BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1991 c. 43, as amended S.C. 2005 c. 22, S.C. 2014 c. 6

REASONS FOR DISPOSITION
IN THE MATTER OF

ALLAN DWAYNE SCHOENBORN

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
January 10, 2019

BEFORE:
CHAIRPERSON: B. Walter
MEMBERS: Dr. R. Stevenson, psychiatrist
Dr. M. Burnett

APPEARANCES:
ACCUSED/PATIENT: Allan Dwayne Schoenborn
ACCUSED/PATIENT COUNSEL: R. Gill,
J. McInnis, Articled Student
DIRECTOR AFPS: Dr. M. Hediger
DIRECTOR'S COUNSEL: D. Lovett, QC
ATTORNEY GENERAL: M. Booker, T. Shaw

INTRODUCTION AND BACKGROUND

[1] On January 10, 2019, the British Columbia Review Board ("*BCRB*") convened an annual hearing to review its disposition in the matter of Allan Dwayne Schoenborn ("the accused"). Mr. Schoenborn is now 50 years of age. This is his seventh full Review Board hearing. He has been at the Forensic Psychiatric Hospital ("*FPH*") since, and even before the Supreme Court of BC imposed its verdict of Not Criminally Responsible on Account of Mental Disorder ("*NCRMD*"), on the basis of three counts of first degree murder (s.235 CC), on February 22, 2010.

[2] The victims of the index offences were the accused's three young children. The events are horrific, notorious, well-known, and have been thoroughly documented. Similarly, the accused's familial, social, developmental, psychiatric and extensive criminal histories are well documented. That history, as well as Mr. Schoenborn's progress under treatment, the Board's findings, and, of course, any victim impact statements filed, all remain current and relevant parts of the evidentiary record before us and therefore their details need not be specifically repeated.

[3] Mr. Schoenborn is diagnosed with Delusional Disorder (in remission), Alcohol and Substance Use Disorders (in remission), and Paranoid Personality traits.

[4] Within the first year of his detention, or shortly thereafter, the symptoms of Mr. Schoenborn's Delusional Disorder, such as delusional beliefs, perceptual disturbances, disorganization and hallucinations, remitted under treatment. He remained abstinent of alcohol and substances. He was and is considered motivated to benefit from programs and treatment opportunities.

[5] The third aspect of Mr. Schoenborn's diagnosis, his Paranoid Personality traits, have, in recent years been the major focus of treatment. Rather than a typical, acute mental illness, personality disorder or traits have more to do with character, attitudes, and distorted thinking. In Mr. Schoenborn's case, he erroneously interprets the intentions and actions of others in a paranoid manner, that is, he inaccurately feels others are out to do him injustice. Such paranoid suspicions, misperceptions or misinterpretations cause such persons to react in an excessively sensitive, angry and/or impulsive manner.

[6] Despite episodes of low mood and frustration Mr. Schoenborn has remained mainly settled and free of problematic behaviour. Nevertheless, his responses from time to time, have justified a continuing focus on coping and anger management treatment. Although Mr. Schoenborn has become involved in episodic altercations, these have generally been provoked by others. But his expressions of anger have decreased over time. He has demonstrated an ability to respond appropriately to provocation and even assaultive behaviour from others. For example, in September 2014, he was assaulted by a specific peer, with whom there was a consistent, established history of conflict, and he was able to refrain from retaliation. Anger and stress management continue to be the central targets of treatment and risk management, to-date. Mr. Schoenborn's willingness to participate in psychotherapy and anger management which has fluctuated in the past has recently been consistently positive. The accused has consistently agreed that he needs to pursue further progress in respect of these issues.

[7] Mr. Schoenborn's progress has been impacted or delayed by an unusual or even unique issue: that of real and substantive risk of harm to the accused himself. The accused's own safety, due to negative and threatening responses of peers, are of significant concern to his treatment providers. Mr. Schoenborn is seen as a chronic and acute target of threats and risk of harm from others.

