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

JRV

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
January 17, 2017

BEFORE: ALTERNATE CHAIRPERSON: B. Long (dissenting)
MEMBERS: Dr. P. Constance, psychiatrist
Dr. W. Pankratz, psychiatrist

APPEARANCES: ACCUSED/PATIENT: JRV
ACCUSED/PATIENT COUNSEL: M. Stanford
DIRECTOR AFPS: C. Harkies, Dr. S. Lessing
DIRECTOR'S COUNSEL:
ATTORNEY GENERAL: M. Wong

Dr. P. Constance, Dr. W. Pankratz concurring:

INTRODUCTION

[1] On January 17, 2017, the Review Board of British Columbia (the Board), conducted a hearing via video in the matter of JRV, age 48, to review the conditional disposition of February 4, 2015. This disposition was extended on February 2, 2016, on the same terms at the request of the accused. At the conclusion of this hearing, the majority of the panel granted JRV an absolute discharge. These are the reasons. 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.

[2] JRV was found not criminally responsible on account of mental disorder (NCRMD) on February 11, 2011 of the index offence of second degree murder committed on November 11, 2009. The victim was his wife, who he shot and killed before setting fire to their bedroom. He was in an acute psychotic state at the time. The details of the circumstances surrounding the offence are extensively detailed in the Admission of Facts at Exhibit 9, and fully reviewed at trial (Exhibit 10).

[3] Briefly, JRV was acutely delusional and believed his wife was possessed by a demon or the Antichrist and he had to kill her because she was the Devil. JRV's diagnosis at the time of the index offence was a profound psychotic depression with mood in congruent features. This diagnosis has remained unchallenged by the three forensic psychiatrists, who have subsequently been involved with his care.

BACKGROUND

[4] JRV is now 48 years of age. His past social and personal history have been extensively documented in his file and the previous reasons of the Board, and therefore it will not be documented again in detail but will be summarized.

[5] JRV's early life and development were unremarkable, except for the death of his mother when he was age 10, following which he was raised by his grandparents. He has no history of behaviour problems. He was an average student and active in sports. He started work at age 15, and about the age of 25 he started his own business which he owned and operated until the index offence.

[6] JRV married his first wife when he was about 20 years of age and had a son. This marriage ended in divorce after five or six years and he had another relationship which lasted five to six years and had a second son. He had previously known the victim (MV) of the index offence. They decided to get together in approximately 2000, and they were married some three years later. They included children from their previous relationships and lived in the Langley/Abbotsford area. There have been no reported incidents of history of abuse or violence in these relationships. Family and friends have described JRV and MV as having a loving relationship.

[7] JRV has no criminal record. He had one drinking and driving charge when he was 18. During the Labour Day weekend in September 2009, JRV was involved in an altercation with a friend when they were drinking. He quit alcohol following that incident and has remained abstinent of alcohol and other substances.

[8] Family members and friends noticed that JRV was not himself about two months before the index offence. He had lost weight, and his symptoms of anxiety, agitation, and fear increased. At the urging of his wife, he sought treatment from his doctor and was prescribed medication to help him sleep (Imovane) and medication to help his anxiety and paranoia (Seroquel). Two weeks later he revisited his doctor. He was feeling somewhat better so the dose of Seroquel was reduced to half. JRV also paid two visits to a naturopath for help with his anxiety, accompanied by his wife. In mid-October, he believed that people were after him and his wife. So to lure them away, he drove to Prince George where a friend of his reported that JRV seemed nervous and paranoid. He paid two visits to the Abbotsford police department in the first two weeks of October to report that he and his family were not safe.

[9] JRV was admitted to the Forensic Psychiatric Hospital (FPH), on December 29, 2009. He was certified under the *Mental Health Act.* Initially, he was found unfit to stand trial. He was discharged to Corrections in May 2010, having been found fit. He was readmitted to FPH for an in-custody assessment on September 10, 2010. On February 11, 2011, he was found NCRMD and returned to FPH. He was held in custody at FPH following his initial Board hearing on April 6, 2011. At his third Board hearing on February 27, 2013, he had been in full remission for approximately three years and was conditionally discharged. He has remained in the community.

