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

ALLAN DWAYNE SCHOENBORN

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
06 April 2010

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. R. Stevenson, psychiatrist**
		Dr. G. Laws, psychiatrist

APPEARANCES:
ACCUSED/PATIENT: Allan Dwayne Schoenborn
ACCUSED/PATIENT COUNSEL: S. Hicks
DIRECTOR AFPS: L. Lee Dr. J. Brink
DIRECTOR AFPS COUNSEL: D. Lovett
ATTORNEY GENERAL: L. Hillaby

[1] CHAIRPERSON: On April 6, 2010 the British Columbia Review Board convened an initial hearing to make a disposition in the matter of Allan Dwayne Schoenborn, the accused, who is 42 years of age. The hearing is convened pursuant to section 672.47(2) of the *Criminal Code.* The Supreme Court of British Columbia on February 22nd, 2010 imposed a verdict of NCRMD and committed the accused to FPH pending a first hearing of this tribunal. Under section 672.47, the Review Board is required to convene within 45 days to make a disposition; however, in the current case the court saw fit to extend that period to a total of 90 days before first hearing pursuant to the powers in section 672.47(2).

[2] Mr. Schoenborn was charged by indictment on April 5th, 2008 with three counts of first degree murder of his three young children. The circumstances of the case have garnered considerable public scrutiny and notoriety. The index offences were horrific and extremely violent.

[3] The accused was found NCRMD after a lengthy trial. The accused conceded that he understood the nature and consequences of his acts. The court found that the Crown had proved beyond a reasonable doubt that the accused caused the death, and indeed intended to cause the death of his children, and that he understood his actions in doing so. It therefore concluded that the offences of first degree murder had been established. The court also determined that, although there were some differences in opinion between the forensic psychiatric expert witnesses who gave evidence, if the accused was psychotic at the time of his illness and motivated to kill his children by that psychosis he might not understand that his actions were wrong. In a careful assessment of the evidence the court found that on a balance of probabilities the accused, in his psychotic state, was unable at the time of his crime to appreciate that it was morally wrong. It therefore imposed a verdict of not criminally responsible on account of mental disorder (NCRMD).

[4] In terms of the accused's history and the factual background as also found by the court, Mr. Schoenborn is now 42 years of age. He experienced some problems with the law as a young man; for example, he has convictions dating from 1984 to 1993 of break and enter, mischief, alcohol-related driving offences, resist arrest, breaches or failures to appear, obstruction, assault with intent, escaping lawful custody, theft, assault and assault causing bodily harm. His criminal record of convictions is more fully detailed at Exhibit 1.

[5] In terms of psychiatric history, when Mr. Schoenborn was 19 and living in Alberta, and having somewhat recently used LSD, marijuana and alcohol, he suffered a psychotic episode. He voluntarily attended at a mental hospital, was admitted and treated. On

admission he was considered to be acutely psychotic. He believed he was talking to Jesus and God. He thought he was having an LSD flashback. Although schizophrenia was mentioned in the collateral records, no formal diagnosis resulted from that single admission. The accused was discharged after a period of some eight days.

[6] The accused settled down after becoming involved with his spouse, Ms. Clarke, the mother of the deceased children, in December of 1993. The first five years of the relationship between 1993 and 1998 were termed relatively happy and normal. The accused worked as a roofing contractor. His wife was a homemaker. They eventually had three children. Relationship issues began to surface with Ms. Clarke's announcement of her first pregnancy. The accused became beset by suspicions of his wife's infidelity as well as doubts about the paternity of their first child. Thereafter, he became suspicious of his spouse consorting with other men. What was initially a concern grew to jealousy and ultimately became an obsession, causing Mr. Schoenborn to suspect neighbours, co-workers, and reading sinister meanings into innocuous events. His unfounded suspicions began to influence his behaviour which in turn affected the relationship. Despite his spouse's denials, Mr. Schoenborn persisted in his angry suspicions.