[8] In its disposition dated May 29, 2015 (Ex. 47), after a lengthy hearing including extensive expert evidence, the Board was persuaded, on its analysis of the evidence, to delegate to the Director the discretion to permit the accused escorted access to the community. In delegating this discretion (rather than mandating or ordering the accused's access to the community), the Board considered and took into account, the Director's process of decision making, that is, how the discretion to actually implement escorted outings is exercised in practice. This process in particular includes "a dynamic assessment that is continually updated by a range of professionals in contact with the accused while always taking into account public safety. Lastly, we note that this privilege is not mandatory but provided at the discretion of the Director, having regard to all of the circumstances in the instant": Ex. 47, par 77. The Director's decision to afford a time-limited, escorted outing also includes, "a fresh analysis of risk issues immediately prior to, and during, any such event": Ex. 47, par. 84.

[9] Although Mr. Schoenborn was not (and has not ever), been granted any form of access to the community, he has generally remained stable and compliant despite periodic expressions of irritability, anger and aggression in relation to ongoing conflict with a specific peer.

[10] Prior to his protracted 2017 BCRB hearing, Mr. Schoenborn experienced some deterioration in his mental state including paranoid beliefs about his treatment providers. The expert evidence suggests that Mr. Schoenborn's period of irritability or setback was precipitated by the stress of an application to the BC Supreme Court to have him designated a High Risk Accused ("*HRA*"), under s.672.64 of the *Code*. That application was dismissed on August 31, 2017, 2017 BCSC 1556. His medication was increased. His mental state stabilized. Mr. Schoenborn responded and reengaged in counselling and treatment.

[11] Mr. Schoenborn's last hearing was completed in November 2017. In once again detaining Mr. Schoenborn on existing conditions, the Review Board found that:

- No community access had been granted;
- The accused's symptoms were once again under control;
- The accused continues to be at acute risk of harm from others;
- Despite ongoing episodes of inter-personal conflict, there has been no violence;
- Overall, the accused's progress in anger management was not as positive or robust as in past years, due to the stress of the HRA proceedings; and
- The accused re-engaged appropriately in psychotherapy sessions and gained insight.

ISSUES AT HEARING AND POSITIONS OF THE PARTIES

[12] It is trite to repeat that in order to justify its jurisdiction, the Review Board must, at every hearing, analyze the evidence against the legal framework of the *Code* and first determine whether the accused constitutes a significant threat to public safety.

[13] For the current hearing, all parties, including Mr. Schoenborn, are in agreement that the accused continues to satisfy that jurisdictional threshold and that a less restrictive alternative to a further disposition of detention is neither necessary nor appropriate: s.672.54; 672.5401.

[14] Given that consensus, the parties' positions and in turn the narrow issues to be determined by the Board at this hearing are as follows:

The Crown argues:

- That condition 2 of Mr. Schoenborn's disposition, which delegates to the Director the discretion to permit the accused to exercise Staff Supported or escorted access to the community ("*SSCO*"), should be removed;
- That the BCRB should not mandate or order that the accused be permitted SSCO's;
- That if condition 2 of the disposition is not removed, or if SSCO's are ordered by the Board, such outings should not be implemented without
  - (i) advance notice to the police, and/or
  - (ii) advance notice to the victims.

The Director Adult Forensic Psychiatric Services ("*AFPS*"), submits that Mr. Schoenborn's next disposition should contain the same terms and conditions as are currently in place, without ordering SSCO's and without requiring the Director to provide the notices set out above.

Mr. Schoenborn submits that the Board should mandate or order the Director to provide him SSCO's, and to do so without the notice requirement sought by the Crown.

[15] Although we consider all the evidence on the record in this case, we only recite that which we consider relevant and necessary to decide the narrow issues before us at this hearing.

