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

SUKHDEEP SINGH SANDHU

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
October 24, 2017

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. S. Iskander, psychiatrist**
		A. Markwart

APPEARANCES:
ACCUSED/PATIENT: Sukhdeep Singh Sandhu
ACCUSED/PATIENT COUNSEL: A. Glouberman
DIRECTOR AFPS: C. Toews/Dr. M. Hediger
ATTORNEY GENERAL: L. Hillaby

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INTRODUCTION AND BACKGROUND

[1] On October 24, 2107, the British Columbia Review Board convened an annual hearing to review the disposition of Mr. Sukhdeep Singh Sandhu, the accused in this matter, who is now 31 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 record in this case, we only recite that which is necessary to our decision.

[3] Mr. Sandhu was charged in January of 2013, almost five years ago, with a number of offences, including attempt murder and three counts of aggravated assault. Mr. Sandhu engaged in a shooting spree in a crowded banquet hall in Richmond, British Columbia while he was overtly symptomatic. On the basis of a number of professional assessments, Mr. Sandhu was, on July 9, 2014, found NCRMD and committed to FPH where he has been detained since.

[4] This is Mr. Sandhu's fifth hearing since his verdict. His personal and psychiatric background, as well as the details of the index offence will not be reiterated as they are well documented in the record.

[5] Mr. Sandhu disclosed a history of depression, panic attacks, and paranoia which were implicated in a self-harm incident or gesture in 2012, during which he slashed his leg with a knife in response to command hallucinations. Mr. Sandhu also has a history of frequent and significant marijuana use since adolescence which may have played a part in complicating or potentiating his illness, although he insists that he stopped using that substance in 2011, two years prior to the index offence.

[6] Mr. Sandhu has no formal criminal record or convictions. There is a documented history of multiple police contacts, including being found in possession and even discharging of weapons.

[7] Mr. Sandhu suffers from a chronic gastrointestinal disorder which has been variously labeled as Crohn's Disease or colitis. It has played a prominent role in the development of his paranoid and delusional beliefs, and his relatively constant anxiety.

[8] Mr. Sandhu's psychotic symptoms resolved within a year of the index offence. He has now been symptom free for almost three years. A further helpful and protective factor is that Mr. Sandhu has the benefit of an insightful, supportive, cooperative and responsible family who have been helpful in escorting him on outings since 2015.

[9] A psychological assessment dated April 20, 2015 identifies at least antisocial personality traits, and also confirms that Mr. Sandhu's psychosis is in remission.

[10] At Mr. Sandhu's most recent hearing on October 26, 2016, the Review Board found him free of psychosis and found no behavioural concerns, aggression or drug use. It commented on Mr. Sandhu's positive and regular family support. It considered him spontaneous and credible in his testimony. The hearing resulted in a disposition of custody contemplating both escorted and unescorted outings into the community.

EVIDENCE AT HEARING

[11] For the current hearing, Dr. Hediger provides a report received as Exhibit 26. It notes that Mr. Sandhu has continued to make important and positive progress. He now resides on the intensive rehabilitation ward of the Elm North Unit. He has been calm and settled. There have been no significant behavioural concerns or aggression. He is entirely compliant to expectations as well as in terms of the administration of his intramuscular medication, which Dr. Hediger notes, he has not asked to discontinue at any time. Mr. Sandhu has remained entirely abstinent from drugs.

[12] Mr. Sandhu's bowel disorder is closely monitored but he continues to express anxiety and concern about it. He has participated and engaged in programs and his anxiety about this illness has improved somewhat with treatment. Mr. Sandhu's group and individual psychotherapeutic sessions target his ongoing anxiety arising due to his GI condition. Although his anxiety may be somewhat disproportionate to the challenges his illness presents, he has clearly benefited from therapy and is able, with far less anxiety, to access the community accompanied by staff. Mr. Sandhu has engaged appropriately and responded well to psychotherapy. Importantly, in light of evidence given at past hearings, he is more open and less guarded, both in program settings and with his treatment team. He continues to be free of psychotic symptoms. Mr. Sandhu's family remains supportive and insightful.

[13] Dr. Hediger believes that Mr. Sandhu could in the course of the next year, be expected, to progress to unescorted community outings which he currently does not seek, again due to the anxiety caused by his bowel illness.

[14] Dr. Hediger testified that a recent psychological assessment, which unfortunately the Board did not receive in evidence prior to the hearing, indicates that Mr. Sandhu does not qualify, and there is no evidence to support a diagnosis of psychopathy, nor of antisocial personality disorder. Dr. Hediger testified that cognitively, Mr. Sandhu presents with a degree of fixed, rigid or concrete thinking, although not to an extent that affects his daily functioning. Although Mr. Sandhu has made some progress in this area as well, his thinking style may be relevant to how he would eventually need to be monitored in the community.