[10] The reports from Dr. Meldrum, his treating psychiatrist and Ms. Lee, case management coordinator, of February/March 2011, February/March 2012, and January/February 2013, during his time at FPH are consistent.

[11] JRV established a solid therapeutic alliance with his treatment team. On his return to FPH, his illness was in remission and his mental state remained stable throughout his admission. He was never reported as being deceitful or manipulative, or showing evidence of antisocial attitudes or behaviours. He was described as a model patient and acted as a role model for other patients. He participated in and completed all the recommended programs and educations and was fully compliant with his medication. He completed 25 psychotherapy sessions with a psychologist from April 2011 to March 2012. He had good insight and exhibited genuine remorse of the killing of his wife.

[12] JRV commenced rapprochement with members of MV's family. He had a large supportive family and his family members met with the team and were educated about JRV's illness and signs of a possible relapse.

[13] JRV was conditionally discharged following the Board hearing on February 27, 2013, to be followed by the Surrey Forensic outpatient team. Dr. Riley, his treating psychiatrist and Ms. Vincent, community nurse, submitted reports in January 2014, January 2015, and January 2016, in preparation for the annual hearings.

[14] Ms. Vincent's reports document his progress in the community and her regular meetings with JRV during the previous three years.

[15] In summary, throughout this reporting period, JRV remained symptom free and maintained a positive therapeutic alliance with his treatment team, reporting by phone, in person and by video. He coped well with the various stresses he experienced, with no relapse of his symptoms.

[16] He is well aware of the factors which are protective to remain well and the importance of maintaining a healthy balance of work, rest, sleep, exercise, and recognizing and managing stress.

[17] JRV initially lived with his cousins in Pitt Meadows for a few months. He was anxious that he might encounter people from the past in Langley/ Abbotsford and in April 2013, he moved to Sunshine Valley to live with another cousin. Shortly thereafter, he purchased his own lot in Sunshine Valley. He sold this property and moved to Kamloops,

where he had secured employment as a machine operator for an excavation company. He purchased a three-bedroom rancher in Kamloops in October 2014, so that his son and his son's young family could live with him.

[18] He successfully navigated these moves and settled in well. He travelled from Kamloops to meet with his treatment team in Surrey on occasions.

[19] He met a number of friends and acquaintances through his work and neighbors, and maintained regular contact with his uncle and cousins who live in the Lower Mainland.

[20] In his report of January 11, 2016, Exhibit 37, Dr. Riley writes in paragraph 11:

> [JRV] is a well-adjusted man with no evidence of abnormal personality traits, no prior experiences of significant trauma or adverse child rearing experiences. He has no history of expressing violent attitudes and this has not been a focus of concern during his time under forensic supervision. He has demonstrated full insight into the nature of his mental illness and although his depth description of this is rather unsophisticated he clearly understands the importance of him remaining well. He has expressed a genuine and lasting commitment to remaining on treatment with the possibility of a relapse of his illness and a recurrence of violent behavior being a real concern for him.

In paragraph 12,

> There has also been no evidence of an affective, behavioral or cognitive instability and the only area of potential concern with respect to [JRV]'s insight and adherence to treatment would be with regard to his ability to recognize [sic] the early warning signs of any future relapse of his illness. [JRV] is genuinely committed to maintaining treatment, as well as maintaining contact with mental health services in the future, he has a stable living situation and good sources of personal support. He is open to approaching others, including the treatment team, when he experiences increased stress and to date he has shown resilience in the face of the stressors he has been exposed to.

[21] JRV requested that his Board hearing scheduled for February 2, 2016, proceed in the absence of the parties and that he remain on a conditional discharge. Dr. Riley writes in paragraph 6 of his January 11, 2016, report, "The hearings are a stressful experience for him as it reminds him of the enormity of his offence and the consequences of that event on all involved, and he also wishes to avoid causing unnecessary distress to the family of his victim".

