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

ERIC KONRAD WILLIAM NELSON

HELD AT: BCRB
Vancouver, BC
March 13 & 14, 2017

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. P. Constance, psychiatrist (dissenting)**
		A. Markwart

APPEARANCES:
ACCUSED/PATIENT: Eric Konrad William Nelson
ACCUSED/PATIENT COUNSEL: M. Rankin
DIRECTOR AFPS: Dr. R. Magee, S. Ambrosio
DIRECTOR'S COUNSEL: D. Lovett, QC
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION

[1] On March 13 and 14, 2017, the BCRB convened an annual hearing to review the disposition of Eric Konrad William Nelson (the "accused"), who is now 56 years of age.

[2] We are entitled to accept some, none, or all of the evidence before us. While we have considered all of the evidence on the record, we only recite that which is necessary to our decision.

INDEX OFFENCE(S)

[3] Mr. Nelson was charged with twelve offences. The first, an alleged assault on Mr. Nelson's former spouse, occurred on September 18, 2012. That charge was stayed. Given the context, we do not consider it further in our decision making: see for example discussions in **R. v. Runnalls**, 2008 ONCA 93, at par.6; **Ranieri (RE)**, 2015 ONCA 444, at paras. 13-17.

[4] The remaining offences occurred over the course of three days between May 15 and 17, 2013, at Ashcroft and Spence's Bridge, BC. On December 19, 2014, Mr. Nelson was given a verdict of NCRMD on eight offences including:

- Mischief to property over $5,000 (s.430(3) *CC*)
- Attempt murder (s.239)(1)(a.1) *CC*)
- Use of firearm while committing an offence (s.85(1) *CC*)
- Theft of a motor vehicle (s.333.1(1)(a) *CC*)
- Assault (s.266 *CC*)
- Use of a firearm in commission of an offence (s.344(a.1) *CC*)
- Extortion using a firearm (s.346(1.1) (a.1) *CC*)
- Mischief (s.430 *CC*)

[5] The relevant index offences consisted of a bizarre series of events in the context of possible delusional beliefs about a calf for which Mr. Nelson had been caring; painting signs on properties while apparently campaigning for the Green Party in the provincial election; responding to defamatory rumors about the victim D.E. and shooting up that victim's property; shooting at D.E., inflicting grievous harm; stealing a truck and

abandoning it; damaging a friend's vehicle, and punching him, and later brandishing a firearm at this individual in order to obtain money.

[6] The index offences are described in detail at paragraphs 3-29 of Exhibit 11 in the evidentiary record.

ACCUSED'S BACKGROUND

[7] The accused was with the victim of the alleged September 2012 assault for 24 years. They have two adult children and had been separated for seven years at the time of the assault.

[8] Mr. Nelson's sister suffers from bipolar disorder.

[9] Mr. Nelson discloses that he was a regular user of cannabis from age 15. There is no evidence that he has used it again since the index offences. He used LSD, peyote and mushrooms a few times.

[10] Before the index offences, Mr. Nelson had no history of violence, criminality, violent ideas or attitudes.

PSYCHIATRIC HISTORY

[11] Mr. Nelson presents with no documented mental or medical health issues. He has no historic admissions to hospital or treatment for psychiatric reasons.

[12] Mr. Nelson has disclosed insomnia and racing thoughts as of age fifteen, which resolved quickly. He has since endorsed bouts of sleeplessness and racing thoughts on a cyclical basis. He experienced such an episode, including increased energy and behavioural changes, in May 2013. He also acknowledges bouts of depression since his early twenties and he has become sad and socially withdrawn during the winter season. The most recent such episode was in the winter of 2013-14 and was accompanied by suicidal ideation.

[13] Mr. Nelson has never been prescribed psychiatric medication, even after the index offences or since his verdict.

[14] When Mr. Nelson was assessed by Dr. Wiehahn for Court he was symptom free. Dr. Wiehahn diagnosed Bipolar Type 1 Disorder (paranoid manic episode). In Dr. Wiehahn's opinion Mr. Nelson was in the throes of a manic episode of his illness between May 15 and 17, 2013, to an extent that qualified him for a verdict of NCRMD: Ex.4.

NCR VERDICT: DECEMBER 19, 2014

[15] Mr. Nelson's verdict, arrived at on the basis of agreed facts, was not contested. The Court concluded that Mr. Nelson suffered from a bipolar disorder and that he was experiencing a prolonged and acute manic state with psychotic features, which impaired his perception, reasoning and judgement.

