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

RAYMOND IRWIN

HELD AT:	**Review Board Offices** **Vancouver, BC** **May 9, 2017**	
BEFORE:	**ALTERNATE CHAIRPERSON:**	**F. Hansford, Q.C.**
	MEMBERS:	**Dr. J. Smith, psychiatrist** **P. Cayley**
APPEARANCES:	**ACCUSED/PATIENT: Raymond Irwin** **ACCUSED/PATIENT COUNSEL: D. Abbey** **DIRECTOR AFPS: Dr. M. Riley, K. Melhus** **ATTORNEY GENERAL: G. Nelson**	

INTRODUCTION AND BACKGROUND

[1] ALTERNATE CHAIRPERSON: On May 9, 2017, the British Columbia Review Board convened a hearing pursuant to s.672.81 of the *Criminal Code* at the Review Board offices in Vancouver in respect of Raymond Irwin, a 46-year-old man who was found NCRMD on March 30, 2006 in respect of the index offence of second-degree murder. The index offence occurred on February 5, 2004 on the Sunshine Coast. The victim was the accused's mother, who travelled from her home in Kelowna after learning that her son had been acting strangely and was experiencing mental deterioration. Shortly after her arrival, and acting on psychotic delusions that his mother was possessed by an entity that intended to kill him, the accused killed his mother in a brutal attack that lasted over a protracted period of time. He subsequently hid the body in a shallow grave in the bush. The trial judge described the attack as torture.

[2] Mr. Irwin's personal and forensic histories have been detailed in previous Reasons for Disposition. Accordingly, although we have considered all the evidence on record, for the purpose of these Reasons we only recite that evidence necessary to our decision.

[3] Mr. Irwin had no history of mental illness or criminal convictions prior to the index offence. He did have a lengthy history of abusing marijuana. This may have played a role in his mental deterioration. He was detained in hospital following the NCRMD verdict. He was conditionally discharged in April 2009 and has lived in the community since then on the conditions of consecutive discharges.

[4] There has been considerable diagnostic uncertainty since the inception of this case, although Dr. Riley, Mr. Irwin's treating psychiatrist, has settled on a DSM-5 diagnosis of Bipolar 1 Disorder, manic episode in 2004 with psychotic features, in remission since 2012. There was a depressive mood episode in 2004 and a possible hypomanic episode in 2012. Dr. Riley notes an unconfirmed pre-morbid history of narcissistic personality traits, which were a focus of concern in 2009 and 2012. Dr. Riley also offers a diagnosis of Cannabis Use Disorder, in sustained remission. He regards this as a potential destabilizing factor and cannot entirely rule out a drug-induced psychotic episode at the time of the index offence. Mr. Irwin does not meet diagnostic criteria for psychopathy and on psychological testing, scored well below the cut-off point for that diagnosis.

[5] The incidents in 2009 and 2012 have been cited as concerning by treating psychiatrists. In 2009, Mr. Irwin prepared a lengthy letter which he faxed to then President Obama. There were no overt positive psychotic symptoms evident at the time although the grandiosity of Mr. Irwin's ideas, including their focus on environmental and economic sustainability to be worked by the President, "hopefully in a TV concept" in which Mr. Irwin would be involved, had a "delusional feel". Before committing the index offence, Mr. Irwin had developed an idea for a TV program which he felt had been stolen for the development of a popular TV show called "The Apprentice". These events occurred when, with medical advice, Mr. Irwin ceased taking antipsychotic medication. After discussing this with his treating psychiatrist, Dr. M. Saini, Mr. Irwin resumed taking Quetiapine.

[6] In 2012, Mr. Irwin expressed difficulty in his ongoing relationship with Dr. Riley and his case management worker. For his hearing in April, 2012 Mr. Irwin submitted lengthy representations to the Board respecting his position and letters to the case manager, which were inappropriate and personal. He was not receptive to her home visits, to mail deliveries or the provision of any personal information that would assist the treatment team in managing him.