[15] Dr. Hediger has met with Mr. Sandhu's family in order to augment his understanding of his patient, and his historic and future environment. Dr. Hediger is cautiously moving towards Mr. Sandhu's reintegration, and they currently enjoy a good therapeutic alliance. There is no evidence of any animus or desire for retribution from Mr. Sandhu’s victims. He could be expected to enjoy staffed outings within two months, and possibly visit leaves on an overnight basis within the next 12 months. Dr. Hediger cautions that unescorted outings will be a challenge and Mr. Sandhu's anxiety may prevent him from seeking these.

[16] Much of the hearing was focused on Dr. Hediger's risk assessment of Mr. Sandhu. In support of a further disposition of custody, Dr. Hediger cites the accused's significantly violent and potentially far more serious index offence; his numerous historic police contacts, including the involvement of weapons; the existence of possible personality issues by history, and the residual risk of relapse to substances. Dr. Hediger terms Mr. Sandhu's insight as reasonable and confirms that he is stable, settled, and asymptomatic.

[17] Dr. Hediger is also of the opinion that despite Mr. Sandhu's positive progress, his patient's overall risk profile is far more complex than his current written assessment would suggest. Dr. Hediger has closely and exhaustively reviewed Mr. Sandhu's index offence with him. Mr. Sandhu claims that at the time he was compelled by paranoid hallucinations and delusions, directing him specifically to commit the shootings. Dr. Hediger has also reviewed Mr. Sandhu's more distant history of police contacts and other events, to gain a

more fulsome understanding of Mr. Sandhu's motivations. He is left with considerable reservations and concerns about Mr. Sandhu's somewhat rigid and unwavering version of past events, leaving him to wonder about other unarticulated or undisclosed motivations. Dr. Hediger candidly admits that he does not fully understand the index offence. His own cautions and concerns have persuaded him to broaden his assessment of Mr. Sandhu's risk profile to include such unascertained elements.

[18] Dr. Hediger accepts that his patient was psychotic at the time of the index offence and has not resiled from a diagnosis of schizophrenia, but he considers that diagnosis not above discussion or debate, especially given the relatively speedy resolution of Mr. Sandhu's symptoms shortly after his verdict. Dr. Hediger's diagnostic questions arise from the fact that Mr. Sandhu's illness did not encompass the full menu of symptoms typically associated with schizophrenia such as diminished cognition, negative symptoms, affective issues, or overt disorganization of thought. Dr. Hediger is challenging himself by continuing to work toward gaining a full understanding of Mr. Sandhu's atypical presentation in order to, in turn, understand how best to anticipate and manage unforeseen risk issues.

[19] These collateral or less than fully understood issues inspire caution. They cause Dr. Hediger to recommend a measured and prudent process of reintegration to a highly supervised and structured environment; to monitor Mr. Sandhu's response to stressors and to avoid the possibility of relapse to substances. He hopes that under such a closely managed and cautious program, some of the outstanding risk concerns may, in time, be resolved.

[20] Mr. Sandhu testified at length. He accepts his diagnosis of paranoid schizophrenia and its symptoms. He described in detail, in a somewhat rote manner, his thinking at the index offence. He was able to provide examples of his extensive, paranoid, fear-inducing delusions, in particular, the component of unpleasant and directive male voices. He denies any such symptoms since December of 2014. He says that he would disclose any relapse to such symptoms in the future to either his treatment team or to his family. He appears to understand that in order to avoid a relapse or re-emergence of such symptoms, he will require medication for life. Mr. Sandhu acknowledges that his bowel illness is a source of stress and anxiety, especially on outings. He was able to describe some strategies for managing the associated stress. He says he experiences some side effects from his medication, but is not discouraged from complying.

[21] In repeating his rote memory of the specifics of the index offence, Mr. Sandhu expressed remorse, albeit in a somewhat detached manner.

[22] Mr. Sandhu testified that he has benefited from his involvement in programs. He has found the relapse prevention module especially helpful to recognize indicators of relapse. He has participated in anger management programming but denies any particular anger problems. He denies any criminal associations beyond a relationship with a past marijuana dealer from whom he purchased the gun he used at the index offence. He was remarkably unable to identify any particular themes or the frequency of his auditory hallucinations beyond them being unfriendly, directive and inducing paranoia. He acknowledges that he never disclosed his symptoms before the index offence.

[23] All parties submit that Mr. Sandhu should remain the subject of a custodial disposition, although, his counsel seeks an order of six months' duration, the addition of visit leave opportunities to Mr. Sandhu's parents' home, and argues that such visit leaves or their frequency should be mandated by the Review Board.

ANALYSIS AND DISPOSITION

[24] The Board's decision making is governed by s.672.54 and S.672.5401 of the *Criminal Code* 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.

[25] The Board must first determine whether, on the evidence, Mr. Sandhu poses a significant threat to public safety as defined in s.672.5401. The Board does not 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 admitted at a hearing to determine whether it meets that threshold.

[26] Codifying the definition of significant threat has not changed its interpretation. The 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)*

[27] 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)*

[28] A finding of significant threat must be based on evidence rather than speculation. 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.