[16] After the verdict, Mr. Nelson was released on an R.O.B. and permitted to reside in Strathmore, Alberta, where he was, by then, employed.

[17] Absent any court-ordered requirements to report to FPS for assessment and treatment, the BCRB, acting pursuant to s.672.121 of the *Code*, ordered Mr. Nelson to attend for assessment prior to his first hearing.

PROGRESS POST-VERDICT

[18] As he was asymptomatic and was not prescribed medication, Mr. Nelson did not receive any form of mental health treatment after his verdict. Mr. Nelson reported to the Kamloops AFPS outpatient clinic weekly by phone. He was considered forthcoming and co-operative, with good rapport and insight. There was no evidence of any pre-existing mental health history. He had implemented relapse prevention techniques, including structured time, and eating and sleeping well. His thinking was organized and no mania was detected. He remained abstinent. He expressed remorse.

[19] Dr. Wiehahn met with Mr. Nelson on February 2, 2015. Mr. Nelson showed no symptoms of his illness. He demonstrated that he had "explored and considered the implications" of his diagnosis and accepted it. Dr. Wiehahn remarked that the most disturbing feature of Mr. Nelson's illness and its effects was that it was "unknown". He opined that Mr. Nelson experiences "[…] one manic episode every decade or two. This is rare but not unheard of."

[20] Dr. Wiehahn conducted an HCR20 assessment which noted:

> 1. No history of violence
>
> 2. No anti-social behaviour
>
> 3. A marital separation, 7 years ago, but an ability to deal with relationship problems;
>
> 4. No history of employment problems

5. No problematic history of substance abuse

6. A major mental disorder, the symptoms of which went undetected; no current symptoms

7. No personality disorder

8. No violent attitudes or supervision failures

9. “Remarkable” insight

10. No violent ideation or intent

11. No affective, cognitive or behavioural instability

12. Complications due to Mr. Nelson’s residence in another province

[21] Dr. Wiehahn characterized Mr. Nelson’s risk of violence for the foreseeable future as low.

BCRB HEARING: MARCH 4, 2015

[22] The BCRB conditionally discharged Mr. Nelson and, *inter alia*, ordered him to return from Alberta within 30 days.

[23] Relevant to our mandate to review the entirety of the historic evidence as part of our decision making, we note in particular:

1. That Dr. Lamba’s report for the defence, dated November 3, 2014, assigned a likely diagnosis of schizophrenic disorder (bipolar type), but noted that diagnostic precision was unnecessary because treatment would not be very different
2. That Mr. Nelson’s symptoms, of both the mania and depression, had historically remitted spontaneously
3. That Mr. Nelson’s disclosure (undetailed), led Dr. Lamba to believe that he may have experienced six episodes including elation, each lasting several days
4. A paranoid episode ten years ago
5. A suicidal gesture in spring 2014
6. That it was considered reasonable not to prescribe medication

7. That the attempt murder was “exceptionally dangerous”

[24] The Board determined to impose its jurisdiction over Mr. Nelson on the basis of the serious index offence and the harm caused; a history of multiple manic episodes, the incidence, frequency and chronicity of which were not well understood, and the significant risk of recurrence, possibly accompanied by violent behaviour.

PROGRESS: MARCH 2015 – APRIL 2016

[25] Following his first hearing and disposition, Mr. Nelson returned to BC. He was provided with housing in Kamloops, where, absent traditional treatment he could be subjected to the close monitoring necessary to ensure public safety. Mr. Nelson obtained employment at a nearby ranch performing work that utilized his skills.

[26] Mr. Nelson remained stable and asymptomatic. He was described as insightful, prosocial, intelligent and he demonstrated good judgement. He was “entirely compliant”. His remorse was characterized as genuine and “striking”. He was described as “distressed and mortified” by the events. Dr. Wiehahn was of the opinion that, from both a clinical and an “ethical” perspective, it was reasonable that Mr. Nelson was not prescribed medication. Dr. Wiehahn submitted in evidence that he was comfortable that there was no biological component to Mr. Nelson’s treatment and said that, “I am not putting anyone at risk by not medicating him”. He added that Mr. Nelson posed no more of a risk of violence than any other citizen.

[27] Given the exceptionally dangerous index offence, and because of the episodic and unpredictable pattern and periodicity of the accused’s illness (which had not changed over time), Dr. Wiehahn’s preferred approach to risk management was one of close monitoring by seeing Mr. Nelson every two weeks in a variety of settings.

