects of marijuana on her bipolar disorder, particularly given the incidence of use of other drugs at or about the time of her other hospitalizations.

[36] Dr. Kolchak considered that Ms. Inkster's illness is not well understood. Her triggers to decompensation, the reasons underlying her past refusals to comply with her medication regimen, her lack of insight and her pattern of decompensation must all be addressed. While not all her relapses were accompanied by the commission of criminal offences, he

considered there to be a concerning history of violence linked to her illness, particularly in the context of hospital admissions, and directed at caregivers. Possible reintegration into the community is impaired by her animosity towards treatment generally and towards her caregivers and treatment team in particular. She is more prone to impulsive violence when ill.

[37] Ms. Inkster rejected her diagnosis of bipolar disorder. She testified that she suffers from posttraumatic stress disorder and that this could be treated by using ativan. She affirmed that she had been prescribed drugs that she did not want to take, but later stated that she would take prescribed medication if conditionally discharged, even though she was “still suffering” from its effects. She was unable to advance a reason why she would take such mediations in those circumstances.

[38] Ms. Inkster also stated that she would prefer not to see a psychiatrist, but if she must, she would prefer to attend at a local mental health clinic in Kamloops or to follow up with the psychiatrist she saw during her recent attendance at Royal Inland Hospital. She felt “safer” with him and thought they had a better rapport. She felt that empathy was lacking within the forensic services and expressed the opinion that forensic clinic staff should be assessed every couple of years. If she must attend FPSC, she wanted to be afforded the right to choose from a few different case managers.

[39] Ms. Inkster denied using drugs since her initial Board hearing, although acknowledged it was possible that she had used marijuana one night. She considers “street drugs”, which she defined to exclude marijuana, to be highly dangerous. She advised that her boyfriend did not use “street drugs” and has been an AA member for 20 years. She testified that she wished to continue to use marijuana but reluctantly stated that she would not do so if conditionally discharged, but only when pressed and after a marked delay in responding. She regards marijuana as different from “street drugs” because it is a “natural herb”.

[40] Ms. Inkster had no memory of committing the index offences. She does not believe that it was possible that she did so. This was consistent with her stated lack of recollection shortly thereafter. She attributed her lack of memory to the effect of psychiatric medications prescribed after the index offences. She admitted to having had occasional difficulties in the past distinguishing between what was real and what was not, but affirmed that she is now aware of the difference. She felt that she was at her baseline.

[41] Ms. Inkster testified that she left her approved residence to live with her boyfriend and his father because she felt “vulnerable”. She stated that her aunt’s objective was somehow to divert to herself an inheritance Ms. Inkster expected to obtain from her grandmother. She objected to her aunt wanting to have control of her in the community, as well as to her aunt suggesting that Ms. Inkster attend some of her activities. Her aunt also did not approve of her relationship with her boyfriend. She had developed a great dislike of her aunt because she “confined me to what she wanted”. She claimed that her aunt had withheld medications that were sent to her house.

[42] Ms. Inkster also attributed her aunt’s complaints about the gathering held in her aunt’s residence in which drugs and alcohol were apparently consumed to Ms. H jealousy of Ms. Inkster’s relationship with her boyfriend. This incident occurred when friends who were coming through town wanted to get together. She described her and her boyfriend as “housesitting” at the residence to take care of Ms. H’s pets. She denied using drugs or alcohol at this time, other than 2 ativan pills to help her sleep. She did not see the guests leave and they were gone in the morning when she awoke. She denied any knowledge of what it happened to her aunt’s spoons.

[43] She stated that her friends accompanied her to the FPSC clinic for support. She felt that “something would transpire” at this meeting. Despite her friends’ actions as described by Ms. Harkies, she recalled that she was quiet and composed.

[44] Ms. Inkster testified that if conditionally discharged, she planned to continue to reside with her boyfriend and his father in his three bedroom apartment. She described that living situation as safe, comforting and a “place of progression”. She intended to rely upon PWD benefits, but eventually planned to secure an entry-level full time job and to do volunteer work.

[45] Mr. U testified that he has known Ms. Inkster for a couple of months through his son, and she lived in his residence for 5 weeks. He describes this experience as “just fine”. He does not like drugs or alcohol in the house. He said that Ms. Inkster could reside with him and his son and that he could assist Ms. Inkster with her reporting requirements. He would support her using medications, if prescribed. He indicated that he was trying to be neutral in this matter.