[7] By 1999 his delusions appeared to have expanded. Mr. Schoenborn began to believe that his spouse not only had a lover but that she and her lover were involved in drugs and that they were poisoning their two-year-old daughter. One bizarre incident occurred when, believing his daughter had been poisoned, the accused attended at a hospital, after being involved in a car accident. He insisted that his child be tested for drugs and sexual abuse. No evidence in support of those concerns was found. Instead the accused was certified at Eagle Ridge Hospital. He was then taken to Royal Columbian Hospital on June 14th, 1999 for a mental state assessment. While there, Mr. Schoenborn told a physician that he was mistaken about his concerns for his child. After ten days, he discharged himself against medical advice. On discharge, Mr. Schoenborn did not adhere to his prescribed medications nor did he attend for psychiatric treatment.

[8] Although the information is conflicting, the records also suggest that drugs and alcohol may have been a destabilizing influence in the accused's life and mental state. Mr. Schoenborn’s beliefs persisted and grew. He believed that his wife and her lover were sexually abusing their daughter. He may indeed have been using marijuana and alcohol more heavily at that time.

[9] The collateral information is relatively limited until 2007 when the accused apparently behaved in a berating and intimidating manner towards his spouse about her alleged infidelity. On one occasion he actually struck Ms. Clarke. He says that the assault was unintentional. In May of 2007, in an incident precipitated by his suspicions of infidelity, he forced Ms. Clarke to engage in sexual activities which resulted in a charge of sexual assault. He was released on bail with a requirement that he have no contact with his spouse, which he breached. In July of 2007 Ms. Clarke recanted and the charge was stayed.

[10] At that point Child Protective Services (MCFD) became involved. This further angered and continued to upset the accused. The accused's mental health continued to decline. He began to experience voices uttering derogatory remarks. He believed that he heard Ms. Clarke talking to people in the bathroom when there was no one there. He believed people were listening or surveilling him. He lacked any insight that his behaviours vis-à-vis his wife were delusional in nature. Finally, in August of 2007 Ms. Clarke moved to Merritt to be closer to her mother. She initially lived with her mother along with her children. She then moved to a motel and subsequently to a rental property at the request of the accused because he believed the motel was full of drug dealers.

[11] The accused's life continued to deteriorate. He was living in his truck until he lost his driver's license and could no longer operate the vehicle. When he was working he slept in a tent wherever he could. He would travel to Merritt to visit and stay with his family. His functioning eventually declined to the point where he was unable to work or to contribute to his family.

[12] In the months before the index offence(s) in April of 2008, his precipitous deterioration continued. Ms. Clarke told him to see a doctor. He felt that nothing was wrong with him. To that point Ms. Clarke had reported that the accused had a close and loving relationship with his children, playing with them, helping with them, and spending as much time with them as he could. He was always concerned about their happiness and well-being. She had never seen him harm them in any way. She did believe it was possible that he might harm her.

[13] In the four or five days leading up to the index offence the Mr. Schoenborn appeared at the children's school in a disheveled state, uttering threats. He was arrested and released on bail. He was in a public altercation on a bus. He was arrested for being drunk. He made a further visit to his children's school in an even more disheveled and anxious state. He was

again arrested for uttering threats. He attempted to run while being booked. The accused was once again released. Child Protection Services (MCFD) believed he was not at this time staying with his children.

[14] On or about April 4th or 5th Mr. Schoenborn was in communication with Ms. Clarke. She informed him that she did not intend to reconcile with him. She described him as depressed but accepting of her decision. Ms. Clarke decided to stay at her mother's house for the weekend while the accused spent time with the children. On the evening of April 5th he called Ms. Clarke to come to the residence. She would not. He continued to try to impress on her his concerns that the children were being molested or otherwise abused. Finally, as described in graphic terms in the court's reasons, the accused separated and killed his three children while they were sleeping. He thereafter attempted to kill himself using a razorblade then a cleaver, as well as through an attempted electrocution. He escaped into rough circumstances. The accused was arrested several days later.