[28] As a result of the depth and severity of concerns communicated by the victim D.E. on hearing that the accused had relocated to the Kamloops area, the BCRB convened a special “own motion” hearing on June 25, 2015. The Director AFPS’ position was that:

> The cornerstone of Dr. Wiehahn’s treatment and safety management plan is close observation and monitoring by the treatment team, so that any onset or emergence of symptoms is detected at the earliest moment. Therefore, Mr. Nelson is seen at least every two weeks, including at work, at home, in the community and at the FPS offices.

> To implement this plan, Dr. Wiehahn believes that Kamloops is the only location, apart from the Lower Mainland, where the appropriate and necessary level of supervision can be provided by the FPS. Mr. Nelson needs gainful employment. Given his background and experience, this must be in a rural area. In relation to housing, Kamloops happens to have two residential placements for forensic patients. Other nearby rural centres do not have appropriate subsidized housing, and Mr. Nelson could not afford to live there. To send Mr. Nelson to a larger urban area where subsidized housing may not be available would be to cut him off from his work.
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> Dr. Wiehahn said his psychosocial treatment approach is premised on careful supervision. It would not be feasible for a case manager to drive to Lillooet every six to eight weeks with telephone calls in between. Kamloops seems the only viable locale. He said that access to forensic services in the Interior or North are inadequate to meet Mr. Nelson's needs. He fears that moving Mr. Nelson to another location would come with serious organizational and social costs. He believes that relocation would adversely impact Mr. Nelson's three most robust protective factors or features: occupation, recreation and prosocial attitude. The last of these relies heavily on a therapeutic alliance with the current treatment team. He agreed that Mr. Nelson's risk is entirely embedded in decompensation due to mental illness: Ex. 15, paras 17, 18, 19.

[29] Nevertheless, in consideration of the somewhat alarming nature of the evidence, which left the Board with concerns for the accused's safety, it recommended, though it did not order, that serious consideration be given to once more relocating Mr. Nelson: Ex. 15.

[30] In the ensuing months, Mr. Nelson remained asymptomatic without medication. His reporting and monitoring requirements were reduced to monthly visits. He continued to cope appropriately and responsibly with stressors, such as those occasioned by the victim's concerns, and to demonstrate good insight. He was committed to maintaining his stability. He began to re-establish and repair his relationships with his children and previous strong supports, as well as making new friends. Illustrative of his genuine remorse and "out of respect for the victim", he voluntarily relocated away from Kamloops to Sorrento. Ex. 16.

[31] Dr. Wiehahn opined that:

> It is my respectful opinion that offering Psychiatric medications like mood stabilizers to treat Mr. Nelson is not appropriate and that the only useful treatment modality is that of supervision. What was learned in the past year is that Mr. Nelson seems quite agreeable to be supervised and the question is will he continue to be as agreeable and co-operative when he is not involved with the Review Board of BC. During the interviews I had with Mr. Nelson he repeatedly assured me that he would continue associating himself with a treatment team wherever he goes. This may be easier said than done

> as Mr. Nelson makes his livelihood off activities outside of larger centres where specialist services like Psychiatric treatment teams are scarce. Ex. 17, par 23.

[32] As of Christmastime of 2015, Mr. Nelson began a new romantic relationship and, by early 2016, the couple planned to relocate to the Kootenay area to renovate a building.

EVIDENCE AT HEARING: MARCH 13/14, 2017

EVIDENCE OF THE DIRECTOR, AFPS

[33] Mr. Nelson moved to Midway, BC, from Sorrento, on April 14, 2016. Midway is located between Grand Forks and Osoyoos. He lives with his partner and her sister. They are converting a commercial building into housing. They plan to remain there.

[34] In his new location, Mr. Nelson's mental health is monitored by an FPS outpatient treatment team. He sees Dr. Magee every six to eight weeks and is in frequent contact, through a variety of media and home visits, with his case manager Ms. Ambrosio.

[35] Mr. Nelson remains stable and asymptomatic. He is co-operative, compliant, has good insight and is very forthcoming. Ms. Ambrosio testified that Mr. Nelson's residence in Midway is located close to the local RCMP station. The police have his BCRB disposition order. Mr. Nelson has an appointment booked to meet with a local community physician.

[36] As the local or community mental health outreach position in Midway is currently vacant, Mr. Nelson could be connected with a team in Grand Forks which would accept him. Grand Forks also has a mood disorder support group.