[7] This marked deterioration in Mr. Irwin's relationship with his treatment team began in March 2012 and was considered at the time possibly to reflect a deterioration in his mental health. Mr. Irwin was increasingly arrogant and entitled, with increased expressions of irritability and frustration with the perceived failings of his team. Dr. Riley, with whom Mr. Irwin has repaired his relationship, is of the opinion that this deterioration may have reflected underlying abnormal personality traits rather than constituting early signs of relapse. Clarification of this issue was rendered difficult because of the absence of therapeutic rapport.

[8] Despite these issues, the treatment team was not overly concerned about the possibility that Mr. Irwin was experiencing a relapse of his mental illness in 2012 and determined that he could still be managed in the community despite ongoing challenges. These concerns did not, in Dr. Riley's opinion "directly relate to his risk to others, and the evidence would suggest that he is only likely to pose a significant threat to public safety in the context of a relapse of his mental illness." The Board noted that Mr. Irwin was not prepared to commit to engage with community mental health authority follow-up

on discharge. As recommended by the Director, the Board made a further conditional discharge.

[9] Mr. Irwin does not meet diagnostic criteria for a personality disorder. Narcissistic personality traits that have been of concern in the past include a grandiose sense of self-worth, a sense of entitlement and a degree of arrogance. These issues have not emerged during his forensic supervision over the past 5 years. The Board has expressed concerns in other Reasons for Decision that his presentation before the Board had been glib. He has not presented in this manner in meetings with his treatment team over recent years. There is also the possibility that his affective presentation may be over-controlled. Such control is not a narcissistic trait. This trait is generally associated with a lack of empathy, which has not been evident to his treatment team.

[10] Mr. Irwin is managed by a combination of two mood stabilizing medications, one of which has antipsychotic properties. He has proven to be committed to his medication regime and appears to be highly motivated by his desire to minimize his risk of relapse rather than by impression management concerns. His risk of relapse will continue to diminish over time, although it is impossible to say when sufficient time will have elapsed for his risk to be considered minimal for that reason alone.

[11] Mr. Irwin last appeared before the Board for an annual review on May 12, 2016. In earlier hearings, Mr. Irwin had been reluctant to provide his treatment team with the names of collateral witnesses who would be able to speak about his functioning in the community and of his past. Before his last hearing, Mr. Irwin provided his treatment team with the names of three witnesses, including Mr. BH, Mr. SS, and JX, his girlfriend. He had recently obtained a referral to Dr. Levin, a local psychiatrist with forensic experience and was being treated by Dr. Ploesser, a psychiatrist, by monthly video link from San Francisco. The Board and the treatment team regarded this mode of treatment as unsatisfactory. Dr. Ploesser refused or neglected to provide his consultation reports to the treatment team despite their repeated requests. The Board considered his involvement with Dr. Levin to be too recent to evaluate.

[12] In its Reasons for Decision of May 12, 2016, The Board reiterated its concerns about Mr. Irwin’s presentation. In addition to refusing to make complete disclosure, his presentation was notable for limited insight into his treatment needs and the propensity to engage in impression management. The two episodes of 2009 and 2012 that

suggested possible imminent mental deterioration were also of concern even though the treatment team had determined that he did not require return to FPH during either episode.

[13] The Board determined that Mr. Irwin should receive another conditional discharge, reviewable within 12 months. While his risk remained well-managed under the terms of the conditional discharge, he had not been sufficiently disclosive, his evidence was overly glib, and he was evasive when pressed for specific information. The Board was also persuaded that the gravity of the index offence remained an important factor in so far as there was "complete lack of predictability and relatively rapid mental deterioration" accompanying the index offence. They considered that the events of 2009 and 2012 reinforced the need for caution. .

[14] The Board concluded *"…these factors persuaded the Board that the accused's risk had not yet diminished below the level of significant threat to public safety. He was therefore not entitled to an absolute discharge".* (Exhibit 73, para 25)

EVIDENCE AT THE HEARING

[15] In preparation for this hearing, the Board received and reviewed a psychiatric report prepared by Dr. M. Riley dated April 11, 2017 (Exhibit 74) and a Case Management Report prepared by Mr. K. Melhus dated April 20 2017 (Exhibit 75). Dr. Riley, Mr. Melhus, Mr. Irwin, Mr. ST, and Mr. BH testified orally.