[22] In April 2016, his care was transferred to the Forensic team in Kamloops.

EVIDENCE AT HEARING

[23] Prior to this hearing, the Board received written reports from Dr. Lessing, his treating psychiatrist, Exhibit 41, and Ms. Harkies, forensic and community liaison nurse, Exhibit 40. In addition, Dr. Lessing, Ms. Harkies, and JRV provided oral evidence. The Director and the counsel for the Attorney General took no position with regards to disposition. JRV, through his counsel, requested an absolute discharge.

[24] Dr. Lessing reported that JRV has remained stable and well settled in his home which he shares with his son, daughter-in-law, and their two children. He has maintained his employment and kept all his appointments with the treatment team. He has good insight into his mental illness and the warning signs of decompensation of his mental state. He is committed to continuing to take his medication. In his meetings with her, Dr. Lessing noted that he often teared up when speaking about his deceased wife. He has been dealing with some stressors (bank loans, excision of melanoma, difficulty travelling while under supervision, and his son was diagnosed with Addison's disease in October 2015) but has coped with these appropriately.

[25] JRV was concerned that he had " somewhere to go" should he decompensate in the community, and therefore he was making sure to keep in contact with his family physician in Logan Lake, and the Canadian Mental Health Association (CMHA) clubhouse in Kamloops. Dr. Lessing completed her report with the observation that JRV presents a low risk to reoffend at this time. During the interaction she and Ms. Harkies have had with JRV, they did not detect any worrisome signs beyond what appeared to be normal reactions to life and family stressors.

[26] In her written report, Ms. Harkies summarizes JRV's progress since April 2016. Initially, JRV had some hesitation about leaving his treatment team in Surrey and transferring to the Kamloops team but this quickly resolved after a few meetings. He was seen to have good insight into his illness. He expressed his fear of returning to a state of mind he had been experiencing at the time of the index offence. He was aware that he needed to maintain his mental health and was aware of symptoms that might indicate a relapse of his illness.

[27] In her summary in paragraph 18 of her report Ms. Harkies writes:

> [JRV] has been co-operative with the treatment team, attending appointments and taking medication as prescribed. He has maintained

> employment, assisted in supporting his son and his family as well as purchasing a new property. He has kept himself busy outside of his work by renovating his homes and the family property near Prince George, with his uncle and cousin. [JRV] has continued to engage with family and has made trips to Burnaby and Surrey for family functions, funerals, to visit and for business. [JRV] has had some stressful situations, such as living in close quarters with his son and his family, losses of family members as well as working full time, maintaining his own business, completing renovations and purchasing new property for which he now has a mortgage. He has also had a change in treatment teams, medication change in April, 2016 and through all the change he has maintained a stable mental health with good coping skills. [JRV] has engaged with the treatment team.

[28] Dr. Lessing gave evidence. She stated she has had no clinical concerns about JRV. During the time that he has been under her care since April 2016 his mental state has been stable with no signs or symptoms of relapse of a depressive illness. Initially, he expressed frustration at changing his treatment team, but after discussion he developed a rapport with her and Ms. Harkies. He has been fully compliant with attendance at his appointments and taking his medications.

[29] Dr. Lessing said that JRV was offered the services of a psychologist for counseling but he declined because he believed he had resolved his main issues and felt he had no need for further therapy. She said she understood this decision and did not push the issue.

[30] Dr. Lessing stated that JRV had sought out a family doctor on his own in Logan Lake and he had seen this doctor. JRV had also contacted the CMHA clubhouse in Kamloops. In her opinion, these two resources were sufficient to manage JRV for symptoms of a relapse. She said that JRV had good insight, which has been sustained for many years, and he had profited from the education about his illness and was well aware of the symptoms which would be a warning of a possible relapse. He has a stable home in which his son and son's family reside. JRV is committed to supporting his family. He remains fully employed.