[37] Mr. Nelson's partner and her sister are aware of his illness and its symptoms. His partner, W.U., would engage the police, the treatment team, or a hospital if problems arise. Mr. Nelson has also re-established good relationships with his adult children and his father. Mr. Nelson's partner and sister-in-law, his own sister, who is moving to Midway, his children and father and the local police all are informed of his illness and would act in response to emerging symptoms.

[38] Ms. Ambrosio is unable to predict how long Mr. Nelson will continue to attend voluntary treatment services but she finds him genuinely engaged and wanting to avoid events similar to those of the index offences.

[39] Dr. Magee has seen the accused five times. He confirms that the core of his treatment strategy continues to be one of monitoring Mr. Nelson's mental stability because,

despite the low frequency of his illness, it is a cycling disorder and Mr. Nelson will "undoubtedly have further episodes". Mr. Nelson accepts monitoring. Dr. Magee also adds:

> Throughout our involvement with Mr. Nelson he has always presented in a very euthymic state. There has been no evidence of either a depression or mania. He has been very compliant with interviews. He has often had to travel a fair way to come and see us and is being quite attentive to these appointments. He has shown a willingness to understand his illness. Furthermore, his partner has come to the sessions and we have tried to educate her so that she can have some awareness of the symptoms of his illness as it evolved. Typically this would not occur overnight some understanding of the evolution of the symptoms over a period of days to weeks is useful to avert would mitigate [sic] another episode. Therefore, we felt that teaching and the supervision was very important to his care. I think it is does become much more of a recurrent problem I think the possibility of utilizing a mood stabilizer may be revisited but at this point in time we will continue with the previous treatment plan of observation and education. Ex. 22, par 7.

[40] Dr. Magee also considers Mr. Nelson's partner as very supportive, informed and engaged and he adds that there is also lots of community support. He calls Mr. Nelson's psychosocial factors "stable".

[41] Dr. Magee has no doubt or argument about Mr. Nelson's diagnosis which, in contrast to others, he terms "well documented". He currently considers Mr. Nelson as "perfectly normal". Dr. Magee has discussed, but not insisted on, initiating treatment with medication, but said that the accused appears happy with his progress and is "entirely co-operative". In his opinion Mr. Nelson is no more impulsive than others.

[42] Dr. Magee testified that Mr. Nelson's historic bouts of depression, or another such episode, are not prominent risk concerns as, in that context, the accused would more likely withdraw or isolate.

[43] Dr. Magee was unable to clearly testify that either the frequency or intensity of Mr. Nelson's manic episodes were increasing. He believes the onset of Mr. Nelson's illness is gradual rather than precipitous, but symptoms, except for isolation, may be subtle. He was equivocal as to whether a further year under supervision would enhance predictability but added that trying to predict progress 5 years into the future would be speculative.

[44] As ongoing monitoring and support are key strategies to managing Mr. Nelson, Dr. Magee, somewhat unusually in our experience, is prepared to continue to see Mr.

Nelson as a patient, even beyond Forensic auspices, on his periodic attendances as a community mental health psychiatrist in Grand Forks. He even allowed that it might suffice to see Mr. Nelson “once in a while”, or on a 6 to 12 month basis; for him to see a case manager every three months, and to establish a good relationship with a family doctor.

[45] On the threshold issue of future risk Dr. Magee’s evidence is that:

1. Mr. Nelson’s risk to others flows from his bipolar illness. The illness is cyclical: there will be a future episode. However its frequency appears low; the mania develops over time; he has been very stable, asymptomatic and free of relapses for several years despite being off medication. He is not violent at all when not ill and past episodes have not involved violence or criminality. Although he will re-experience the illness it will not likely progress to the point of significant threat or past damage. It would be dependent on how long after relapse he is untreated.
2. Mr. Nelson has consistently been described as insightful and is very attentive to his appointments and interviews. His very engaged partner has participated in psycho-education to make her aware of incipient symptoms; he is not socially isolated. He lives across the street from an informed police detachment and has an appointment with a family physician. Dr. Magee would accept him as a voluntary patient. Although insight can wane and impulsivity can increase with symptoms, the associated risk depends on the rapidity of decline. This will depend on maintaining his current positive level of psychosocial supports.
3. Mr. Nelson is accepting of, and co-operative with a management strategy based on monitoring at a frequency considered necessary by his doctor.
4. Mr. Nelson’s depressive episodes are not considered prominent risk factors.

[46] By way of summary, Dr. Magee agrees that, to maintain public safety, Mr. Nelson requires a sound psychosocial network, ongoing monitoring and periodic medical follow up.