ANALYSIS AND DECISION

[46] We are required by s. 672.54 of the *Criminal Code* to absolutely discharge Ms. Inkster unless we find that she constitutes a “significant threat”. Pursuant to s. 672.5401 of the *Criminal Code,* a person is considered a significant threat if she constitutes a significant risk of causing serious harm of a criminal nature to the public, whether that harm is physical or psychological in nature and whether or not violence is involved. (*See* ***Davis, Baranyais***). If we determine that Ms. Inkster is a significant threat, then we are bound to make the least onerous and restrictive disposition that is necessary and appropriate having regard to the safety of the public, the mental condition of the accused, the reintegration of the accused into society, and the accused’s other needs. Of these criteria, the safety of the public is paramount (***See s. 672.54***, ***Lacerte, Baranyais***).

[47] It has only been 2 ½ months since the Board addressed the question of whether Ms. Inkster presented a “significant threat" disentitling her to an absolute discharge. In determining at her initial hearing that she was a significant threat, the Board considered that she was suffering from a well-established diagnosis of bipolar type I disorder manifested in periods of mania, psychosis and depression and which had resulted in numerous hospitalizations in the recent past. Attempts to manage her in the community had repeatedly failed when Ms. Inkster decompensated, resorted to substance abuse and discontinued prescribed psychiatric medications. The Board noted that she could decompensate over a period as short as 2 to 3 days. When ill, Ms. Inkster is emotionally labile, and her actions have been unpredictable, incoherent, impulsive, and destructive. She also acts aggressively, particularly when her behaviour is constrained by first responders and caregivers. During the index offences, this behaviour escalated to an assault on a member of the public, on police officers who attempted to arrest her, and on a nurse who had placed herself in a vulnerable position in order to carry out compassionate nursing care. Ms. Inkster lacks insight into her illness, need for medications and the risk she poses to others.

[48] Dr. Kolchak testified that assessing risk in Ms. Inkster’s case remains a difficult task because the duration of her past psychotic episodes is unknown. He agreed with Dr. Lessing that her medical condition can deteriorate or become exacerbated very quickly. He does not regard her profile as typical and was unable to opine that previous decompensations would have been due solely to medication noncompliance. There is no clear or common understanding of the development of her symptoms. Her most recent relapse at FPH did not involve illicit substances.

[49] Dr. Kolchak considered that Ms. Inkster's pattern of violence was escalating up to the time of the index offences. The role of illicit substances, including marijuana which she took prior to the index offence, in promoting her decompensation to violence is uncertain. He considers that she recently relapsed, requiring placement in seclusion and that she only began to recover from the effects of this incident over the last two weeks.

[50] Ms. Inkster's lack of insight remains a significant concern. She has no real allegiance to her medication regimen, would not accept supervision or direction from her treatment team or her aunt, remained committed to the use of marijuana as medicine, and did not accept that the events leading to her NCRMD verdict ever occurred.

[51] There has been no significant change in Ms. Inkster's risk profile since her last hearing. Indeed, that risk appears greater than it did at that hearing. Her recent history indicates that if Ms. Inkster decompensates, as we think is likely to occur if she is absolutely discharged, then she would present a significant risk of physical and psychological harm to members of the public and in particular, to first responders or caregivers. Dr. Kolchak testified that if Ms. Inkster's mental condition deteriorates, as it has repeatedly in the past, there would likely be further violence along the lines of the index offences. He testified that in his opinion, she is currently certifiable under the *Mental Health Act* if she were absolutely discharged. We agreed and concluded that Ms. Inkster remained a significant threat, as that term is defined in the *Criminal Code,* and therefore is not entitled to an absolute discharge. She must remain within the Board's jurisdiction.

[52] We must therefore consider making the disposition that is necessary and appropriate. S. 672.54 of the *Criminal Code* requires us to assess as our "paramount consideration" the safety of the public. This section also identifies as relevant considerations the mental condition of the accused, the reintegration of the accused into society, and her other needs.

[53] Ms. Harkies testified that a complaint had been filed against her by Ms. Inkster. There was also reference in the evidence to possible complaints being filed against FPH staff. As we noted in the ***Lacerte*** case *(BCRB July 15, 2014),* punishing Ms. Inkster for breaching the terms of her conditional discharge or for having filed a complaint, or intending to file a complaint respecting Ms. Harkies or FPH staff, is not the proper object of a disposition. We do not, therefore, consider the fact that such complaints have been or might be made to be relevant to our decision.

