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

BENEDICT BERNABE TOMAJIN

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
March 8, 2017

BEFORE:	**CHAIRPERSON:**	**B. Walter (dissenting)**
	MEMBERS:	**Dr. L. Grasswick, psychiatrist**
		K. Polowek
		Dr. L. Murdoch (ex officio)

APPEARANCES:
ACCUSED/PATIENT: Benedict Bernabe Tomajin
ACCUSED/PATIENT ADVOCATE: T. Reyes
DIRECTOR AFPS: Dr. M. Hediger, B. Lohmann
DIRECTOR'S COUNSEL:
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION

[1] On March 8, 2017, the British Columbia Review Board convened a hearing to review the disposition of Benedict Bernabe Tomajin, the accused, who is now 30 years of age. On August 8, 2011, Mr. Tomajin was charged with second degree murder of his mother, contrary to s. 235 (1) of the *Criminal Code*. When police responded they found that the accused's mother had been stabbed multiple times in full view of witnesses. On arrest, the accused reported having heard voices for several months before the index offence. He was a reported user of alcohol and crystal meth, if not at, at least proximate to, the time of the offence. He had also consumed beer on the date of the offence.

BACKGROUND

[2] The accused immigrated to Canada from the Philippines in 2007, at the age of 20. In or around 2009 to 2010, he married a woman from the Philippines and they lived together in the victim's home. The relationship ended in October of 2010, amidst allegations of the accused’s paranoia, as well as aggression. On August 18, 2010, he was accused of assaulting his wife, which he denied. The domestic difficulties appear to have arisen in the context of the accused's drug and alcohol use. He disclosed that he had been using crystal methamphetamine from age 14, with intermittent episodes of abstinence, after his arrival in Canada.

[3] After the breakup of his marriage, Mr. Tomajin started to binge drink briefly. He apparently also resumed his use of crystal meth at least on a weekly basis, again, interspersed with periods of abstinence. He resumed using that substance in April of 2011. Shortly thereafter his auditory hallucinations started. Although the index offence occurred in August, Mr. Tomajin reported that his last use of crystal meth was in June 2011.

[4] In March of 2011, Mr. Tomajin was apprehended and hospitalized due to an apparent suicide attempt. He also called police in June of 2011, in response to voices. Although he has no criminal record, Mr. Tomajin has experienced a number of police contacts in the context of disturbing behaviour.

[5] Mr. Tomajin was first assessed by Dr. Smith, a forensic psychiatrist, who diagnosed a psychotic disorder, including persecutory and delusional beliefs and auditory hallucinations, developing in the context of crystal methamphetamine use.

[6] On February 5, 2014, on the basis of an agreed statement of facts filed with the court, Mr. Tomajin was given a verdict of NCRMD and committed to FPH. On February 28,

2014 he was admitted to FPH from North Fraser Pretrial Center, at which time he denied any recent auditory or other psychotic symptoms and presented as settled and cooperative. His diagnosis was considered unclear and a work in progress. Mr. Tomajin has been detained since his admission to FPH after his verdict.

[7] Over the years, Mr. Tomajin has been subjected to an array of tests and programs. In March of 2015, testing suggested that he was average or above in reasoning ability and not psychotic. As of his admission, and on the basis of the remission of his psychotic symptoms Mr. Tomajin has not been on any antipsychotic medication. As a result of periodic episodes of low mood or depression, he is prescribed an antidepressant medication. Mr. Tomajin has attended programs and has participated appropriately. He has been behaviourally stable, settled, and cooperative.

[8] Outstanding concerns include that he may be vulnerable to stress and that he has difficulty acknowledging an anger component in his makeup, but he was, even as of 2015, able to participate first in assessment outings and then progress through the various levels of privileges available in the hospital.

[9] Importantly, given the context of the index offence and his history, Mr. Tomajin has remained entirely abstinent of substances, despite opportunities to use while in hospital. He denies experiencing any cravings to use drugs or alcohol.