[31] With regards to risk, Dr. Lessing's opinion was that a relapse of a similar psychotic episode is the most significant risk factor causing a recurrence similar to the index offence. The index offence was a single, very dramatic event occurring during a psychotic depression, which responded fairly quickly and fully to medication. There is no history which has identified or documented any other significant risk factors. The result

from the HCR-20 and from her clinical assessment is that JRV presents a very low risk of reoffending in the absence of a relapse.

[32] Dr. Lessing stated that the ideal would be for JRV to be linked to a community psychiatrist or community mental health team for longer term follow up. However, it was almost certain that a community mental health team would not accept JRV because he has been asymptomatic for seven years and does not present with any significant issue that needs to be dealt with.

[33] Dr. Lessing was of the opinion that JRV's backup plan of connecting with his family doctor and CMHA, and his insight and awareness of his illness was sufficient to mitigate his risk. Although JRV's son has not received any formal education about his father's illness, his son is well aware of JRV's illness and symptoms that would be a signal of a possible relapse.

[34] Ms. Harkies stated that she had visited the home of JRV. She described it as neat and well-kept and had no concerns of the domestic situation. She had spoken with JRV's son and he was aware of his father's illness and situation.

[35] JRV gave evidence. He said he planned to continue with his moving forward with his family and his home life. He is "going to take things from day to day" and focus on a healthy lifestyle of adequate sleep, healthy diet and reducing stress while continuing with his work and support of his family. He said that dealing with his mental health is an "ongoing daily thing". He would work around the house and help his family get back on track.

[36] He agreed with Dr. Lessing's report on the diagnosis of depression. Before the index offence, he had no knowledge of mental illness and depression, but now he understands the illness from the education and therapy he has received. He is aware that a relapse is possible and will continue using his antidepressant medication (Celexa). He said that the signs of a possible relapse would be lack of sleep, not eating, paranoia, delusions, and hallucinations.

[37] He has discussed his illness with his son who would recognize changes in his mental state. He has the support of two cousins who are like a brother and sister and with whom he speaks every few days. He has had three visits with his GP who is aware of his diagnosis of depression, but he has not yet told him of his index offence. He said he was

on the wait list for a doctor for two years, and the doctor in Logan Lake, a 45-minute drive away, became available.

[38] When asked why he had not followed up to engage in further counseling, he said he had dealt with his main issues and wanted "to move on". He was not averse to making contact with a psychiatrist or mental health team in the community, but he did not believe he required that support because he had insight into his illness, the need for ongoing medication and, the support of his family, his family doctor, and the CMHA clubhouse.

[39] JRV expressed his guilt and remorse for the terrible thing he had done. He said, "I'll have to live with that for the rest of my life," and that he would do anything to prevent a similar episode happening again.

[40] In closing submissions, Dr. Lessing on behalf of Director took no position. Mr. Wong, on behalf of the Attorney General sought a conditional discharge, but for a shorter period of six months to enable JRV to connect to community mental health services.

[41] Ms. Stanford on behalf of JRV said that JRV has been in full remission for approximately seven years, has full insight, is committed to maintaining his mental health, and is knowledgeable about his illness and signs of relapse. He has good community supports. She sought an absolute discharge for her client.

ANALYSIS AND DISPOSITION

[42] When the Board makes a disposition under 672.54, it should take 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.

[43] On disposition, we must first determine if JRV is a significant threat. If he does not pose such a threat, he is entitled to an absolute discharge.

[44] Section 672.5401 of the *Criminal Code* (Part XX.1) provides a statute of the definition of a significant threat:

> For the purpose of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to the members of 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.

[45] In the matter of ***Bart Davis***, July of 2014, the BCRB concluded that the words "a risk" in section 672.5401, are properly interpreted as equivalent to, "a significant risk".