[54] The least restrictive and onerous disposition we could possibly make in this case would be a conditional discharge. At Ms. Inkster's initial hearing, several significant factors were identified touching on public safety, and as they have already been discussed with respect to the question of "significant threat," we will not repeat them. The Board was prepared to grant a conditional discharge because Ms. Inkster's discharge plan included protective factors. Unfortunately, those protective factors rapidly fell away after Ms. Inkster's conditional discharge when she quickly developed antipathy to her FPSC treatment team and to her aunt, developed a romantic interest in a new boyfriend, and decided to reside with him rather than in the residence approved by the Director. Ms. Inkster's hostility towards supervision and direction from her aunt and her treatment team reflects her lack of insight into her illness, the risk she poses, and her perception that the involvement of FPSC staff in her life was unjust and unwarranted. All these factors led her to reject ongoing supervision and support mandated by the conditions of her discharge. The speed at which her relationship with her aunt and FPSC staff changed after her initial hearing and the grant of a conditional discharge is remarkable. Her stated reasons for this deterioration are difficult to credit.

[55] The breakdown of the therapeutic alliance that appeared to have been established with FPSC staff and Ms. Inkster's evolving attitude towards supervision was consistent with her historical distrust of, and hostility towards assigned supervisors. Her conduct after conditional discharge also seems to have been similar to her conduct preceding past relapses leading to re-hospitalization. Community management has failed on at least 11 previous occasions, and consistent mandatory supervision and support continues to be required to moderate Ms. Inkster's risk of violence. Her illness and the triggers leading to an onset of a manic episode are not well understood, which also supports mandatory supervision and support. In the circumstances, further psycho-education intended to enhance her insight, as contemplated by the Board, could not occur under the aegis of the FPSC in the community.

[56] Ms. Inkster does not accept that she committed the index offences, does not accept her diagnosis, does not accept that she requires treatment, does not accept that marijuana may be harmful to her mental health, and resents the involvement of third parties in her life. She has engaged in conduct that exposes her to consumption of drugs and alcohol and made it impossible to properly supervise her in the community. Without such supervision, her risk of decompensation is significantly greater and in Dr. Kolchak's opinion, which we

accept, increases the risk that she will engage in violent behaviour of the type that occurred during the index offences.

[57] We have also considered that Ms. Inkster's discharge plan is to reside with Mr. Ure and her boyfriend. While Dr. Kolchak considers Jared to be well intentioned, his beliefs about psychiatry and the advice he appears to have given Ms. Inkster are at odds with that of her psychiatrists and professional FPSC staff. Dr. Kolchak described him as "ambivalent" about Ms. Inkster's recommended treatment. Ms. Inkster has a strong attachment to Jared, and the advice she appears to be receiving complicates her management in the community and will make the development of any therapeutic alliance more difficult and stressful. Dr. Kolchak was also of the opinion that it would be essential that Ms. Inkster reside in a stable environment in which her stress is minimized. For this purpose, he recommended that an OT assessment be conducted of any proposed residence in the community.

[58] Dr. Kolchak stated that further assessment of Ms. Inkster at FPH would be of assistance in determining the pattern of her decompensation and in improving her insight. He noted that on the information available, it was difficult to say whether a personality disorder is an issue in her presentation. It may be possible to consider this diagnosis during the term of a custodial disposition. He considered Ms. Inkster's behaviour and her rejection of psychiatric medications to be the product of her mental illness. In view of her relapse at FPH, adjustments to her medication seem to be required. In his view, a short custodial disposition would be of assistance in stabilizing her medication regimen to ensure an optimal response.

[59] We therefore concluded that public safety would not be adequately protected by conditionally discharging Ms. Inkster, as she has proven to be unmanageable by FPSC staff in the community. We also concluded that her present mental condition makes management in the community problematic. Her re-integration into the community would not be facilitated by a conditional discharge when the issues underlying multiple failures of community placements have not been addressed. We therefore determined that a broad custodial disposition was both necessary and appropriate. No less restrictive disposition would adequately protect the public or provide an environment in which Ms. Inkster's insight and mental condition could be improved.

[60] Considering that Ms. Inkster is a young woman and that there is a reasonable prospect that significant progress can be made in the near future, we made this disposition reviewable within 6 months.

Reasons written by F. Hansford, QC in concurrence with Dr. P. Constance

Mr. Walter (Dissenting):

[61] My dissent does not take issue with the finding of my colleagues that Ms. Inkster satisfies the threshold for our further jurisdiction over her. My dissent is in respect of the majority's choice of the necessary and appropriate disposition of the case under s.672.54 of the *Code*.