EVIDENCE OF CROWN’S EXPERT, DR. MELDRUM

[47] Dr. Meldrum produced an independent assessment which included an in-person interview with Mr. Nelson and his partner.

[48] In reviewing Mr. Nelson's personal history and relevant circumstances, Dr. Meldrum observes that he and his partner do not endorse any significant financial stress at this time. Mr. Nelson has been disclosive of his circumstances and both he and his partner have become educated about his illness. The couple has no plans to relocate and are well connected in their new community.

[49] Mr. Nelson acknowledged that the dissolution of his past, long-term relationship contributed to a decline in his mental state in 2012. His symptoms as of September 2012 included mania, insomnia, isolation, lability, loss of appetite and increased energy. He developed psychotic symptoms about his calf. He also disclosed to Dr. Wiehahn a history of depressive episodes, including a seasonal component, as well as insomnia and behavioural changes.

[50] Dr. Meldrum agrees with Mr. Nelson's diagnosis of Bipolar 1 disorder but she also entertains a differential diagnosis of schizoaffective disorder. She does not have a clear opinion as to the periodicity of the episodes of his illness but on the evidence she agrees that he has experienced two manic episodes with psychosis, although she also testified elsewhere that there may have been as many as six such episodes. She also agrees that the periodicity of the illness may be more frequent than every ten years and that it might increase with age, as might its severity. Given the differential diagnoses, Dr. Meldrum said that she would have recommended that Mr. Nelson be given a thorough medical evaluation. She would also likely have suggested treatment with medication so as to lower the risk of a future episode. Dr. Meldrum agrees that Mr. Nelson currently appears to have good follow-up in the community. She expressed some concerns about what she appears to consider Mr. Nelson's unstable or non-mainstream lifestyle.

[51] On the issue of future risk, Dr. Meldrum appears to have considered what she perceives as the accused's past unstable lifestyle; his ability to self-manage his illness; his historic or possible future relapse to marijuana use; unstable relationships; re-emergent employment or financial stressors, and his vulnerability thereto.

[52] By way of protective factors or strategies, Dr. Meldrum acknowledges that Mr. Nelson's ability to self-manage his illness would be helpful. She recommends that he and his supports become more informed about the illness. He should initiate a relationship with a general practitioner and attend a bipolar support group. She also suggests the

development or articulation of a “safety plan” and believes that Mr. Nelson’s willingness to continue to see Dr. Magee and an outreach worker is crucial to his future management.

[53] According to Dr. Meldrum, Mr. Nelson intends to remain abstinent of cannabis, has valued his relationships with his treatment providers and has taken their advice to heart in order to maintain his stability. He has undertaken learning about his bipolar disorder and believes he would recognize symptoms of relapse and seek help. Mr. Nelson is realistic about the inevitability of future episodes though hopefully they will not be as severe. He appeared less aware or embracing of the psychotic component of his illness, about the risks associated with alternative or over-the-counter remedies, and may downplay somewhat his need for professional supervision. He would benefit from further education.

[54] Dr. Meldrum concludes:

> With respect to current clinical factors, Mr. Nelson has been described as having insight which has been characterized as improving but does still have some gaps in his knowledge with respect to Bipolar Disorder and his potential triggers. However, he has been stable since 2014 with no self-reported or observed symptoms of mood instability or psychosis. He has been reported to be fully compliant with all aspects of outpatient treatment.
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> Mr. Nelson states that his current living situation is stable. He has housing and adequate finances. He characterizes himself as being in a stable, loving and long term relationship. In addition to support from his common-law wife, he states he has support from others including his children and sister-in-law and other people in the town of Midway. He has met the mental health outreach worker on one occasion and states he would plan to continue to see her as well as Dr. Magee. He believes he has sufficient personal and professional support. He indicates that if granted an Absolute Discharge he would continue with those professional supports. He indicates that in the past, stress was a risk factor in developing his manic and psychotic episodes. However he is confident he will manage stress more adaptively in the future and those unique circumstances are unlikely to reoccur.
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> Assuming that Mr. Nelson’s description of the onset of his illness and the stability of his current psychosocial situation is accurate and his insight is genuine, while it does appear entirely likely that Mr. Nelson will become ill again with either depression or with mania with psychosis, it is unlikely, assuming that all his current circumstances remain unchanged, that he would again become ill to the point that he would pose a significant risk of harm to members of the public. Ex. 24, paras 63, 64, 69

MR. NELSON'S EVIDENCE

[55] Mr. Nelson's evidence regarding his own background since his arrival in BC in 1972, appears not to confirm the perception that he has led an unstable or nomadic lifestyle, at least prior to the dissolution of his marriage of 24 years. He appears to accept that the events leading to the index offences were part of a psychotic episode from which he continued to recover after his arrest and relocation to Alberta. He says that he spent almost a year in Alberta until he was ordered back to BC by the Review Board's order of March 4, 2015.