[15] Following his arrest and hospital treatment Mr. Schoenborn, in preparation for his trial, was interviewed by two expert forensic psychiatrists. Dr. Lohrasbe, whose report we have at Exhibit 7, interviewed the accused in August and September of 2009, on two occasions for a total of six hours. The interviews took place in the presence of the accused's defence counsel. Dr. Lohrasbe described the accused as fragile, labile, intense and thought-disordered. Mr. Schoenborn provided rambling answers to Dr. Lohrasbe's questions. He disclosed his childhood and family history. He disclosed his earliest suspicions and doubts about the paternity of his three children, the victims of the index offence(s). He described his alcohol and drug use. Dr. Lohrasbe also reviewed records relating to the accused's previous psychiatric admissions.

[16] Dr. Lohrasbe found it difficult to give a definitive psychiatric opinion from the history he was able to glean. He did agree that at the time of his interviews the accused possibly suffered from a delusional disorder or schizophrenia in the form of delusions, hallucinations, thought-disorder, disorganized speech and labile mood. He also noted that an accused with a history of substance abuse could in fact present as unusually paranoid. He noted the accused's eruptive and explosive, angry outbursts. He also identified auditory hallucinations. Dr. Lohrasbe acknowledged that the accused was suffering from some form of paranoid psychosis, either a delusional disorder or schizophrenia. He acknowledged that the accused had longstanding difficulties with marijuana and alcohol. He also considered that the accused presented with paranoid personality disorder as well as antisocial, narcissistic and borderline

traits. Nevertheless, he was ultimately ambivalent as to whether or not the accused satisfied the criteria for an NCRMD verdict as articulated in section 16 of the *Criminal Code*.

[17] Dr. O'Shaughnessy was called as a forensic expert for the defence. He interviewed the accused in April of 2008, soon after his arrest, and in June of 2009. Mr. Schoenborn endorsed olfactory hallucinations as well as delusions in the form of fixed, firm and false beliefs that his wife was having an affair and that his children were being sexually abused or exposed to drug use. Dr. O'Shaughnessy agreed that the accused suffered from a psychotic illness, either a delusional disorder or schizophrenia. He agreed that the accused had previously suffered psychosis. He suggested that the accused was presenting with an ongoing delusional disorder whose symptoms were fluctuating. Ultimately Dr. O'Shaughnessy's opinion was that the accused's mental illness rendered him incapable of understanding the wrongfulness of his actions; that in killing his children to protect them from a life of abuse Mr. Schoenborn thought his actions were morally correct.

[18] On February 24, 2010, following his verdict, the accused was admitted to the Forensic Psychiatric Hospital under the warrant of the Supreme Court. In anticipation of this first hearing of the Review Board, additional documentary evidence was submitted, first in the form of a social history dated March 25, 2010, (Exhibit number 11). In addition to the historic picture outlined above, this document at paragraph 18 suggests that the accused, as an adult, experienced a number of head injuries and was involved in numerous alcohol-related motor vehicle accidents. At least one such injury involved a loss of consciousness. At paragraph 22 the report confirms that the accused's education stopped or plateaued at grade 9.

[19] We also have a submission from Mr. Schoenborn's inpatient case manager Ms. Lee (Exhibit 12) which chronicles the accused's progress since his admission from Kamloops Regional Correctional Centre. On admission February 24th the accused was secluded on the secure A2 ward of this hospital. He was closely observed as he endorsed ongoing suicidal ideation and voices of a derogatory nature. He also presented as paranoid and angry. When interviewed he disclosed both auditory and visual hallucinations as well as ideas of reference. He reported having abstained from alcohol and marijuana since 2007. He was frequently agitated and hostile while in seclusion. On February 20th, although he had become somewhat more cooperative, he disclosed a plan of suicide by starvation. By early March he was slowly permitted periods out of seclusion at mealtimes. Despite his plan to starve himself, he began to consume small quantities of food. He also requested a change of psychiatrist. By March

12th he was dehydrated and malnourished but consumed meals without difficulty. On March 16th he was diagnosed with Hepatitis ‘C’.