[29] In formulating our opinion with respect to Mr. Sandhu's capacity to pose a significant threat to community safety, we take into account Dr. Hediger's risk assessment, including the highly violent events comprising the index offence just four years in the past.

[30] Cognizant of Dr. Hediger's current concerns regarding actual facts and his access to Mr. Sandhu's motivations, we remind ourselves of Dr. Tomita's assessment found at Exhibit 10, dated August 7, 2014. At paragraph 17, sub paragraph 22 of that report, Dr. Tomita raises as a complicating risk factor that:

> [T]here were no obvious signs from people who knew Mr. Sandhu that he was about to undergo a precipitous decline in functioning to the point that he acted against the victims.

[31] The documented history suggests that Mr. Sandhu is able to function while symptomatic without showing significant warning signs urging those in his environment to take preventive action. It would appear that his illness can, in fact, trigger or escalate to severe violence on a spontaneous, unpredicted basis. At paragraph 19 of his assessment, Dr. Tomita also says:

> Mr. Sandhu's case remains problematic as we do not have a full and confident understanding of how his psychiatric symptoms evolved to the point that he decided to shoot the victim and the events unfolded to involve the shooting of other victims.

At paragraph 21,he says:

> The crux of the difficulty now is being confident that we are accessing Mr. Sandhu's mental state fully and accurately.

And he later adds in paragraph 23 that:

> There are gaps in the data which are important with respect to risk management. Mr. Sandhu, as already noted, has been stopped on multiple occasions by the police with potential weapons in his vehicle.

[32] Although on the evidence, Mr. Sandhu has become far more trusting and disclosive and enjoys a positive therapeutic rapport with his psychiatrist, Dr. Tomita's cautions of more than three years ago are a haunting preview of Dr. Hediger's ongoing reservations with respect to this case.

[33] Under the circumstances and given the consensual positions of the parties on the issue of disposition, we have no hesitation in finding that Mr. Sandhu continues to pose a significant threat to public safety, justifying our ongoing jurisdiction.

[34] Having concluded that Mr. Sandhu remains a significant threat, we are required to reconsider and apply the criteria in s.672.54 to the evidence to arrive at the necessary and appropriate disposition in this case:

> The “necessary and appropriate” standard came into force on July 11, 2014. Before then, the *Criminal Code* required that the disposition be the “least onerous and least restrictive to the accused”. This court has endorsed the Board’s view that the two standards are synonymous – in other words, the “necessary and appropriate” disposition is also the “least onerous and least restrictive” disposition: ***Ranieri*** *(Re)*, 2015 ONCA 444 (CanLII), 336 O.A.C. 88, at paras. 20-21. The change in language was meant to clarify the standard and make it easier to understand, not to modify it. Thus, the jurisprudence developed under the least onerous and least restrictive standard continues to apply to dispositions under the necessary and appropriate standard: ***McAnuff*** *(Re)*, 2016 ONCA 280. *(Par 22)*

[35] Again, given the consensual positions of the parties as to disposition and insofar as Mr. Sandhu has only recently begun to exercise outings on an escorted or assessment basis, his behaviour and functioning in the community remain undetermined and unassessed. The necessary and appropriate disposition in the circumstances remains one of detention under s. 672.54(c).

[36] On the issue mandated visit leaves, we reflect that although the Board has the authority to supervise and, indeed, direct an accused's progress and reintegration, that authority has traditionally been applied on the basis of evidence of unreasonable delay or a lack of accountability on the part of the Director or a treatment team in furthering an accused's reintegration. In this case, we have been provided with no evidence that, given the complexity of his risk profile, Mr. Sandhu's access to the community or his overall reintegration has been unreasonably retarded. Indeed, Mr. Sandhu's anxiety is such that he acknowledges the stress of community outings. He clearly states that he does not wish to begin the process of unescorted community access. He is at an early stage of his reintegration and although prudent steps forward are indicated, he is at a very preliminary stage in that process. We see no compelling reason to persuade us that the Director will not afford Mr. Sandhu visit leaves to the care of a supportive, responsible, and insightful family environment when in its discretion, Mr. Sandhu's risk and mental state can be managed in the context of such privileges.

[37] Mr. Sandhu seeks a six month order. The Review Board has indicated that the presumptive 12-month duration of our dispositions under s. 672.81 are not conditions of a disposition, and are in no way binding. Therefore, although we have no compelling reason to anticipate evidence that would warrant a different disposition in six months' time, as we reminded parties at the hearing, the accused is free at any time to apply for a hearing in less than 12 months.

[38] Finally, as to the Crown's submissions regarding expansion of the area restrictions in Mr. Sandhu's current disposition, we were presented with no evidence that the current restrictions are inadequate to protect named victims or about the actual measured distances between Mr. Sandhu's parents' home and the residences, schools, or workplaces of any of the victims. As imposing a new area restriction without more geographic data might indeed thwart Mr. Sandhu's opportunities for visit leaves, we decline to alter our disposition in this respect.

Reasons written by B. Walter, in concurrence with Dr. S. Iskander and A. Markwart.