THE EVIDENCE

[16] The evidence on behalf of the Director was provided in the form of the report (Ex.69), and the *viva voce* testimony of Dr. Hediger, who has been Mr. Schoenborn's treating psychiatrist since January 2012.

THE ACCUSED'S CLINICAL PROGRESS

[17] Dr. Hediger continues to endorse, as Mr. Schoenborn's diagnoses, Delusional Disorder, multiple Substance Use Disorders (alcohol, marijuana, hallucinogens, and cocaine), and Paranoid Personality traits.

[18] The symptoms of Delusional Disorder, such as delusions or hallucinations, including false beliefs of a paranoid nature, are not in evidence. They resolved early and have been in remission in response to treatment, except for a breakthrough in 2016-2017 during a period of considerable stress, which in Dr. Hediger's opinion was occasioned by the Crown's HRA application. Mr. Schoenborn has good insight into his need for medication. There are absolutely no issues or concerns in regard to his compliance.

[19] Mr. Schoenborn has maintained total abstinence from alcohol and substances since his admission to FPH. After initially participating in drug and alcohol treatment, early in his tenure at FPH, Mr. Schoenborn has declined further alcohol and substance program opportunities. Dr. Hediger agrees that, in light of the accused's abstinence, absent any evidence of cravings, and though alcohol/substance use remains a risk factor for future consideration, this aspect of his diagnosis is not currently a major or active clinical or risk management issue. Mr. Schoenborn says he would attend drug and alcohol programs once back in the community.

[20] It is Mr. Schoenborn's personality traits, in particular, his emotional regulation, impulse control, and anger management issues, which remain the focus and targets of current treatment. This aspect of the accused's functioning is exemplified by his tendency or predisposition to interpret interactions and situations as negative, disrespectful, insulting or even threatening toward himself. His personality features leave him prone to misinterpreting or misperceiving even otherwise innocent or neutral comments in a negative way. He can then escalate or react impulsively and disproportionally to provocations rather than "letting

things go". These issues are interrelated and they are being addressed by psychotherapy treatment.

[21] Dr. Hediger testified that Mr. Schoenborn's ability to reflect upon and to manage such incidents, without escalating even to verbal aggression, has demonstrably improved. His ability to identify and tolerate his own thinking errors in relation to perceived insult and to moderate his anger and his response, rather than responding verbally, has increased because of his consistent and active participation in psychological counselling to deal with these features of his personality construct. With his ongoing positive engagement both the frequency and intensity of negative incidents is diminishing. He has developed reasonable cognitive insight into his emotional reactivity. His thinking is more flexible. He has, in therapy, demonstrated an ability to reflect on his communication style and he recognizes that at times, he can come across as aggressive.

[22] Despite this positive progress in these areas of both clinical and risk concern, Dr. Hediger says that further intervention, management and monitoring is required to help the accused utilize and apply his insight and understanding in the course of his day-to-day behaviour. Dr. Hediger says that Mr. Schoenborn agrees and is motivated to continue to engage in therapy. His rapport with his treatment providers and his attitude toward treatment are positive. Dr. Hediger also adds that no recent negative interactions have risen to a level of violence or even worrisome verbal responses. Under cross examination Dr. Hediger summarized his evidence in this area as follows:

> [ ]The issues when they have surfaced does (*sic*) indicate everything that we have been speaking about, but there haven't been any concerning incidents. We haven't, for example, thought of seclusion or transferring Mr. Schoenborn off the unit. He – he's – he tends to settle himself down actually quite quickly now. After these incidents, as he indicated *(sic)*, it's fairly easy to talk to him about these incidents, to process them. I do think he learns from them.

[23] There also exists the ongoing or residual concern (given the accused's profile), that in the community the risk of a "negative interaction" would increase.

EVIDENCE ON THE ISSUE OF ESCORTED COMMUNITY ACCESS (SSCO)

[24] In light of the restricted scope of the hearing, much of Dr. Hediger's lengthy evidence focused on the issue of Mr. Schoenborn's access to the community under staff escort and supervision (SSCO).