[20] On a couple of occasions, including on March 17th, he presented in an aggressive and angry stance towards staff. He continued to present as paranoid and delusional. At the time of this hearing he remains on the restrictive A2 ward. Under questioning Ms. Lee indicated that Mr. Schoenborn would like to be conditionally discharged as he had already been in custody for two years and believed he could be managed in the community.

[21] The Review Board received a lengthy written submission and had the benefit of oral evidence from Dr. Brink, the accused's treating psychiatrist. In his report (Exhibit 13), in addition to Ms. Lee's factual accounts, Dr. Brink said that the accused presents with a "striking sense of entitlement" in his demands. When asked to provide examples Dr. Brink indicated that the accused early on demanded access to photographs of his children. He did not believe that he was required to accept or submit to hospital rules. He has, despite the court’s warrant, demanded access to the community. He is impatient with the progress of his treatment in this hospital, and he requested a change in his psychiatrist. According to Dr. Brink that sense of entitlement suggests that Mr. Schoenborn would have great difficulty in complying with treatment requirements and adhering to supervision in the community on his own devices.

[22] Dr. Brink testified that after an initial refusal of nutrition Mr. Schoenborn has now resumed eating a steady diet along with supplements. His temperament has improved. His thinking is organized. Indeed Mr. Schoenborn spoke quite clearly and articulately throughout the course of the hearing. He has recently increased his range of affect and expression. He agreed to commence treatment with Olanzapine. The initiation of that medication is relatively recent and its effectiveness has yet to be assessed. He continues to present with delusional thoughts. Since coming to the hospital, and although he continues to endorse his historic symptoms, the accused has disclosed olfactory and auditory phenomena suggestive of psychosis. He also endorses beliefs which apparently have no basis in fact. These may not be true delusions but the products of his paranoid personality. He continues to believe that his treatment team interviews are recorded and broadcast for the benefit of other physicians. Although Dr. Brink has yet to refine the accused's diagnosis, he is clear that the accused is suffering from a psychotic disorder, likely a delusional disorder. He also has historic substance abuse disorders and presents with a paranoid personality disorder, the implications of which have yet to be assessed. Overall, the accused has what Dr. Brink terms a “profound” lack of insight into his illness.

[23] Dr. Brink recommends the accused's ongoing detention as he has yet to fully explore and gain a psychiatric understanding of Mr. Schoenborn, including about his true, underlying motivations for the index offence(s). Moreover, Dr. Brink is not yet confident whether or not the index offence(s) were motivated by the accused's AXIS I mental disorder or his AXIS II personality characteristics. He will continue to explore the accused's obsession or preoccupation with the sexual abuse of his children. He will also strive to establish some form of trusting, therapeutic relationship in the face of the accused's ongoing paranoia and mistrust. He also wishes to undertake further exploration of the accused's feelings of being rejected or ousted from his family and assess how these feelings affected his behaviour and may be implicated in the index offence(s).

[24] Dr. Brink testified that overall the accused's behaviour has improved somewhat. He has been able to tolerate reasonably lengthy interviews even on sensitive subjects. In terms of his understanding of his illness, his plans, his willingness to accept treatment, and in terms of the index offences and their gravity, the accused continues to lack insight. Despite some verbal altercations, he has not been overtly aggressive or assaultive in hospital. Dr. Brink confirmed that it is far too soon to assess the effectiveness of the accused's medications in controlling his symptoms.

[25] In addition to evidence of the accused's mental state, it is of course the task of the Review Board to come to a conclusion regarding the accused's risk to public safety. On that issue Dr. Brink rendered a written assessment in which he highlights the accused's history of violence including spousal assault; assault of a brother-in-law prior to the index offence(s); historic altercations in bars, and what appears to be, in our estimation, an overall readiness to resort to physical confrontation. We also take into account the ultimately violent and horrific nature of the index offence(s) and the fact that, according to the expert, the accused lacks any insight into the enormity of his acts. Dr. Brink also indicated that the accused's aggression could be expected to exacerbate with the intensity of his paranoid delusions. On that note he reminds us that the accused continues to endorse not only the paranoid beliefs which animated his behaviour at the index offence(s) and which remain active, but that he also continues to develop what might be termed new delusional beliefs.