[56] Once back in BC, Mr. Nelson was assisted with JHS housing and he gained employment at a ranch in the Kamloops area. After the Board's June 2015 suggestion that he relocate once more to accommodate the victim's concerns, he got an opportunity to reside in Sorrento. He continued to see Dr. Wiehahn.

[57] Mr. Nelson met his current partner W.U., in Alberta and he disclosed his circumstances to her. They have now been cohabitating for about two years and they reside with W.U.'s sister in Midway. Once their renovation project is complete, he may be able to gain seasonal employment as a groundskeeper.

[58] Mr. Nelson's partner knows his background and has met his treatment team. He says that a general practitioner has agreed to accept him as a patient as of April 3, 2017. He said his delay in connecting with a GP is because he has been seeing his FPS treatment team regularly, because he was doing well, was asymptomatic and now living with informed people. The suggestion that he connect with a GP was longer term and Dr. Magee had agreed to continue to monitor and treat him. Mr. Nelson says that he has followed every requirement of his treatment team. He stated that it was important for him to remain in contact with a bipolar support group to avoid any recurrence. He appears agreeable to attending a bipolar support group, possibly in Penticton. Mr. Nelson testified that he is willing to comply with a doctor's advice and accepts that he may require medication at some point.

[59] Regarding the progress of his illness, Mr. Nelson testified that his symptoms of insomnia and racing thoughts at age 15, resolved after several weeks. His high school time was unremarkable but he again experienced bouts of insomnia in college. He says that he may have experienced depressive symptoms or effects of bipolar illness for several months at the end of his first marriage in 1987, but these resolved without treatment after

several months. He endorses some further “manageable” periods of depression without suicidal thoughts, usually during winter months, for one or two months, between 1995 and 2007, when his marriage ended. He was alone during the winter of 2008 and experienced the most marked and profound episode of depression of his life. He says he had another winter bout prior to the index offences which was not as severe.

[60] Mr. Nelson testified that he did not experience mania until spring 2013, and says that this remains his sole full-blown episode.

[61] Mr. Nelson provided his account of events between November 2012 and the index offences in May, 2013. As the relevant events have been documented by the Court and the Board, we do not repeat them. Mr. Nelson said that his mania during this period was preceded or precipitated by insomnia and included symptoms of feelings of invincibility; elevated mood, painting things green and not eating. His symptoms resolved during his time in custody until a further depressive episode in January 2014. He endorsed no symptoms during the winter of 2016-2017. He was never medicated.

[62] Mr. Nelson provided an account of the shooting incident, including how he came to learn about the victim and his thinking at the time, all of which has been extensively documented. He says he felt morally bankrupt afterward.

[63] Mr. Nelson was again asked to describe his understanding of the symptoms of his diagnosis and listed racing thoughts, rapid speech, low appetite, feeling invulnerable and depression but he denies any auditory or visual hallucinations. He says he is invested in maintaining his mental health.

[64] Mr. Nelson also testified that he is now more vigorously engaged socially. He has stopped using St. John’s Wort tea on the advice of Dr. Wiehahn. Mr. Nelson took issue with statements contained in the RCC (Ex.1), which we do not consider dispositive in this matter.

ANALYSIS AND DISPOSITION

[65] The Board’s decision making is governed by s.672.54, and s.672.5401 of the *Criminal Code* (as amended) which provide:

> **672.54** When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the

accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:

(a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;

(b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

(c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

672.5401 For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public — including any victim of or witness to the offence, or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent.

[66] The Board must first determine whether Mr. Nelson poses a significant threat to public safety as defined in s.672.5401. Although it is considered an expert tribunal in respect of the subject matter within its jurisdiction, the Board is not required or entitled to conduct its own assessment of an accused's significant threat to public safety. As must any adjudicative body, the Board can only evaluate the evidence presented at a hearing to determine whether it meets that threshold.