[25] Although the accused's disposition has, since 2015, contemplated or considered escorted community access (SSCO) in the discretion of the Director, it has not been implemented, or even applied for, in the context of the hospital's internal, administrative approval process. Dr. Hediger believes that further progress or improvement, in terms of Mr. Schoenborn's ability to deal with, and tolerate, emotional and anger management challenges, especially as these might arise or be triggered in the community, is required. More particularly, the issue which requires additional work is the accused's ability to tolerate or control his response to a negative incident in the community - to let things go rather than ruminate and react. Though Mr. Schoenborn says he would remove himself from confrontation, comply with staff direction to manage the situation, and return to hospital in the event of a confrontation, Dr. Hediger is not yet confident in his ability to manage such an eventuality appropriately.

[26] In his testimony, Dr. Hediger described the range or levels of FPH's outings, including "Assessment SSCO's", involving a single patient with no less than two staff, as well as small and larger group SSCO's. Dr. Hediger essentially restricted his evidence in this case to the lowest form of outing, the "Assessment SSCO", components of which involve unique, individualized, plans including:

- determination of the number of staff escorts;
- determining the venue, destination and duration of the outing;
- identification and assessment of attendant risks including of "public exposure"; and,
- contingency planning, including the management of any negative interactions;

[27] Dr. Hediger also acknowledged that such outings can include escort by a highly trained, uniformed Forensic Security Officer ("*FSO*"), and said that, "… we can do almost anything that we need to do, and we can customize it and personalize it to the needs of the specific individual…".

[28] Under cross examination, Dr. Hediger actually acknowledged that Mr. Schoenborn could be considered for an Assessment SSCO with careful consideration of the proposed venue or setting and of any potential risks that might be encountered. He sees no particular difficulty if the accused is accompanied by a group of staff, in an environment

where there exists no opportunity for contact with the public, for a brief period of time. When asked whether it would be appropriate at some point for the accused to be tested in the community in a prudent, managed way, Dr. Hediger said, “If we’re defining (the public place) as a walk along an area where there’s no public involved… for a brief period of time, that’s able to be considered”. At the least, he thinks, this could be accomplished or implemented within a period of six months. He as much as conceded that a brief, controlled outing to an isolated destination, with no likelihood of public or victim contact is not now unreasonable. He also testified that Mr. Schoenborn is not considered an elevated elopement risk. There has at no time been evidence of any animus toward victims or former family members.

[29] Despite what may appear as extraordinary measures, Dr. Hediger testified that planning an SSCO in Mr. Schoenborn’s case would not differ from the “standard procedure” that would be undertaken in respect of any other patient. He essentially said that Mr. Schoenborn is not unique. He is relatively common among FPH patients in terms of his clinical presentation. What is unique or distinguishing about this accused is the high profile or notoriety of his case.

[30] In response to the Crown’s submission to amend Mr. Schoenborn’s disposition and to withdraw even the discretionary possibility of SSCO’s, Dr. Hediger testified that despite recognizing and accepting his issues and being motivated to engage and gain further improvement, Mr. Schoenborn feels that he has done what is required of him to warrant SSCO’s. It is then entirely understandable that he would experience the withdrawal of even the potential for SSCO’s as a setback with a likely negative impact on his mood and engagement.

[31] Dr. Hediger testified that for the Board to order mandatory SSCO’s would require a “cumbersome” and significant process of planning, although he did not say how this would be different from the apparently meticulous and detailed process which occurs before any Assessment SSCO as described above.

FPH POLICY & PROCEDURES RE SSCO’S

[32] The Crown submitted into evidence, the hospital’s policy guidelines which govern SSCO’s: Ex. 72. Although it is not argued that the Review Board’s authority to make or implement its orders is fettered by internal FPH polices or procedures, the material filed is

helpful in describing or setting out the careful and fastidious pre-outing planning process spoken to by Dr. Hediger. That process would apply equally should the Director in his discretion decide to provide, or if the Board were to order that Mr. Schoenborn be granted SSCO's. Our consideration of the evidence of the relevant, component elements of an Assessment SSCO are set out below.

