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

RICHARD DALE MARANDA

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
November 3, 2016

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. R. Stevenson, psychiatrist**
		P. Cayley

APPEARANCES:
ACCUSED/PATIENT: Richard Dale Maranda
ACCUSED/PATIENT COUNSEL: M. Isman
DIRECTOR AFPS: R. Jaffer/Dr. R. Lacroix
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION AND BACKGROUND

[1] CHAIRPERSON: On November 3, 2016 the British Columbia Review Board convened an initial hearing pursuant to s. 672.47(3) of the *Criminal Code* to make a disposition in the matter of Richard Dale Maranda, the accused, who is 46 years of age.

[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] Mr. Maranda was charged that on May 18, 2014 he committed second degree murder, contrary to s. 235(1) of the *Criminal Code*. Mr. Maranda's father, the victim, was found deceased in his residence. Witnesses reported that the accused's vehicle had earlier been seen in the vicinity of the home. The accused was not on the scene and police embarked on an investigation which included the use of the accused's cell phone coordinates in order to determine his location. He had undertaken a significant journey before returning to the Lower Mainland. When he was eventually apprehended, the accused was wearing bloodstained garments. When interviewed the following day in cells, he admitted to killing his father.

[4] Psychiatrists were engaged to assess Mr. Maranda. Mr. Maranda has had two previous hospital admissions, apparently in a grossly psychotic state, but he had been stable on medications for some years prior to the index offence. He previously assaulted his father with a knife while psychotic but has no other convictions.

[5] Before the previous offence, the accused had apparently been non-compliant with his medications. There is some indication that the accused may also not have been compliant for a period of time shortly before the current index offence, although his actual compliance remains unclear. It is reported that Mr. Maranda's mental state deteriorated in the time leading up to the homicide, but family members were unable, despite some escalation in his alcohol use, to identify any clear signs that he had decompensated to psychosis. It is reported that Mr. Maranda had developed paranoid ideas and beliefs about his father and that individual's risk to other family members, prior to the index offence. It is evident that the accused is capable of declining rapidly either while compliant, and certainly while non-compliant, without others close to him identifying much noticeable change in his mental state.

[6] On August 8, 2016, more than two years after the index offence, the Supreme Court of British Columbia imposed a verdict of NCRMD and made a disposition that the accused be detained at the Forensic Psychiatric Hospital (FPH) pending a hearing of the British Columbia Review Board.

EVIDENCE AT HEARING

[7] Dr. Lacroix is Mr. Maranda's treating psychiatrist at FPH. He provided an assessment dated October 26, 2016 which was admitted as Exhibit 10 in this proceeding. Dr. Lacroix's report reviews the accused's psychiatric history with its first onset around 1999 or 2000 and including past hospital admissions. He cites a number of issues including the accused's escalating use of alcohol prior to the index offence; social stressors in the accused's life, including his wife's miscarriage; occupational stress, possible non-compliance and some behavioural changes but absent acute psychosis.

[8] In his report and orally, Dr. Lacroix states that although the accused is currently not overtly symptomatic and his psychosis is well controlled on injectable medication, Mr. Maranda remains somewhat difficult to access in terms of his internal thinking processes. He is credited with making an effort to become more disclosive recently. Given his presentation, Dr. Lacroix has referred Mr. Maranda for a psychological assessment respecting his personality construct.

[9] Mr. Maranda presents as a private person. He has had difficulty describing his psychotic symptoms in the past. He appears highly motivated to both present and be perceived as well. Fortunately, Mr. Maranda responds quickly to medication. Dr. Lacroix is of the opinion that he has had at least three past episodes of psychosis possibly related to non-compliance.

[10] Mr. Maranda is currently on the maximum secure or restrictive A2 Unit of the hospital. Once psychological testing has been completed, and following this hearing, he will be referred to the less restrictive Elm Unit, where he will be enrolled in relevant programming. It is not anticipated that Mr. Maranda will have unescorted access or community visit leaves in the next 12 months while his illness and its impacts are still under exploration. That said, he has presented no behavioural concerns or aggression at the hospital and is described as cooperative and polite.

[11] It is somewhat troubling that although Mr. Maranda appears less hesitant of late to describe his internal experiences, and has taken steps to correct past statements that

he has made, he continues to claim little or no memory about the details of the index offence. He has not yet been pushed on that issue. It is unclear whether Mr. Maranda is confused, has forgotten, or is simply avoidant about such details.

[12] Mr. Maranda testified briefly. He accepts that he has schizophrenia and alcoholism. He says that he plans to remain medication compliant and to cooperate and participate in programs. He believes that he has an understanding of the seriousness of his illness. He looks forward to further discussions with his doctor. He was able to define symptoms of his illness. He admits to episodes of non-compliance in the past. He is not sure whether he was compliant or non-compliant in the period leading up to the index offence, or if non-compliant, for how long.

[13] The parties at the hearing were in agreement that the accused ought to be given a disposition of custody allowing for escorted community access only, albeit in the discretion of the Director.

ANALYSIS AND DISPOSITION

[14] In our analysis of the evidence and in making a disposition, we must first determine whether or not the accused poses a significant threat to public safety. In that respect, in addition to Dr. Lacroix's written risk assessment, we also apprised ourselves of the fact that the accused has previously been the subject of an NCRMD verdict and under the jurisdiction of the Review Board.