[46] Under section 672.54 in ***Winko*** versus British Columbia (1999), the Supreme Court ruled, "Unless the Board or Court makes a positive finding on all of the evidence that the NCRMD accused poses a significant threat to the safety of the public, D (the accused) must receive an absolute discharge".

[47] "A significant threat to the public means a real risk of physical or psychological harm to members of the public from conduct that is criminal in nature".

[48] To answer the question of significant threat we must consider: the need to protect the public from dangerous persons, the mental condition of the accused, the re-integration of the accused into society, and the other needs of the accused.

[49] We are mindful of the gravity of the index offence and the grievous loss MV's family has suffered. But we are bound by the law.

[50] JRV committed the offence in the state of profound psychotic depression with mood incongruent features. He is predisposed to a mood disorder because of a family history of mood disorders, but he himself has no previous mental health history. His diagnosis has remained consistent. He has responded well to medication and has a good prognosis.

[51] In Exhibit 22 of February 2012, paragraph 30, Dr. Meldrum states, "It was this illness that directly lead to the index offence as JRV does not have any other of the premorbid risk factors that would elevate his risk for violence."

[52] Exhibit 26b, March 2012, paragraph 20, in an oral testimony to the Review Board, Dr. Meldrum stated that prognosis in JRV's case in particular was positive, as he is one of the 60 or 70 percent of patients with this diagnosis who respond readily to treatment.

[53] In paragraph 22, Dr. Meldrum stated that in her opinion the only details that are helpful in risk management are details of his symptoms which were readily observable in the weeks leading up to the index offence.

[54] At Exhibit 31 of January 7, 2014, paragraph 15, Dr. Riley in his report wrote, "In the absence of a relapse of illness JRV would appear to be a very low risk for reoffending." In his report of January 12, 2015, at Exhibit 34, paragraph 10, Dr. Riley's opinion was that JRV's risk remained unchanged.

[55] In his report of January 11, 2016, Exhibit 37, paragraph 13, he wrote, "JRV will eventually need to be bridged to local mental health services as apart from the

seriousness of the index offence there are otherwise relatively few factors that would indicate that he is a significant threat to public safety staff [sic]."

[56] Dr. Lessing, in her written report and in her verbal evidence at this hearing, stated that in her opinion JRV was a low risk of reoffending both from the HRC-20 measures and her clinical judgment. She stated that the causative factors in the index offence had been dealt with. i.e. JRV's psychotic depression. Further risk abatement and management will depend on the prevention of a relapse of JRV's illness, leading to a psychotic state.

[57] The Board enquired of two topics of concerns specifically in regards to his risk management.

[58] Firstly, the Board was concerned that JRV had declined to take advantage of counseling with a psychologist attached to the Kamloops clinic, which was offered to him. JRV stated that he had resolved his main issues during his stay at FPH. The treatment team did not push for further intervention.

[59] Secondly, there was a concern that JRV should, ideally, be referred to a community psychiatrist or mental health team. Dr. Lessing explained that there were practical difficulties with this and, in her opinion, JRV's connection to his family doctor, the CMHA clubhouse and the support of his family was sufficient to manage his risk without further formal community psychiatric follow up.

[60] JRV has remained in sustained remission for seven years. He has been fully compliant with all treatment and contacts with his forensic teams. He has been described as a model patient and a role model to the other patients when he was at FPH. He has full insight into his illness.

[61] His illness did not present precipitously or without warning. There were clear signs and symptoms that were readily observable in the several months prior to the index offence during which he became anxious, fearful, paranoid and eventually overtly psychotic with delusions. This was noted and reported by family and friends. He and his wife did seek help.

[62] At the time, he and his family were uninformed and naïve about mental illness and depression in particular. This is no longer the case.

[63] During JRV's admission to FPH, members of his family met with his treatment team and were educated about JRV's illness and symptoms. Family and friends are now

informed and well aware of symptoms that may be of concern and would immediately take action.