I. PRE-OUTING ASSESSMENT

- Once approved for an outing hospital staff determine its composition in terms of staff-to-patient ratio;
- Prior to the outing, staff will determine and know the destination of the outing with consideration to location; location of parking; location of washrooms and all washroom exits; potential for public contact; any limitations outlined in a Review Board order; potential risk; and strategies to mitigate risk;
- SSCO destination will generally be within 15 minutes drive from FPH and under two hours in duration; and
- Suitability of the destination is assessed considering the level of community integration appropriate for the patient; the degree of public access and potential for public interaction; the distance from the Forensic Psychiatric Hospital; the patient's ability to participate in the outing, taking into consideration the purpose and destination; a review of any alerts, or limitations to specific geographic locations or persons; any No Contact Orders; expected time of return; and
- A pre-outing suitability clinical/mental status assessment is conducted.

II. REQUIREMENTS DURING OUTING

- At least, two trained staff will accompany a single patient;
- Patient is at all times kept within visual line of sight and in close proximity to staff;

- Smoking is not permitted;
- Hourly contact with Forensic Security Office is maintained and expected time of return is confirmed;
- Staff may terminate the outing at any time for reasons of patient, staff or public safety or if the destination is deemed inappropriate;
- Any problematic interactions are documented including injuries or elopement attempts which are dealt with according to policy;
- Post-outing procedures include documentation of return, searches of the patient and recommendations.

[33] It is agreed, on the evidence, that an Assessment SSCO may, in addition to two staff, also include a Forensic Security Officer ("*FSO*"), based on a specific risk mitigation plan: Ex. 73.

THE ACCUSED'S EVIDENCE

[34] Mr. Schoenborn testified that he currently attends psychotherapy sessions of 40 to 45 minutes' duration, every three weeks, as well as other programs. He described his conversations with his therapist. He described incidents involving conflicts with other patients which might provoke a verbal exchange. He says he is able to walk away more readily than in the past. He agrees there is still work to be done in this area. He also believes he could "brush off", and not engage in an interaction while on an SSCO in order to advance in his therapy.

[35] Mr. Schoenborn says that even a hypothetical outing, limited to a 500 yard walk down a highway and back (obviously escorted), would be "enticing" to him. He says he would be thankful for what he can get. He says he is not interested in elopement or in becoming a "fugitive".

ANALYSIS AND DECISION: SSCO'S

[36] With the agreement of the parties we confine ourselves to the narrow issues of whether to mandate outings for Mr. Schoenborn, whether to withdraw the discretion in the Director to afford SSCO's or whether to maintain the status quo in place since 2015.

[37] It is conceded that Mr. Schoenborn continues to satisfy the threshold jurisdictional issue, that is, he continues to meet the definition of significant threat:

> 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): ***Calles v. British Columbia (Adult Forensic Psychiatric Services)***, 2016 BCCA 318, (para 15).

[38] Having concluded that Mr. Schoenborn 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, 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, para 22

[39] All the parties are in agreement that detention remains the necessary and appropriate disposition.

[40] We remind ourselves that in ***Tulikorpi,*** (2004) 182 CCC (3d) 193, the SCC said that the requirement to make the least onerous and least restrictive disposition also

extends to, and includes the conditions which are contained in the disposition: see also ***Mazzei*** [2006] S.C.J. No. 7.

[41] Simply put, the Crown argues that condition number 2 in Mr. Schoenborn's disposition is neither necessary nor appropriate based on Dr. Hediger's evidence that, despite slow improvement, the accused's residual personality issues (the implications of which are set out above), are such that he is not ready for SSCO's. He continues to face challenges of perception and impulsivity.

[42] The Crown further argues that nothing in the evidence justifies or supports Board-ordered or mandated SSCO's.