[67] Despite the implementation of s.672.5401, in 2014, the Courts have held that this has not changed the interpretation of significant threat, in substance. The jurisdictional threshold test remains that articulated in **Winko v. British Columbia (Forensic Psychiatric Institute)**, [1999] 2 S.C.R. 625:

> [T]he threat posed must be more than speculative in nature; it must be supported by evidence: *D.H. v. British Columbia (Attorney General)*, [1994] B.C.J. No. 2011 (QL) (C.A.), at para 21. The threat must also be "significant"; both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A miniscule risk of grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. (Par. 57)

[68] In **R. v. Carrick**, 2015 ONCA 866, the Court specifically adopted the above formulation from **Winko** and added:

> In short, the “significant threat” standard is an onerous one. An NCR accused is not to be detained on the basis of mere speculation. The Board must be satisfied as to both the existence and gravity of the risk of physical or psychological harm posed by the appellant in order to deny him an absolute discharge (Par. 17)

[69] Even more recently in **Calles v. British Columbia (Adult Forensic Psychiatric Services)**, 2016 BCCA 318, the BC Court of Appeal confirmed that:

> A significant threat to public safety is defined in s. 672.5401 of the *Criminal Code* to mean “a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent”. The threat posed must be more than speculative and be supported by the evidence. It must be significant “both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of grave harm will not suffice”, nor will a high risk of trivial harm: Winko, at para. 57. (para. 15)

[70] In summary, a finding of significant threat must be based on evidence rather than speculation. It must be significant in the sense that there must be a real risk of physical or psychological harm to individuals in the community that is serious, in the sense of going beyond the merely trivial or annoying. The conduct of concern must be criminal in nature. There must be a foreseeable and substantial risk that the accused would, or is likely to commit a serious criminal offence if discharged absolutely. In making these determinations, we must have regard both to the interests of individual liberty as well as to the paramount consideration of public protection.

[71] Both the probability of the harm and the severity of the harm must be significant. Prior to **Winko** it was sometimes argued that a miniscule risk of grave harm was significant. An alternate argument was that a high risk of trivial harm occurring could be significant. Both arguments are expressly rejected in **Winko**: there must be a significant risk of serious harm occurring.

[72] There is no argument that Mr. Nelson’s index offence, in the context of a dramatic decompensation, occasioned serious harm and grievous injury. Evidence regarding the historic trajectory or progress of his illness, that is, whether he has had one, or six episodes of mania in his life, or whether such episodes are increasing in frequency or severity, remains equivocal. We do not expect that further investigation would yield more precision given the absence of any formal historic documentation whatsoever: the lack of

reliable historic medical evidence is not likely to change. That Mr. Nelson does not, or may not precisely recall, untreated and undocumented episodes of sleeplessness, racing thoughts or depression, some thirty years in the past, which were not the subjects of medical intervention, renders him an average, not a poor historian. Memories fade with time.

[73] Mr. Nelson's future safety in the community is not dependent on achieving clarification or agreement on whether his exact diagnosis is one of bipolar or schizoaffective disorder. Dr. Magee says the diagnosis is "well documented". Dr. Lamba said diagnostic precision is unnecessary. Two FPS psychiatrists agree. Even the independent expert, who also entertains a differential diagnosis, does not strongly disagree. In any case, Mr. Nelson's prescribed treatment regime would not, given its history, likely change appreciably. His original Forensic psychiatrist saw no risk in not medicating him. Dr. Wiehahn considered medication "inappropriate". Although he has never been directly asked to do so, Mr. Nelson has said that he would accept medication if it were prescribed in response to concerning signs or symptoms.

[74] Mr. Nelson has never resisted, or less than fully complied with any and all recommendations of his treatment providers. He has taken their advice to heart. He appears sincerely invested in maintaining his mental health. Immediately after his verdict, he participated willingly in implementing relapse prevention strategies. He "explored and considered the implications of his diagnosis". He has now established a robust, if not perfect, informed network of close social relationships. His partner, her sister, his family, and law enforcement are informed. He has been offered the unique benefit of, and is willing to continue his relationship with, and to see his forensic psychiatrist in the community. He has an appointment to see a local physician in his community, which all agree is a crucial component of future management plans. He cannot be faulted for not having seen a local mental health outreach worker when that position is currently vacant and while he has been in consistent (and "very attentive") contact with his forensic team members.