[16] Mr. Melhus reported that the treatment team felt able to reduce the frequency of appointments with Mr. Irwin over the reporting period. Mr. Irwin has had nine clinical appointments with his community psychiatrist, Dr. Levin, since his last hearing. Accordingly Dr. Riley felt it unnecessary to see him with the same frequency as before Dr. Levin became involved.

[17] Mr. Irwin continues to live in the same residence with two roommates, one of whom - ST - was interviewed by Mr. Melhus on several occasions and who also testified at this hearing. He continues to be employed as a truck driver. Mr. Irwin was prepared to give his treatment team information respecting additional collateral contacts but excluded his employer and landlord for fear that if they discovered his status, then he would be evicted and discharged from employment. There have been no known complaints from the landlord, and Mr. Irwin appears well regarded by his employer, who has given him raises three times over the last year and who offered him a management

position in the company. Mr. Irwin turned it down as he felt it would be overly stressful. His current duties involve deliveries out of the town and, with the consent of his treatment team, out of province. All of these tasks have been handled without incident. For recreation, he works out at the local gym, uses the local swimming pool, and plays ice hockey once or twice a week in season.

[18] Mr. Irwin recently broke up with his girlfriend. Although they seem to be on amicable terms, she was not re-interviewed as she might not be an objective source.

[19] Mr. Melhus received a telephone call from SH, BH's wife. She knew Mr. Irwin before the index offence. He is welcome at their house and she sees him as part of the family. They enjoy his company. She considers him to be courageous to return to Sechelt where people know who he is and the nature of his crime. He seems to have been well received by members of the community. She considers him a good support for her children. He is godfather to her son. He is doing well and has shown no signs of instability or of being overstressed. His mood has been stable, he sleeps well at their house, communicates well, and has not used any alcohol or drugs while at their house or while out on social occasions. He is more outgoing and social now than he was before the index offence. He has "grown a lot" in the past two years. He handled the breakup with his girlfriend well. She undertook to call Mr. Melhus if ever she had a concern about Mr. Irwin's mental state.

[20] ST ("Sean") testified that he has known Mr. Irwin since 2011. Despite concerns and conflicts with the third roommate in their residence, Mr. Irwin had been handling himself well. Sean is fully advised respecting Mr. Irwin's status and was prepared to fully apprise himself of Mr. Irwin's warning signs of deterioration. He reported that Mr. Irwin seems to get enough rest and sleep, there had been no overt stress, no indicators of delusional or suspicious thinking, and no unusual presentation or behaviours. He described Mr. Irwin as friendly and easy to get along with. There have been no difficulties with the landlord in the past five years. He has never seen Mr. Irwin use street drugs or alcohol. Mr. Irwin has reported to Sean that he would never do so again and is so adamant about this point that he persuaded Sean to cease using medical marijuana. They plan to continue as roommates for the indefinite future, although they are considering moving to get away from their other roommate.

[21] Sean would not hesitate to contact the authorities if concerned about Mr. Irwin. He also undertook to contact the Surrey clinic during clinic hours or the FPH on-call manager if the clinic is closed. He regards Mr. Irwin as a friend and wishes to support him in any way he can. Mr. Irwin seemed relieved to share detailed information about his mental illness with Sean, who considered that his past failure to fully disclose his history had given rise to trust issues that they have sat down together and resolved. He describes Mr. Irwin as having "grown a lot in the past year or two". He considers Mr. Irwin to be "up front and honest". They have had only one conflict involving a degree of anger by Mr. Irwin that was speedily resolved. Mr. Irwin has handled conflict with their other roommate calmly and without any deterioration of his mental state.

[22] Sean accepts that he has a role to play in helping to manage Mr. Irwin's risk. He has met Dr. Levin as part of Mr. Irwin's disclosures to him. He will look out for aberrant behaviour, changes in sleeping patterns, drug abuse, grandiose delusions, and any changes in the routines Mr. Irwin has adopted to assist him in remaining stable. He did notice some changes in Mr. Irwin in late 2011/early 2012 that he attributed to the difficulty of adapting to life in the community after being detained at FPH.