[43] The Director submits that the discretionary SSCO condition in Mr. Schoenborn's disposition should continue on the basis that:

- the condition would only be implemented when the accused is mentally stable and his risk manageable, and even then under a complex, stringent and multifactorial process; and
- the condition serves a motivational purpose in maintaining the accused's therapeutic engagement; removal would have a negative effect.

[44] On the issue of mandating SSCO's, the Director submits that:

- the accused's capacity to manage a negative interaction in the community is untested;
- the accused's public profile, raising a real risk of a negative interaction in the community, is of concern; and
- the expert evidence regarding the accused's clinical progress does not warrant mandatory SSCO's.

[45] Mr. Schoenborn submits that:

- discretionary SSCO's have not, despite his progress, been granted; this constitutes a "treatment impasse"; and

- Dr. Hediger's evidence is that with careful planning, limited outings are not untenable

[46] Mr. Schoenborn has remained stable, compliant and the symptoms of his illness are under control; drugs and alcohol are not a current issue.

[47] Dr. Hediger's evidence in relation to Mr. Schoenborn's clinical progress and the improvements he has made in the personality-based areas of impulsivity, emotional regulation and managing anger (the current primary targets of treatment), is clear. Mr. Schoenborn has demonstrably improved in the areas which continue to be of concern. He has shown an ability to manage provocative incidents or interactions, and to moderate his emotional response, without engaging in even verbal, much less physical aggression. Having gained insight into this realm of his functioning, Mr. Schoenborn agrees that further positive progress is needed. He is both willing and motivated to continue to engage and to actively participate in treatment.

[48] Dr. Hediger's evidence on the issue of SSCO's is more equivocal. He says SSCO's have not been provided because more progress is required in the clinical realm discussed above. He seeks a higher level of confidence in the accused's ability to manage confrontation, especially given his sense that because of the notoriety of his case, the risk of a triggering event in the community is real.

[49] Dr. Hediger resists the notion of mandatory outings because of the significant and "cumbersome" planning this would entail. He does not describe that it would differ appreciably from the process that precedes any Assessment SSCO for any patient.

[50] That said, Mr. Schoenborn is, from a clinical and risk management perspective, not atypical or different from other accused patients in FPH, many of whom are granted access to the community. In any case, the careful, rigorous planning and assessment procedures described in the evidence, are implemented consistently. What appear to be unique obstacles for Mr. Schoenborn are his curtailed ambit within the hospital due to an acute level of threat to his person and his public profile, raising the possibility of a negative event in the community. Neither of these are within Mr. Schoenborn's control or ability to meaningfully ameliorate. Nor are these issues which are amenable to clinical intervention.

A Treatment Impasse?

[51] Since ***Mazzei***, courts have said that the Board is required to inquire into the question of a treatment impasse as part of its inquisitorial function: ***Re Trang***, (2017) ONCA 63. A treatment impasse may exist where there has been a lengthy period of incarceration without treatment or progress toward reintegration. In such cases the Board must consider imposing conditions (eg. ordering an independent assessment), to break the impasse: ***Re Ginn*** (2017) ONCA 921; ***Re Gonzales*** (2017) ONCA102. Mr. Schoenborn argues that because discretionary SSCO's have not been implemented for several years, there exists a treatment impasse. This case does not, in our view, justify that label.

[52] Not only has Mr. Schoenborn's treatment achieved positive progress in increasing his insight and control in problematic areas of his personality functioning, he agrees that further improvement is achievable and desirable. To that end, he remains a motivated, engaged, participant in future treatment and program opportunities.

[53] Despite the current slow pace of achieving even Assessment SSCO's, **we are not persuaded that it is reasonably necessary to order mandatory outings as a condition of Mr. Schoenborn's disposition at this time.**

[54] However, having carefully considered the Crown's respectful and measured submissions on the issue, for the reasons set out above, as well as to avoid the very real possibility of inflicting serious damage on Mr. Schoenborn's motivation, engagement and therapeutic trajectory, **we are not persuaded, on the evidence, that after 3.5 years, it is necessary or at all reasonable to remove condition 2 from the accused's disposition**.