[75] Most importantly from a risk perspective, Mr. Nelson remains stable, asymptomatic, very co-operative and compliant, insightful, genuinely engaged and committed to preventing any recurrence. Mr. Nelson has demonstrated genuine horror in reaction to his conduct while ill. Dr. Wiehahn described Mr. Nelson as prosocial and intelligent with genuine, indeed "striking" remorse. He appears committed to learning more

about his illness by joining a community support group. He is, on all evidence, entirely abstinent of marijuana. Any remaining gaps in Mr. Nelson's knowledge about his mental health do not conflate with lack of insight.

[76] The whole of the evidence, from various assessors and treatment providers, is that Mr. Nelson has done remarkably and unusually well in marshalling a "stable" array of psycho-social supports to monitor and maintain his stability. His physicians have said that he is unlikely, under current circumstances, to become ill to the point of significant threat. While future episodes may be inevitable, the evidence suggests that they will develop over time, not precipitously. While we are entitled to prefer the evidence of the professionals who know Mr. Nelson best, even the independent expert concludes that, under current circumstances, Mr. Nelson is not a significant threat: Ex. 24, par. 69.

[77] In the majority's opinion, to deny Mr. Nelson absolute discharge on the evidence before us would amount to placing an impermissible onus on him to prove that he is not a significant threat: see **Marzec**, 2015 ONCA 658, par. 30, 33.

Reasons written by B. Walter, in concurrence with A. Markwart.

DR. CONSTANCE, DISSENTING:

[78] The offences, occurring over a period of several days, included assault and attempted murder; the latter was impulsive with minimal provocation on an individual who was unknown to him.

[79] Mr. Nelson's diagnosis is either a bipolar disorder with psychosis or a schizoaffective disorder. While treatment of both is much the same, the prognosis is less positive for a schizoaffective disorder and psychosis.

[80] This was Mr. Nelson's first major episode with psychosis. Although he has no reported contact with mental health previously, he has a lifelong history of mood difficulties commencing at age 15. The periodicity of recurrences is unclear at this time. Mr. Nelson said in evidence that he had between 6 to 10 times when he had experienced likely hypomanic episodes.

[81] His son, W.M.N., gave evidence at the preliminary enquiry (Dr. Lamba's report Tab 10b) that his father had seasonal mood swings particularly in the winter becoming more manic although not as extreme as at the time of the index offences.

[82] Dr. Lamba in his report stated that Mr. Nelson reported that he has experienced episodes, less frequently than depression, when he feels elated, has poor judgment and feels increased energy on five or six occasions.

[83] Mr. Nelson's sister, who herself has bipolar illness, thought that he was manic in 2012. It is not known whether or not this was an episode which was distinct from that active at the index offence.

[84] Mr. Nelson's health history is by self-report. His evidence has been described as unclear and unreliable. There is a lack of collateral information. There has been no follow-up with his children and sister.

[85] The undisputed evidence is that Mr. Nelson will inevitably have a relapse of a manic state and the most likely presentation will be with a psychosis, which will more than likely take the form of the psychosis that was active leading to the index offences. The timing of a relapse is unknown, but from the available evidence, could be within a year or two considering his most recent episode was 4 years ago.

[86] Dr. Magee stated that Mr. Nelson would benefit from further education and understanding of his illness to improve his insight.

[87] Dr. Meldrum testified that she would have undertaken a full and thorough examination of Mr. Nelson including blood work and if satisfactory would have recommended medication for his illness. Dr. Meldrum's opinion was that Mr. Nelson still lacked insight especially with regards to his psychotic break and what the risks of such a relapse would mean.

[88] It was agreed by all parties that Mr. Nelson requires a solid and regular mental health plan with appropriate monitoring and follow-up.

[89] At the time of the hearing the necessary supports were proposed but were not in place. Mr. Nelson is not on prophylactic medication. Mr. Nelson had not met with his Family Physician. Dr. Magee stated he would be willing to follow Mr. Nelson in the community but the logistics of initiating this referral are unclear. The Community Mental Health nurse position is vacant and there has been no replacement to date. Mr. Nelson

has not connected with a support group. Although his partner is supportive, their relationship is relatively recent and she herself is untested with regards to a relapse.

[90] Dr. Meldrum stated in her evidence that all predictions of low risk are contingent upon current conditions remaining in place. This would not be the case if Mr. Nelson were absolutely discharged at this time.

[91] The single most important risk reduction strategy - robust social and mental health supports - is not in place and therefore Mr. Nelson’s risk abatement is not sufficiently mitigated at this time and therefore he continues to pose a significant threat to the safety of the public, and the least restrictive and onerous disposition is a conditional discharge with the same conditions.

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