[23] Mr. Melhus considered Sean as a reliable source of collateral information, genuine and forthcoming. His evidence at the hearing was measured, sincere and not overstated.

[24] Mr. Melhus also received telephone calls to and from Mr. BH, who testified at this and at previous hearings. Mr. Irwin knew Mr. H before the index offence through their mutual interest in sports and decided after the offence that he would visit him at FPH to provide support, since he had no-one else who cared to visit him. He considered this "the right thing to do" and was not religiously motivated. He knew Mr. Irwin before the index offence as a phenomenal athlete but a chronic marijuana user. He did not see him in the weeks immediately preceding the index offence. They have since become close to the point that they consider each other "brothers". He continues to be supportive.

[25] Mr. H described Mr. Irwin's mental state as stable. Even when passionate about safety concerns at work, he was able to remain calm and collected. He sees him once every 2 weeks or more, depending upon his son's ice hockey or lacrosse schedule. Mr. Irwin comes to most of his son's games. He visited the family in Sechelt in October

2016, and over Christmas that year. He fits in well with the family's Christmas Day celebrations. He has been coming to the Sunshine Coast for visits for the past 10 years.

[26] Mr. H advised that Mr. Irwin is very steady in his habits and behaviours. He is "as anti-drugs as any person I know". They discuss their situations and their lives on an intimate basis as friends. Any changes due to deterioration in his mental health would be readily discernable. He has not seen any indications of mental instability or decompensation. Mr. H has attended the last 4 Review Board hearings and the evidence he has heard has, in his words, illuminated his understanding of past manic behaviours. In the event of deterioration, He would take steps to see that Mr. Irwin got care and treatment, up to and including calling the authorities. He concluded that he believed that the Forensic Services had achieved its objectives in treating Mr. Irwin.

[27] Mr. H was an impressive and articulate witness. His evidence appeared to be sincere.

[28] Mr. Melhus testified that the past year has gone well for Mr. Irwin. By his own report, the observations of his treatment team, the observations of collateral witnesses and by Dr. Levin's assessment, his mental state remains stable. He has developed and maintains a good rapport with his treatment team during clinical appointments and numerous phone calls. He is insistent that he will keep taking medications for the rest of his life, that he will maintain contact with a psychiatrist and if absolutely discharged, will be mindful to monitor his own mental health symptoms, listen to his support network if they suspect he is not doing well, and will not hesitate to get prompt additional mental health support if required. He maintains healthy lifestyle habits, gets adequate rest and enough sleep, spends time with friends, and exercises regularly. He takes medications as prescribed and is adamant that he will continue to do so because he fears relapsing to psychotic behaviour. There has been no evidence that he has used illicit drugs or alcohol and he is adamant that he will never do so again.

[29] Mr. Melhus considered that Mr. Irwin's risk for self-harm, his risk to use illicit drugs, and his risk of harm to others, were low. Relapse would be possible if he used illicit drugs or stopped taking medications, or if he failed to pursue mental health follow-up and support. He must take care of that he does not become overwhelmed and stressed to the point he is not able to cope.

[30] Dr. Riley met Mr. Irwin on 6 occasions over the last year. He also consulted with Dr. Levin, who confirmed that he will continue to follow Mr. Irwin whether he is given an absolute discharge or not. He sees Dr. Levin every 4 to 6 weeks.

[31] Dr. Riley considers the past year uneventful. Mr. Irwin's mental condition has remained stable. He has cooperated with his treatment team, with the conditions of his order and with recommended treatment and supervision. He maintained stable employment in a position he enjoys and where he has received multiple raises over the last year. His concerns about disclosure to his employer and landlord are not unreasonable. His roommate has been fully incorporated into his support network and has been fully apprised of Mr. Irwin's history and situation. Information from collateral sources now confirms that Mr. Irwin has reliably reported his functioning to the treatment team over the past five years. His supporters have committed to assisting in identifying any emergent mental health concerns in the future. The relatively small scope of his support network is a concern, although the people he has engaged to assist him are committed and competent.