[55] Although, Mr. Schoenborn's disposition will continue on current terms and conditions, the Board recommends or expects that, within the ensuing six-month period, he should be provided with an Assessment SSCO, within the framework and process of the discretion delegated to the Director to do so. Having regard to Dr. Hediger's evidence that careful highly individualized planning is possible and bearing in mind the rigorous parameters of the Director's own policy requirements, there is no conceivable reason why an Assessment SSCO, escorted by two staff as well as an FSO; to a rural destination; beyond any municipality inhabited by any victim; away from, or even in a non-public area and for a limited period of time could not be implemented without raising, even the

possibility of any unmanageable or unassumable risk to anyone. In our view, this comports with the Director's obligation to remain vigilant to ensuring the disposition is the least onerous and least restrictive in the circumstances: see for example ***Re Campbell***, 2018 ONCA 140 at para. 52, 53, 59. Mr. Schoenborn has properly been subject to the full weight of the Criminal Justice System for close to a decade. There exists no principled reason or basis why he should be deprived of the policy objectives and presumptions Parliament has seen fit to entrench in the *Code* for all NCR accused persons. If our recommendation is not implemented the Board may wish to reconvene of its own motion to reconsider the issue of mandated SSCO's.

ANALYSIS AND DECISION: NOTIFICATION OF POLICE OR VICTIMS

NOTIFICATION OF POLICE

[56] In the course of the hearing and submissions we learned that the Director, at all times, retains the discretion in any specific case to provide advance notice to the RCMP and does so (including photos) when this is considered a necessary, additional safeguard. Similarly the statement of Officer Floris (Ex 71), indicates that there exists a close and regular relationship between the RCMP and FPH on public safety issues.

[57] We are not persuaded to impose on the Director a mandatory requirement to provide advance notice to the police in the event the accused is awarded an Assessment SSCO. We defer to the Director's judgement, as the expert assessor and risk manager, in this respect.

NOTIFICATION OF VICTIMS

[58] The Crown argues that the notification to victims, of an Assessment SSCO to be exercised by the accused, is mandated pursuant to s.8 of the *Canadian Victims Bill of Rights* (s.c.2015), ("*CVBR*").

[59] Section 8 *CVBR* gives victims the right to request information about:

> **(b)** hearings held for the purpose of making dispositions, as defined in subsection 672.1(1) of the *Criminal Code*, in relation to the accused, if the accused is found not criminally responsible on account of mental disorder or unfit to stand trial, and the dispositions made at those hearings.

[60] A disposition is defined as: …"an order made by a court or Review Board under section 672.54, an order made by a court under section 672.58 or a finding made by a court under subsection 672.64(1): s.672.1(1)".

[61] The Crown says that a delegation of authority to the Director, to increase or decrease restrictions on an accused's liberty under s.672.56, is deemed to be a disposition. Therefore, the exercise of such discretionary authority is itself a disposition and subject to s.8 of the *CVBR*: that is, in order to meet its objectives, notice of the time and location of a planned outing is required.

[62] ***Re DB*** (2017 CanLi 93597 (QCTAO)), held that s.8 of the *CVBR* gives victims the right to a Review Board decision, including the conditions of release. It does not suggest that a delegation of authority under s.672.56, or perhaps more to the point, the Director's discretionary exercise of that delegated authority, is to be subject to s.8.

[63] Section 672.56, is intended to enable the Director to respond to day to day issues, without requiring a hearing at every adjustment of a patient's privileges. The Crown's argument would have the Board engaged in micromanaging every case under its jurisdiction. It would be inconsistent with providing the Director the necessary ability to make adjustments to privileges based on the health of the NCR accused, (including the ability to act immediately if needed), if the hospital were required to provide victims with notice of every such adjustment should victims request such information. It would also of course be manifestly unworkable.