[62] While acknowledging that they are not dispositive, the index offences are nevertheless relevant. I note that they occurred within three successive days and while Ms. Inkster was in the throes of her illness. While I agree that they satisfy the jurisdictional threshold, they cannot be considered to fall at the highly violent end of the spectrum of such offences which daily come to the Board's attention. They did not prevent a previous panel from discharging Ms. Inkster with conditions less than three months earlier and just a month after her hospitalization.

[63] Ms. Inkster's personal and clinical histories are relevant to disposition. She is described as having experienced numerous hospital admissions as of 2009, including as many as eight between 2011 and 2014 and yet another in Calgary. There is no credible evidence of any admissions between 2014 and 2016. Although she is described as insightless prior to the index offences, she has, since the onset of her bipolar illness, remained free of criminal justice involvement with the supervision and support of community based, civil mental health services.

[64] My colleagues refer to Ms. Inkster's progress and management under civil auspices as "inadequate to prevent frequent relapse". I respectfully disagree. Given the cyclical nature of her illness, punctuated by frequent hospital admissions, I would characterise Ms. Inkster's management, by a team or teams with which she was able to establish positive therapeutic rapport, as manifestly successful and effective. I do not consider the management or treatment of a bipolar disorder, which includes even frequent relapses and admissions, as

inadequate, unsuccessful or unusual. Relapses are part of the illness. To consider them a measure of successful or unsuccessful management reveals a profound misunderstanding of the illness. Ms. Inkster's manic episodes, while said to have been accompanied by (undetailed) aggression, instability and impulsivity, have apparently not resulted in convictions or even charges. In this sense Ms. Inkster's progress and management has, despite her serious mental illness, not differed markedly from that of multitudes of similarly afflicted individuals who reside and function in our communities. Her history does not at this stage justify her detention.

THE BREACH

[65] The current mandatory hearing is occasioned by an Enforcement Order of October 26, 2016, committing Ms. Inkster to FPH on the basis of a breach of conditions imposed by the Board just a month earlier. It is unclear whether the alleged breach was based in non-compliance with treatment (which was not a condition of her disposition), due to non-reporting as directed, or to the fact that she sought a second opinion about her illness. In any event, the case manager's breach letter to the Kamloops RCMP, giving rise to Ms. Inkster's arrest and the Enforcement Order (Ex. 14), does not, in my opinion, actually allege a breach of her conditions. It is essentially a repetition of a progress report to Dr. Lessing at Exhibit 15. The Review Board obviously does not sit in review of the Court's decision.

[66] It appears that at the first meeting between Ms. Inkster and her new Forensic team things were not overtly unpleasant. Ms. Inkster's apparent unhappiness, in the opinion of her case manager, with the "involvement of the Board in her life", and her "frustration" at having to report, do not, in my view, amount to a breach. They would not satisfy the criteria for, or justify a return to hospital under clause 4 of the September 27, 2016 disposition. Her sentiments and demeanour, as described, were not indicative of decompensation or an increased danger to herself or others. I have a similar interpretation of Ms. Inkster's "animated mood and affect" due to her new "love interest".

[67] It appears that the trajectory of Ms. Inkster's return began in earnest as of October 11, 2016, when her "aunt" and landlord began to report information of "unusual behaviour" and unidentified "personal problems" to the treatment team.

[68] On October 13, 2016, Dr. Lessing met with Ms. Inkster to assess her mental state in the context of unelaborated concerns about her "behaviour, relationships and housing", as well as additional concerns or perhaps suspicions about medication compliance. Ms. Inkster

requested a medication change which was refused. She declined to attend for blood testing. On October 18 she was “overly friendly and intrusive”. Nothing in this description of events is in my opinion remotely suggestive and certainly could not be interpreted as evidence of decompensation or elevated risk.

[69] On October 19, the “aunt” essentially reported that Ms. Inkster’s living space was a mess: that she had found an empty whiskey bottle, a baggie of marijuana, and finally that spoons were missing. On October 20, the “aunt” reported Ms. Inkster’s boyfriend, not the accused, as “threatening”. The breach letter uses less alarming language, that is, “rude” and “disrespectful.” The “aunt”, as was her right, withdrew her offer of housing. She took some “drugs” she found to the RCMP. Ms. Inkster denied any symptoms; indeed none had been alleged. The case manager enlisted police assistance to recover Ms. Inkster’s property from the aunt’s house and asked Ms. Inkster to report to the clinic on October 21, 2016. On that date Ms. Inkster appeared in the company of friends who were “loud and boisterous” and drinking from “brown bottles”, later determined to be root beer. The case manager and Mr. Brooks determined to have Ms. Inkster apprehended and hospitalized.