[32] On review of Mr. Irwin's situation in 2012, Dr. Riley does not consider that he experienced a relapse at that time. There would clearly be some risk associated with any relapse of Mr. Irwin's mental illness since his psychotic symptoms, including persecutory delusions, were associated with an index offence of extreme violence. Mr. Irwin's symptoms rapidly responded to treatment and he has not experienced a psychotic relapse since the index offence. The concerns raised respecting his mental health in 2009 and 2012 did not reach the point where they could be considered psychotic relapses, nor did these events directly impinge on his level of risk to members of the community.

[33] Dr. Riley considered Mr. Irwin's Bipolar 1 disorder has been in remission since 2012, and his cannabis use disorder has been in sustained remission since the index offence. A return to abusing drugs nevertheless remains a potentially destabilizing factor. Mr. Irwin is adamant that he will remain abstinent, as he has been since 2004. He takes a combination of two mood stabilizing medications and is genuinely committed to taking this medication for the rest of his life. He is internally motivated by his desire to minimize his risk of relapse, which will continue to gradually diminish over time. Mr. Irwin has reported that he wishes also to continue meeting with Dr. Levin, which seems to Dr. Riley to be realistic and clinically appropriate. He has proven resilient in finding

employment and while a loss of his employment or of his current housing may be destabilizing, he is well supported and qualified to find other work. Dr. Riley was of the opinion that whether Mr. Irwin requires additional forensic oversight is no longer a clinical issue but is rather to be decided on legal grounds.

[34] Mr. Irwin proved to be an articulate witness on his own behalf. We were unable to characterize his presentation at this hearing as “glib” or contrived. It did not appear to involve any more by way of impression management than one would expect from a person testifying on his own behalf. Much of his evidence was corroborated by Mr. T, Mr. and Mrs. H, and Mr. Melhus.

[35] Mr. Irwin testified that he accepted his diagnosis of bipolar disorder. He understood that this meant that he could undergo episodes of depression or mania in the future and that his condition must be managed with this in mind. This includes a commitment to medication, to management of his lifestyle, to developing and maintaining a support group, to monitoring his sleep and eating habits, to mindfullness of stress, and to continuing to seeking out professional psychiatric help. He turned down a promotion at work in part to facilitate stress management. He is detail oriented and if he should lose focus or concentration, this will quickly become apparent by a deterioration in his performance at work.

[36] Mr. Irwin could identify and list warning signs for his illness. The steps he would take if he began to deteriorate depended upon his symptoms and their intensity. If there was any fluctuation in his regular routine, his first option would be to make an appointment with Dr. Levin, or to seek admission to hospital, particularly if his friends recommended that he take that step.

[37] Mr. Irwin stated that he has “zero tolerance for drugs”. He said that he has no time for them in his life and was not happy with the role they played before the index offence or during it. He said that he was” unwavering” about never using them again.

[38] Mr. Irwin admitted that he had experienced difficulties with his treatment team in 2012. He subsequently came to appreciate Dr. Riley’s approach and not to discount concerns expressed about his mental health by people close to him. He dealt with these issues by taking time off work, with his employer’s approval. He agrees that there was a change in his presentation but noted that he never discontinued his medications or resorted to abusing drugs. He agreed that he was subject to additional stress. He

learned that he must be careful to manage his life to avoid stress, as he did when he refused a promotion. He also finds Review Board hearings less stressful than they were in the past because he better understands the Board's role and function.

[39] Mr. Irwin plans to continue to see Dr. Levin whenever Dr. Levin feels he should. If for any reason Dr. Levin should not be available, he will call his family doctor if he needs a prescription, or go to hospital for anything more urgent. His support team in community will involve Dr. Levin, his roommate, Sean (who has met Dr. Levin already), Mr. and Mrs. H, and his ex-girlfriend, whom he still sees casually as a friend. He would like to reach out to a civil mental health treatment team if absolutely discharged but does not know whether they will accept him, given his current level of stability.