[64] In introducing the *CVBR* (then) Minister MacKay said:

> Fully implemented, the bill would also extend rights to every stage of the criminal justice process: during the investigation and prosecution of an offence; during the corrections process; during the conditional release process, or parole; and while there are proceedings in the courts and before review boards in respect of an accused found not criminally responsible on account of mental disorder, or who is unfit to stand trial. However, the bill would also provide that the application of the rights cannot interfere with the police or crown prosecution's discretion and must be reasonable in the circumstances. In other words, this is a rubicon that we did not

cross. Going back into the archives, this was in keeping with a parliamentary report entitled, “A Voice, Not a Veto”. That statement encapsulates the intent here.

[65] In ***Re Campbell***, the Ontario Court of Appeal, when speaking about s.672.56(2) recently cautioned:

> Hospitals must be left to do their work free from constant review and all of the demands that a decision-notice-review-decision-notice-review approach would impose.:para 63.

[66] The BCRB and the Director are authorized to permit an accused access to the community when it is safe to do so. They therefore have the discretion to refuse a victim’s request for information. We also note that previously the Board decided that disclosing such information would “put staff and the accused, as well as, potentially, members of the public, at considerable risk in the event such information were to fall into the wrong hands”. Such public safety concerns are entirely appropriate as well as mandatory considerations. Section 20 of the *CVBR* cannot reasonably intend to interfere with the Review Board’s authority or the discretion duly delegated to the Director, especially if doing so would endanger the safety of an individual:

> **20** This Act is to be construed and applied in a manner that is reasonable in circumstances and in a manner that is not likely to:
>
> **…**
>
> (c) interfere with the discretion that may be exercised by any person or body authorized to release an offender into the community;
>
> (d) endanger the life or safety of any individual; …

[67] It is therefore our view that s.8(b) of the *CVBR* does not provide the right to notification about “dispositions” (s.672.1(1)), but rather to information about “hearings held for the purpose of making dispositions….and the dispositions made at those hearings”. Victims have a right to information about the hearing and the orders made; not about the Director’s discretionary exercise of authority, delegated in a disposition (which obviously does not entail a hearing process). Therefore s.8 of the *CVBR* does not require mandatory notification of SSCO’s on the request of victims.

[68] For similar reasons we decline to order that the Director must, in the course of exercising his delegated discretion provide the notice sought by the Crown.

DISPOSITION

[69] Mr. Schoenborn is detained in custody at FPH on the following conditions.

1. THAT he be subject to the general direction and supervision of the Director, Adult Forensic Psychiatric Services ("the Director");

2. THAT, at the Director's discretion he may have escorted access to the community, having regard to his mental condition and the risk he poses to himself or others;

3. THAT he not acquire, possess or use any firearm, explosive or offensive weapon;

4. THAT he not use alcohol or any drugs except as approved by a medical practitioner;

5. THAT at his discretion, the Director may monitor the accused's compliance with this order by testing using urinalysis for the use of alcohol or unprescribed drugs and the accused shall submit to such testing upon the demand of the Director;

6. THAT he have no direct or indirect contact with Darcie Clarke, Valaine Clarke, Stacy Galt, Mike Clarke or Barb Phillips;

7. THAT he keep the peace and be of good behaviour; and

8. THAT he present himself before the Review Board when required.

THE CHAIR (DISSENTING IN PART)

[70] I would simply indicate that, for the reasons articulated, I would have been persuaded to order highly limited, constrained Assessment SSCO’s, under the same stringent and prudent conditions set out above. I cannot recall another accused who, having demonstrated the clinical response and the therapeutic progress that Mr. Schoenborn has, would after 9 years in custody continue to be denied such a modest step.

Reasons written by B. Walter in concurrence with Dr. R. Stevenson and Dr. M. Burnett.

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