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

MANGAL SINGH

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
09 December 2008

BEFORE:

CHAIRPERSON:	A. Pollak
MEMBERS:	Dr. W. Warrian, psychiatrist
	L. Chow

APPEARANCES:

ACCUSED/PATIENT:	Mangal Singh
ACCUSED/PATIENT ADVOCATE:	T. Reyes
DIRECTOR AFPS:	S. Letwin Dr. G. Gharakhanian
ATTORNEY GENERAL:	G. Kabanuk

Released January 20, 2009.

[1] These are the reasons in the matter of Mangal Singh, a 78-year-old man found not criminally responsible by reason of mental disorder on 5 September 2003. On 9 July 2008 an order was made detaining Mr. Singh in hospital. That order was reviewed within six months of its having been made, pursuant to section 672.63. On 9 December 2008 a hearing was convened to review that disposition, pursuant to section 672.81(1) of the *Criminal Code*. At the conclusion of the hearing the disposition and reasons were reserved. These are the reasons for disposition.

[2] The index offence was the second degree murder of Mr. Singh's wife on 2 March 2002. Mr. Singh reported that his wife had asked him to kill her. They were at home in the house they shared with their daughter and her family. He remained in the home, with his wife's body in their bedroom while emergency paramedics examined the body.

[3] Before the onset of his mental illness in 2001, Mr. Singh had been a high-functioning and responsible family man. Prior to the index offence, he had been treated for profound depression and anxiety. At the time of the index offence he had not taken his medication for about two months and was actively psychotic.

[4] Mr. Singh has been suitable for management in a community setting since at least September 2005. The recent reports are that he remains cooperative and compliant in all aspects of his care, with no overt symptoms of his illness. He enjoys visits leaves to his daughter's or son's home, and other community outings with staff.

[5] The difficulty in his reintegration has been that he requires a supervised placement in the community because the medication regime required to manage his illness safely is beyond his ability to self administer. The additional complication is that he does not agree to accommodation in any setting in which he cannot have a private room. Thus far the only facility in the community that would offer him that level of privacy has insisted that he be supervised in a mixed-gender setting prior to his being accepted for placement. The Forensic Psychiatric Hospital has no mixed-gender setting to offer. More recently, the treatment team has received information that a mental health boarding home, Chrysalis House, is converting its accommodation to private rooms and that within the next year they will likely be in a position to offer Mr. Singh accommodation.

[6] The diagnosis is major depression with psychotic features, in remission with medications, and early dementia.

[7] In his evidence at the hearing, Dr. Gharakhanian stated that there has not been much change in Mr. Singh's presentation since the last hearing in this matter. He linked Mr. Singh's risk for violence to circumstances in which he would discontinue his medication, leading to a deterioration in his mental state and an associated risk of his "acting out." Given the nature of his index offence, Dr. Gharakhanian was of the opinion Mr. Singh ought to be accommodated in a single-bed, private room in a care facility in the community.

[8] Dr. Gharakhanian also added that in the absence of continued Review Board jurisdiction, Mr. Singh's care would be managed under the *Mental Health Act* until suitable accommodation could be found for him in the community. He said he would certify Mr. Singh under that Act and maintain him in hospital until some other place became available, and that similar options for accommodation would be available to Mr. Singh under either the forensic or the civil mental health structures.

[9] Dr. Gharakhanian also noted that Mr. Singh's dementia is, for the time being, stabilized because his cardiac condition is now well managed. He does still expect some deterioration, as likely Mr. Singh's dementia originates in some degenerative condition, as well as his cardiac condition.

[10] Ms. Letwin, Mr. Singh's Case Management Coordinator, noted in her evidence that Chrysalis House is a mental health resource, and not seniors' housing. She said that Mr. Singh currently functions well with the younger population in the hospital. Although the single focus of his risk management is on the responsible administration of his medications, given the nature of the index offence, Mr. Singh's family is understandably unwilling to accommodate him at home. His family has reported to the treatment team that Mr. Singh may be exposed to the stress of negative attitudes from people in the community because of the nature of the index offence.

[11] In his current report, Dr. Gharakhanian notes,

> "His depressive and psychotic symptoms are in remission with medications and his current regimen of medications has been quite effective. However he needs to be monitored closely in a supervised setting for his own safety and the safety of others since the natural history of his mental illness is such that relapses could happen even in medication compliant individuals. Given the seriousness of the index offence, his mental condition should be closely monitored in the community. The intensity of psychiatric care and supervision that he requires may be available in the community provided he resides in a closely monitored facility."

[12] Although Mr. Singh did not instruct his advocate to lead any evidence, he did not object to answering questions we put to him. He understood that he was before the Review Board because he had killed his wife. He understood that he needs to take medication three times daily. He said he has never managed his medications on his own, but he was willing to try. He also acknowledged that he has a poor memory.

[13] Mr. Singh told us that he is currently living on the Elm South unit of the hospital, where he is responsible for the coffee service, and also some cleaning. He said he goes to the gym every weekday at 10:00 a.m., and that he visits on weekends with his family. He said that he is happy at FPH and would rather stay there than move to Riverview Hospital, a psychiatric hospital under the civil mental health system.