[40] When asked if he was in control of his mental health, Mr. Irwin replied that his mental health management would be a collaborative effort. He is a vital element but not the only one. There is no known cure for his illness and therefore he must continue to be treated and managed. Dr. Levin will also play a large role. While his support network may be small, they are all good friends and committed to assisting him, so he regards them as of high quality. When asked what was in it for him to continue with Dr. Levin, he responded "everything" and stated that "I need ongoing psychiatric support in order to help assure that what happened during the index offence will never recur". He doubted whether he would be able to recover from another manic episode.

[41] Mr. Irwin does not regard the possible legalization of marijuana as a real challenge to his commitment to abstinence. He pointed out that marijuana is prevalent and readily accessible in the community on a routine basis and he has remained abstinent nevertheless. He says he has no interest in drugs because "I get higher in normal life than I ever did using drugs". If he encounters marijuana use, he holds his breath until he can exit the area, rolls up car windows if he is in a car, and generally avoids users. When last he checked into a motel, he insisted on a room change because of the marijuana smell emanating from other rooms in that wing of the hotel. He stated that he doesn't want drugs in his life and he does not need them.

[42] He has saved sufficient funds to cover him for a year if, for any reason, he should lose his job.

ANALYSIS AND DECISION

[43] Dr. Riley concluded his risk analysis as follows: *"As a clinician, I am unable to conclude that Mr. Irwin's level of risk for relapse and further violence meets the necessary legal threshold for him to be deemed a significant threat to public safety."* Nevertheless, the Director took no position in respect of the matter of an absolute discharge or on the appropriate disposition that the Board should make if we did not grant an absolute discharge. We are, of course, entitled to accept Dr. Riley's opinion in whole or in part, or to reject it altogether.

[44] Crown Counsel suggested that Mr. Irwin remained a significant threat, was not entitled to be absolutely discharged, and that the necessary and appropriate disposition was a further conditional discharge on the same terms as the disposition under review. Counsel for Mr. Irwin submitted that the evidence did not establish that he was a significant threat and that he was therefore entitled to be absolutely discharged.

[45] The statutory framework we must apply is found in s.672.54 and 672.5401 of the *Criminal Code*. A person who is not a significant threat is entitled to be absolutely discharged. The term "significant threat" is defined in s 672.5401 and applies to a person who represents "a risk of serious physical or psychological harm to members of the public… resulting from conduct that is criminal in nature but not necessarily violent."

[46] We must first determine whether Mr. Irwin remains a significant threat. If he is a significant threat, we must make the necessary and appropriate disposition, taking into account the criteria listed in s 672.54. In arriving at our decision, we are not bound by the positions adopted by the parties and must arrive at a decision based upon the record and the evidence presented at this hearing.

[47] The Board has consistently held that the words "a risk" in s 672.5401 must be interpreted as requiring a determination that an accused is a "significant risk" rather than a low risk. (***Davis, Baranyais***) This approach has been adopted and applied by the courts. In ***Calles v. British Columbia (Adult Forensic Psychiatric Services), 2016 BCCA 318***, the B.C. Court of Appeal stated 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)

[48] In ***R. v Carrick, (2015) ONCA 866*** the court held that:

"…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 (Para. 17)

[49] In ***Calles v. British Columbia (supra)***, the BC Court of Appeal provided further guidance on this question, stating that the Board must not adopt an interpretation of the term "significant threat" that places a burden on an accused to negate any future possibility that he might pose a significant risk of causing serious harm of a criminal nature to a member of the public. While we must consider possible future events, the evidence must take the Board beyond mere speculation. If applied over broadly, and in situations requiring a considerable degree of conjecture, the effect would be to foreclose ever granting anyone an absolute discharge. The Board must be careful not to impose a legally impermissible onus to disprove threat on an accused. The determination we must make in this case is a legal rather than a clinical decision.