[64] Other than the index offence, JRV has no history of violence and no criminal record. He has a history of stable long term relationships.

[65] He has remained abstinent from alcohol and other substances following the altercation on Labour Day 2009.

[66] He has expressed genuine remorse for the offence and for the profound loss to MV's family. He has repeatedly stated his fear of committing such an offence again.

[67] JRV has solid social supports. His immediate family and son have a good understanding of his illness and are able to recognize the signs of a possible relapse. He has the support of his family doctor and is registered with the CMHA clubhouse that has close association to community mental health services.

[68] The expert opinions offered by all the clinical teams have consistently considered him to be at low to very low risk of any type of re-offence and the Board has not been presented with any evidence to the contrary.

[69] His mental condition has been stable for seven years and he has been consistently reported to be a well-adjusted prosocial individual.

[70] He has successfully navigated his reintegration into society in an adaptive and appropriate manner without a change in his mental state.

[71] His other needs of establishing family and social contact, gaining full time employment and "getting on with my life" are being achieved.

[72] Having reviewed all of the available evidence, the majority of the Panel was unable to reach the conclusion that JRV met the threshold of a significant threat. He therefore no longer requires the supervision of the Review Board and Forensic Psychiatric Services and is therefore entitled to be discharged absolutely.

B. LONG, DISSENTING:

[73] I agree with the description of the index offence and the review of the accused's background and progress under forensic treatment as set out at paragraphs 1 to 22 of the majority reasons. However, with the greatest of respect to my colleagues, I was unable to agree that the accused no longer posed a significant threat to public safety.

[74] The index offence was the most serious known to the law. The accused murdered his wife, who by all accounts he deeply loved and was the person closest to him. The accused committed the index offence in response to delusions associated with the development of psychotic depression. However, the factors and dynamics leading to the accused's psychotic depression have never been clearly understood.

[75] It was common ground that the accused's risk for future violence is dependent upon the likelihood of developing another bout of mental illness. The problem that has bedeviled all risk assessments in this matter is that the accused has only ever experienced one episode of mental illness that resolved relatively quickly following hospital based treatment. These circumstances have made prediction of the risk of future illness particularly challenging.

[76] In the absence of a robust understanding of the causes of the accused's illness, the presence of protective factors that might mitigate the accused's future risk of relapsing to illness is especially crucial. I found that there were insufficient protective factors in place at this juncture considering the extreme violence of the index offence.

[77] There seem to be general agreement that psychiatric monitoring is desirable and would be prudent in the circumstances. The Board was advised that this might be difficult because of the lack of psychiatrists in the accused's immediate community combined with his current asymptomatic presentation. Significantly, the accused has not made any actual efforts to obtain psychiatric follow-up either locally or in any other communities. Thus, whether he would in fact be refused such services is unknown. Although the accused has found a GP in a nearby community, he has not disclosed the index offence to him. I do not consider the services in a GP in such circumstances to be a suitable substitute for ongoing psychiatric monitoring.

[78] Psychological counselling has been offered to the accused. This he has refused. He considers his issues have been addressed and prefers to "move on" with his life. This attitude is also reflected by his lack of effort in seeking psychiatric follow-up. In my view, the gravity of the index offence requires more than this.

[79] The accused does not take any psychiatric medication. Thus, any prophylactic effect that medication might provide is not available.

[80] The importance of ongoing monitoring was noted in Dr. Riley's report of January 11, 2016 (Exhibit 37), where he concluded as follows:

> However, it remains my clinical opinion that [JRV] would benefit from remaining subject to a disposition order and that in the absence of treatment, support and supervision he would be at risk of relapse of mental illness, which in turn could result in him posing significant risk to public safety. (My emphasis)

[81] Considering the seriousness and utter unpredictability of the index offence, the lack of understanding of the cause of the accused's psychosis, the difficulties in risk assessment, and the absence of continuing psychiatric monitoring, I concluded that the accused remained a significant threat to public safety. I would accordingly make a further conditional discharge.