[15] Mr. Maranda’s first verdict consisted of a charge of aggravated assault, the victim of which was also his father. That assault consisted of burning the victim by throwing a pot of boiling water onto him. Mr. Maranda commenced stabbing the victim about the face and neck, and almost biting off an ear. At that time, the evidence suggested an apparent history of schizophrenia since 1999 or 2000. Leading up to the offence, the accused was not compliant in consuming his medications and, in fact, had ceased doing so at least three weeks prior to the attack on his father.

[16] The accused had no previous criminal history, although an incident in March of 2000, the subject of charges which were stayed. At that time, as well, Mr. Maranda presented with no significant alcohol or drug abuse problems.

[17] Mr. Maranda was given a verdict of NCRMD on August 15, 2003 and released on a Recognizance of Bail. By September of 2003, his treating psychiatrist, Dr. Adilman, did

not, based on the absence of symptoms, his strong family support, good insight and compliance, consider Mr. Maranda a risk to the community.

[18] At his second hearing before the Review Board on September 13, 2014 the accused was resident with his mother. He was fully compliant and free of symptoms. He had good insight and was gainfully employed. On the basis of that evidence, the parties, including the Crown, agreed that an absolute discharge was appropriate. The Board agreed.

[19] In determining whether the accused is a significant threat to public safety under s. 672.5401 of the *Criminal Code*, the Board has reviewed the historic and more recent evidence and finds as follows: 1) The accused has an established history of schizophrenia and he has experienced at least three episodes of psychosis resulting from that illness; 2) Although generally pro-social, we find that the accused now has a history of serious violence. He was involved in a workplace incident in 2000. He assaulted and severely injured his father, the victim of the index offence in 2003 while he was ill, and he brutally murdered his father on May 18th, 2014 while under the influence of delusional beliefs; 3) We find that although the accused acknowledges his illness and while his insight appears sound, there is an established history of non-compliance certainly prior to the 2003 offence and possibly, and even likely, prior to the current index offence; 4) By virtue of Mr. Maranda's own responses in the course of the current hearing, it appears that although he has an intellectual grasp of his illness, we find that his understanding of its impact on his behaviour and its devastating potential on others remains less than complete; 5) The evidence suggests and we find that the accused is vulnerable to social and environmental stressors, possibly as a product of his schizophrenic illness, and that he has a tendency not to seek appropriate and timely help while experiencing such stressors. Mr. Maranda has yet to establish a trusting and therapeutic rapport with those who treat him at FPH. He is also diagnosed with an untreated alcohol use disorder which escalated, and may have been implicated in medication non-compliance prior to the index offence.

[20] Although the evidence suggests that Mr. Maranda is not overtly psychotic currently, his presentation is somewhat concrete or inflexible, and it may be that he has some undisclosed negative symptoms of his illness.

[21] Finally, we adopt the admonition added to Justice Williams' Reasons in making the NCRMD verdict and quoting the assessment of Dr. Smith, at paragraph 89 of her assessment which is found at Exhibit 5:

> Finally I would emphasize the need for future risk assessors to exercise extreme caution with respect to Richard Maranda's mental state and the potential harm he could pose to others. While it is my opinion that his violence has been driven by psychotic symptoms, he is clearly a very difficult man to assess and unlike many people who suffer from a chronic mental illness the symptoms of his illness are not always easy to elicit and can be readily overlooked. He is not forthcoming about his inner world and this together with his relatively polished social veneer and reasonably high level of functioning can be misleadingly reassuring. It is also important to be aware that his mental state can decline very rapidly with psychotically driven violence emerging before there have been any noticeable changes in his mental state.

[22] In addition to the court's reference to this statement, Dr. Lacroix specifically adopted its cautions and concerns in his evidence before the Review Board. Much of Dr. Lacroix's evidence confirmed that Mr. Maranda is difficult to assess, his high level of functioning can mislead, and his inner workings are not, perhaps as a result of his impression management or non-disclosiveness, easy to elicit. He is simply as yet not adequately forthcoming about his inner thought processes.

[23] On the basis of these findings, we have no hesitation in concluding that Mr. Maranda poses a significant threat of serious harm as that concept has from time to time been defined in the case law, including *Winko*. At this early stage in Mr. Maranda's progress and treatment, our ongoing jurisdiction over him is amply justified.

[24] Having so found, the Review Board must then proceed to consider and impose the necessary and appropriate disposition under s. 672.54. We find that Mr. Maranda is as yet at a very early stage of treatment for his illness. There is much yet to be discovered. His reintegration into society remains a somewhat distant prospect. Public safety, which is the paramount consideration, under s. 672.54, as well as our desire not to be disproportionately restrictive renders a disposition of custody necessary.

[25] Mr. Maranda is just beginning his treatment and his education about his established illness. Once this hearing is concluded, he will be offered a variety of testing and program opportunities, as well as treatment for his alcohol issues. He will then be considered for or afforded liberties on a prudent and cautious basis, having regard to his

residual risk. We therefore find that a disposition of custody is also appropriate for Mr. Maranda under the current circumstances.

[26] Our order will be subject to review in the usual 12-month period.

Reasons written by B. Walter, in concurrence with Dr. R. Stevenson and P. Cayley