[50] Punishment of an accused who has been found NCRMD is not an appropriate consideration when considering whether he is a significant threat or what the appropriate disposition might be. The horrific nature of an index offence is relevant in determining the nature of the risk that an accused might pose, but if he is not a significant threat, he cannot be detained to punish him for conduct for which he has been found not criminally responsible. (***See Lacerte, Baranyais)*** If a person who has been found NCRMD is no longer a significant threat to public safety, "the criminal justice system has no further application" and we are not entitled to refuse an absolute discharge out of "an abundance of caution" as "that is not the legal test". (***R. v. Marzec, 2015 O.N.C.A. 658***)

[51] The evidence clearly establishes that should Mr. Irwin relapse to psychotically driven behaviors, he is capable of inflicting life-threatening injuries on people who become enmeshed in his psychotic delusions. It would be impossible to characterize the harm he might cause as anything other than serious harm of a criminal nature, based

on his history. It is therefore necessary to consider the degree of risk that he will inflict such harm in the future. As the Supreme Court of Canada stated in the ***Winko*** case, a small risk of great harm will not suffice.

[52] Dr. Riley did not provide in his written report a full HCR – 20 V3 analysis. These factors have been explored in detail both in the evidence in this case and in earlier cases. Upon reviewing these factors, we were unable to find that Mr. Irwin is a significant threat of causing serious harm of a criminal nature to a member of the public and therefore we were required by law to absolutely discharge him. These factors also support Dr. Riley's conclusion that there is no clinical reason to conclude that his risk for relapse and further violence meets the necessary legal threshold of "significant threat" and we accept his assessment of this risk.

[53] In arriving at this finding, we have considered that Mr. Irwin has not experienced an episode of mania since the index offence 13 years ago. He has not acted violently or expressed violent ideation since the index offence, and had no such history before that date. He has developed good insight into his illness, his need for treatment and medications, and the risk he poses to others. He accepts his diagnosis, is committed and motivated to continuing with prescribed medications and to follow-up mental health treatment indefinitely. He has sought out care proactively in the community. He has developed a good therapeutic rapport with his current treatment team. He has demonstrated that he can remain mentally stable over at least the last 5 years, despite stress involving employment and his relationships with others. He has developed a workable and adequate discharge plan which addresses his mental health management and which involves a small group of supportive, committed friends and a treating psychiatrist. He is committed to abstinence from drugs and alcohol, and has been abstinent since the index offence. He is internally motivated to maintain abstinence by fear of relapse. He is committed to seeking out and accepting additional mental-health assistance and treatment recommended to him or when he recognizes that his mental stability might be deteriorating. He has also developed an understanding of the role of stress in provoking an episode, and has developed a routine and made decisions (such as rejecting a promotion) to manage stress in his life.

[54] At Mr. Irwin's last hearing, the Board cited several concerns in refusing an absolute discharge. We have not lost sight of the analysis advanced at that hearing. However, we did not find Mr. Irwin to be glib at this hearing or be engaged in impression

management to a degree that would call his commitment and evidence into question, particularly when it is now corroborated by collateral witnesses. Mr. Irwin has, by all accounts, made great progress over the last two years and has made appropriate disclosures to his support network and his treatment team. He has now developed a solid relationship with Dr. Levin who will continue to see him. The events of 2009 and 2012, while concerning, have not been repeated and did not in Dr. Riley's opinion, amount to manic episodes, indicate the onset of psychosis or materially affect risk. The index offence was grave, but it occurred 13 years ago. Any further resort to violence will depend upon relapse for which alcohol and drug abuse or treatment non-compliance might be key drivers. Neither of these events appears likely, based on the evidence before us. A relapse not induced by these factors may occur unpredictably, but the discharge plan in place addresses that possibility.

[55] The evidence at this hearing demonstrates that the risk Mr. Irwin poses has been sufficiently attenuated that refusing a discharge would require us to speculate that his discharge plan will fail and that, in the face of evidence to the contrary, he will refuse treatment and resort to drug abuse. This sequence of events is largely conjectural and to found our judgment upon that reasoning would be to place the burden on the accused to demonstrate that he will never be "a risk" to the public. This is not permissible in law. In our view, the evidence as a whole was no longer adequate to meet the onerous burden of establishing that Mr. Irwin was a "significant threat".

Reasons written by F. Hansford, Q.C. in concurrence with Dr. J. Smith and P. Cayley

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