[26] Further on the issue of risk assessment, Dr. Brink cites the accused's history of vocational and relationship instability, suggesting some impaired capacity to attach and remain involved in meaningful relationships. He also cites the accused's significant history of alcohol and substance difficulties, including alcohol use proximate to the time of the index

offence(s). These are of course suggestive of an elevated risk to others especially in combination with a psychotic illness. Mr. Schoenborn himself has admitted that cannabis has in the past rendered him paranoid and that alcohol agitates him. He has nonetheless continued to use those substances. In addition to the accused's psychotic illness, Dr. Brink also raises personality features, the risk implications of which have yet to be fully explored. Personality disorders are notoriously stable and difficult to ameliorate through treatment. We are reminded that the accused also has a history of noncompliance with treatment and with supervisory, including court orders, again suggestive of lack of insight and elevated risk.

[27] In terms of accepting his illness, the accused is at best ambivalent. Dr. Brink speaks to the matter of insight in that aspect as follows:

[28] “He has little, if any, insight into the presence of a major mental illness and continues to minimize and deny several aspects of matrimonial abuse clearly documented on file. His tenure in this hospital has been largely characterized by anti-authoritarian attitudes and Mr. Schoenborn clearly is a man highly suspicious of others and events around him. He has spoken in derogatory terms about the Review Board and of staff in this hospital in general. It is, of course, necessary to await the potential benefit of antipsychotic medications and its impact on his general functioning and attitudes overall. At present, Mr. Schoenborn exhibits active symptoms of a major mental illness in the form of hallucinations and paranoid delusions and has demonstrated a significant degree of impulsivity in his interactions with the staff and on at least one occasion raised his fist in anger at a staff member.”: Exhibit 13

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[30] All in all, at this early stage, considering much needs to be done to clarify the implications of the accused's underlying personality disorder, the true nature of his psychotic illness, the efficacy of his medication and his vulnerability to destabilization, Dr. Brink has no option but to recommend the accused's ongoing detention from both clinical and public safety perspectives. Moreover, Mr. Schoenborn currently has no meaningful supportive resources nor any realistic plans in the community. Certainly, as he currently presents, he is at high risk of impulsive behaviour, of relapse to substance abuse and to more severe symptoms. He remains reactive and angry, as his behaviour frequently indicated throughout the course of the hearing in response to the evidence of other witnesses. On a more positive note, Dr. Brink is no longer actively concerned that the accused is committed to self-harm or suicide, although he acknowledges that his patient remains impulsive and highly unpredictable.

[31] Mr. Schoenborn provided evidence. He chose to speak on his own behalf despite the Board having assigned counsel to assist him. He acknowledged that his treatment team, Crown counsel or, for that matter, members of the Review Board might have difficulty in dealing with him because of his communication style and because of educational gaps or limitations. He gave us examples of how he might use language quite differently than the rest of the assembly. He spoke at some length about being labelled narcissistic. He felt that the fact that the current hearing unfortunately fell on the two-year anniversary of the index offence was a deliberate action of the Review Board, indicating some ongoing paranoia.

[32] Mr. Schoenborn wished to be conditionally discharged whereupon he would collect social assistance, seek housing near the Fraser River, and build houseboats. He proposes to keep a low profile after a considerable period of public notoriety. He indicated that he would like a 180-day order so that he could make a better response at his next hearing. He said he accepts that he has a mental illness, the symptoms of which include paranoia which is triggered by his misunderstanding of verbal cues or stimuli in his environment. He agreed to report as directed to a treatment team. He indicated that he would like to get to the bottom of his illness and get it fixed. He remains in pain, having already been secluded or detained for 23 months. He believes he has been a role model while in a correctional institution and sees no benefit to a further year in detention. He believes that staff here talk down to patients and he finds this frustrating. He acknowledged that he deals poorly with anger and frustration. He blames this on his limited education as an “eastside roofer”.