[14] The closing submissions of all three parties were very brief. The Director sought another custody order in the same terms as the last. Counsel for the Attorney General asserted that Mr. Singh still meets the threshold test for our jurisdiction. He said that a custody order was the least restrictive, least onerous order appropriate, adding that it was not ideal, but we could hope Mr. Singh will have a visit leave to try out a community placement in the coming year. Mr. Singh, through his advocate, noted that he would like to maintain status quo while awaiting placement in the community.

[15] We recognize that at the time of the last disposition, another panel of this Board saw itself in a position analogous to the Review Board in the matter of Brockville Psychiatric Hospital v. McGillis, [1996] O.J. No. 3430, 93 O.A.C. 226, 2 C.R. (5th) 242, 66 A.C.W.S. (3d) 139, 32 W.C.B. (2d) 216 (Ont.CA). In that case, the Ontario Review Board was satisfied that the accused could only safely reside outside of the hospital if he lived in a place approved by the hospital administrator (in this jurisdiction known as the Director). Clearly the accused in McGillis, and the accused six months ago in the instant case, were found to be a significant threat to public safety.

[16] However, in the reasons of the last panel in this case, we also note the following:

> "We do need to reflect, however, that it is in our view becoming significantly problematic to continue Mr. Singh under our jurisdiction under the current circumstances. Mr. Singh has given no indication that he is a significant threat to any other individual as long as his medical and, to some extent, his care needs are met. There is some urgency to finding a less onerous and less restrictive residential resource for this accused than his current hospital-based environment."
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> ***Disposition Information***, Exhibit 27, para.14

[17] After considering the disposition information, and the evidence and submissions of the parties at the hearing, we conclude that Mr. Singh no longer meets the test for our jurisdiction. We have in mind the following direction of the Supreme Court of Canada in coming to that conclusion:

> ¶ 49 … absent a finding that the NCR accused represents a significant risk to the safety of the public, there can be no constitutional basis for restricting his or her liberty.
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> ¶ 51 This interpretation does not expose the community to undue threats to its safety and well-being. The task of the court or Review Board is to determine whether the evidence discloses a "significant" or real risk to the community should the NCR accused be released. If that risk exists, the NCR accused remains under supervision, either subject to conditions while living in the community or detained in a hospital… [T]he court or Review Board [is] required to determine whether or not releasing the NCR accused would pose a "significant risk" to public safety. If, at the end the day, the court or Review Board cannot so conclude, the legal justification for confinement is absent and the NCR accused must be released.
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> ***Winko v. British Columbia (Forensic Psychiatric Institute),*** [1999] 2 S.C.R. 625, para.49-51

[18] We had in mind the particular interpretation that court has provided of the words "significant threat."

> ¶ 57 … Section 672.54 provides that an NCR accused shall be discharged absolutely if he or she is not a "significant threat to the safety of the public". To engage these provisions of the *Criminal Code*, the 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 minuscule risk of a 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: *Chambers v. British Columbia (Attorney General)* (1997), 116 C.C.C. (3d) 406 (B.C.C.A.), at p. 413. In short, Part XX.1 can only maintain its authority over an NCR accused where the court or Review Board concludes that the individual poses a significant risk of committing a serious criminal offence. If that finding of significant risk cannot be made, there is no power in Part XX.1 to maintain restraints on the NCR accused's liberty.
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> ***Winko, supra***, para.57

[19] The only history of threat or violence before us in this matter is the index offence. We do not find we can conclude that Mr. Singh continues to present a significant threat to others based only on the index offence, and we rely on the following in support of that conclusion:

> ¶ 60 When making this difficult assessment of whether an NCR accused poses a significant threat to the safety of the public, a court or Review Board may be expected to be aware not only of the need for public protection, but of the fact that a past offence committed under the influence of mental illness may often bear little connection to the likelihood of reoffending, particularly when the NCR accused is successfully following a treatment program. At the same time, the commission of an offence in the past may in some circumstances constitute a link in a chain of events that demonstrates a propensity to commit harm, albeit unintentionally. The specific situation of each NCR accused must always be examined carefully.
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> ***Winko, supra***, para.60

[20] This is not a case in which the index offence would "constitute a link in a chain of events that demonstrates a propensity to commit harm." The links of causality in this case include the psychotic features of Mr. Singh's illness, his dementia which impairs his ability to manage his own medications, the likelihood that his mental state would deteriorate in the absence of medications, and the possibility that while psychotic he might harm someone. These links have been made just once in Mr. Singh's history, albeit with tragic consequence. Mr. Singh has no demonstrated propensity to commit harm, having a history of just one violent act committed while he was unmedicated, ill, and unsupervised in the community.

[21] The evidence before us was that the key to Mr. Singh's risk management is the responsible administration of his medications. The evidence was that this would be the approach to his care with or without our jurisdiction. At the time of the index offence, Mr. Singh had been unmedicated for two months. The evidence before us was that Mr. Singh will be in a supervised care facility, where a key aspect of his care will be the administration of his medications by staff.

[22] Dr. Gharakhanian's evidence about relapse in compliant individuals was general, and not specific to Mr. Singh. Given Mr. Singh's favourable history before and since the index offence, and in particular in the past three years, we did not find that the evidence before us supported a finding that his current and future risk to others is sufficient to meet the threshold for our jurisdiction. Accordingly, we have made an order for his absolute discharge.

Reasons prepared by Ms. Pollak, 29 December 2008. Dr. Warrian and Ms. Chow concurring.