[70] The BCRB is a judicial body whose authorities may only be exercised and imposed on the basis of relevant and cogent evidence. There was, in my opinion, nothing in the evidence of the case manager or the double hearsay of the aunt, reported in the context of relationship difficulties, which would have satisfied the return criteria in clause 4 of Ms. Inkster’s disposition. I find that the treatment team’s actions in this case were precipitous. They were certainly antithetical to the establishment of anything amounting to a therapeutic alliance in the future.

[71] Furthermore, while it is trite doctrine to state that, as an administrative tribunal, the Board is not strictly bound by formal rules of evidence, and it enjoys latitude, this does not permit the wholesale, uncritical reception and consideration of any and all information, irrespective of its source or reliability. The information reported by the aunt was about little more than Ms. Inkster’s hygiene and habits. It contained no element of credible clinical information regarding Ms. Inkster’s mental state or risk.

[72] I find that the prejudicial effect of the so-called evidence which was the basis for the breach proceeding, far outweighed any probative value whatsoever. It should not have been admitted.

[73] To summarize, and although it is not necessary that the Board review the decision to launch enforcement proceedings, as it would do following a return by the Director, under s.672.81(2.1) of the *Code,* in light of its ultimate consequences for Ms. Inkster's liberty interests, I find that the decision to breach Ms. Inkster, because she was "challenging and argumentative" was premature and lacking any sound evidentiary foundation. It would certainly have been experienced, by Ms. Inkster, as punitive.

PROGRESS AT FPH

[74] The evidence of Ms. Inkster's progress following her admission to FPH includes that:

- She was, on admission, settled, normal, cooperative and appropriate; she was neither delusional nor homicidal and displayed no symptoms of psychosis;
- She admitted to daily marijuana use; Dr. Kolchak was unable to speak to the effect of marijuana on Ms. Inkster's mental state;
- A week or so after her admission she demonstrated disorganisation and auditory and visual symptoms; her affect became labile; in his oral evidence Dr. Kolchak only referred to her thought disorganisation;
- Once her injectable medication was adjusted she became more organised; she continued to deny her illness; the plan is to implement a further medication change;
- Dr. Kolchak considered her a moderate risk of violence absent overt mania, whereupon she could demonstrate impulsive violence;
- The pattern of Ms. Inkster's illness, on the basis of limited information, appears to be that she can develop symptoms quite quickly and she appears to respond to treatment;
- There are no grounds to support a personality disorder diagnosis; there is much about Ms. Inkster's presentation that is unknown which complicates risk prediction;
- She is in a supportive romantic relationship, though her boyfriend has unorthodox views of psychiatry and the role of medication;
- Despite allegations of non-compliance in March 2015, Ms. Inkster in fact continued to receive her injections of Invega Sustennna.

[75] Ms. Inkster testified that if discharged she would reside at her boyfriend's father's house. She did not establish any rapport with her forensic case manager in the community, despite the majority's impression that one had been established but that it broke down (para

55). To suggest this could, after just one month, be attributed entirely to a mentally ill accused person is unrealistic. It reflects an inordinate and impermissible emphasis on the patient's deficits. It imposes entirely unfair expectations. It absolves the service of responsibility.

[76] My analysis of the evidence leads me to find that Ms. Inkster was subjected to premature sanctions, admitted to FPH where she is now detained, with absolutely no evidence of any appreciable escalation in her threat to public safety. Under a different and more tolerant treatment team any medication changes, monitoring, and collateral information gathering could be accomplished in the community to which she was discharged but a month past.

[77] I remind my colleagues that the *Code* and the underlying policy objectives of Part XX.1 presume least restriction. The Board must proceed from the premise that an accused should be out of custody: detention is not the default option. Any change in Ms. Inkster's circumstances should only have occurred on the basis of persuasive evidence rather than an overstatement of increased risk to the public, such as would rebut that presumption. Such evidence is lacking in this case. Ms. Inkster's detention is a disproportionate response to her relatively benign, if challenging, behaviour in the community; behaviour to which the forensic system had the authority and capacity to respond. The majority decision places Ms. Inkster in the untenable, punitive and legally impermissible position of bearing the onus of proving her entitlement to a less restrictive disposition. Ms. Inkster is in law entitled to another opportunity to be discharged subject to conditions.

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