[33] He explained the roofing trade at some length, including that "tempers flare on the roof", but he has coped without what he believes is significant violence in his life. He illogically continued to consume marijuana in an effort to prove to himself that it was not marijuana that caused his paranoia. He spoke of his father as a hardworking man who tried his best but drank a lot. He noted that all childhoods including his own contain tragedies and misfortunes. He acknowledged that his index offence was probably unnecessary. He hopes that he was wrong and that his children were not actually being abused. He believes that the issues that existed continue and are too deep to contemplate any reconciliation with Ms. Clarke. He said that he harbours no hope in that respect.

[34] He denies paranoia in broader aspects of his life but was unable to demonstrate any meaningful insight into how his illness influenced his current legal status. He was able to respond to questions from Mr. Hillaby that the NCRMD verdict was properly applied. He spoke about other symptoms that he has experienced. He indicated that his paranoia first

surfaced when his daughter was 15 months old. He believes he can be effectively treated in the community and that he should be discharged to get on with the next stage of his life.

[35] The Review Board withdrew to consider all of the evidence and the positions of the parties. We are reminded that, having considered evidence of the accused's past and current mental state, his prospects for reintegration and his other needs, the Review Board must first determine whether or not this accused poses a “significant threat” of serious harm within a reasonably foreseeable timeframe. The Supreme Court of Canada has reminded us that risk prediction is indeed a protean construct, influenced by all manner of information; that exact or scientific predictions, especially when they involve human behaviour, are beyond current knowledge. Nevertheless, having considered this accused's history of violence as outlined in the body of the evidence, his preexisting criminal record, his history of domestic discord at times achieving levels of physical and sexual assault, and of course considering the ultimately grim and horrific nature of the index offence, we have no difficulty in concluding that this accused at the current stage of his treatment and labouring under limited insight, poses a nonspeculative significant threat such as warrants our jurisdiction over him.

[36] In coming to that assessment the Review Board is also required under section 672.541 of the *Criminal Code* to consider any Victim Impact Statement filed. In this case we have received such a report from victim Darcy Clarke at Exhibit 14. In her Victim Impact Statement of May 23rd, 2010 Ms. Clarke expresses the depth of her relationships with her deceased children, the impact of the accused and his obsessions on their lives, and her efforts prior to the offences to obtain assistance and support. She also details in graphic language the impact on her of the accused's offences psychologically, emotionally, medically, materially and socially. She expresses her ongoing bewilderment, her loss and her real and continuing fear of the accused. It is also clear to us, given the accused’s attempts to prevent the admission of the Victim Impact Statement at the outset of the hearing, that he remains to some extent obsessed by or fixated on Ms. Clarke. Clearly, to the extent that it is relevant, the Victim Impact Statement amply supports a finding of significant threat.

[37] Having so concluded, the Board must of course re-examine the evidence and then impose the least onerous and least restrictive available disposition: s.672.54. As we indicated to Mr. Schoenborn at the close of the hearing, and in considering once again Dr. Brink's risk assessment, including the need to further explore the accused's illness, his motivations and violence triggers, considering his lack of insight into mental illness in general, his as yet failure to come to grips with the depth and gravity of the index offences, and considering that the

accused indeed demonstrates ongoing and possibly new symptoms of psychosis and paranoia including his ongoing obsessions about the negative impact of MCFD on his family and himself, we have no option but to detain him on narrow conditions. these were shared with Mr. Schoenborn at the close of the proceeding.

[38] For the record, despite the narrow nature of the detention order that we imposed, we also saw fit to order an absolute prohibition on any contact between Mr. Schoenborn and his spouse, Ms. Darcy Clarke. Should anything change on that front or, if for example, Ms. Clarke sees fit to confront Mr. Schoenborn, the Board will consider a request for a further hearing to deal with that issue.

Reasons by Mr. B. Walter and concurred in by Dr. R. Stevenson and Dr. G. Laws

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