EVIDENCE AT HEARING

[10] In preparation for the current hearing, Mr. Tomajin submitted a number of program evaluations or summaries intended to demonstrate that he has participated appropriately in a dual diagnosis program, which includes an anger management component. He has also appropriately completed transit skills and a drug and alcohol program named Matrix, the goal of which is abstinence from all substances. That summary reports that he has yielded no positive urine screens and that his attendance and engagement were positive.

[11] Mr. Tomajin's family is in regular contact with him and, as of August 2016, he has been approved for day leaves under the supervision of family members. His family's feedback from those experiences has been positive.

[12] Mr. Tomajin has apparently apologized to his family for the index offence and has been forgiven. He has made a promise never to drink or use drugs in the future. He has already been introduced to an outpatient treatment team.

[13] Dr. Hediger is Mr. Tomajin's treating psychiatrist. His evidence, written and oral, is that he is extremely happy with the accused's progress. Mr. Tomajin has done extremely well and been stable and entirely symptom free for some time. He demonstrates both medication and treatment compliance. Since his admission to hospital there has been no evidence of any drug or alcohol issues. He has participated in recommended programs. Dr. Hediger suggests that the accused has good insight into his illness, including the risk implications of substance use. He has been free of any verbal or physical aggression or concerning behaviour in any form, including in the context of extensive and progressive community access, including under family supervision. He remains free of prescribed antipsychotic medication. Dr. Hediger believes Mr. Tomajin is motivated to remain abstinent, as he has been these past years.

[14] On the issue of diagnostic clarity, Dr. Hediger's analysis is that Mr. Tomajin first experienced symptoms of psychosis in 2010, a year or so preceding the index offence and proximate to the time of his marriage breakup. He was certainly severely psychotic at the time of the index offence. Any diagnostic conundrum originates in the fact that Mr. Tomajin's symptoms of psychosis appear to always have occurred at or close to the time when he was using crystal methamphetamine. This renders the identification of a cause of his psychotic symptoms or diagnosis less clear. Another complicating factor is that Mr. Tomajin's psychosis apparently continued for some period of time after his arrest and while he was in a secure setting where he would not have had access to substances. However, as Mr. Tomajin has been free of antipsychotic medications for several years, with no active positive or negative symptoms, Dr. Hediger, at this stage, prefers a diagnosis of drug induced psychosis rather than a schizophreniform type of psychotic illness.

[15] Further, Dr. Hediger also testified that on the diagnostic front, he assigns no personality disorder or traits.

[16] In terms of analyzing the accused's outstanding risk or potential risk of harm, Dr. Hediger's analysis begins with the serious and ultimately violent and fatal index offence in the context of severe substance induced psychosis. Therefore, the possibility of a relapse to substance abuse is Mr. Tomajin's key outstanding risk factor. From a positive

perspective, Mr. Tomajin has been entirely abstinent since the index offence. He has good insight into the risks associated with substances and the need to remain abstinent, especially given the high risk combination of alcohol and crystal meth.

[17] Dr. Hediger considers Mr. Tomajin genuinely remorseful and motivated to abstain. He repeats that Mr. Tomajin has been well engaged in programs and treatment. He is calm, has good family support, and no extended history of violence. Nevertheless, Dr. Hediger has outstanding concerns that in the context of relationship problems, possibly financial stressors, or even boredom, and based on Mr. Tomajin's use of destabilizing substances from a young age, that he could under a variety of stressors relapse. Dr. Hediger believes that Mr. Tomajin may underestimate his own chances of remaining abstinent. Mr. Tomajin is also described as capable, high functioning and conceptually and cognitively adept. He is unguarded and enjoys good rapport with his treatment team. He has taken advice without resistance.

[18] Pressed on the issue of his residual concerns, Dr. Hediger cited family dynamics; the possibility of stressors arising from intrafamilial issues or conflicts which could subject Mr. Tomajin to unexpected stress. Second, Dr. Hediger raised some concern about the lack of timely responsiveness of Mr. Tomajin's family to providing meaningful feedback when contacted by the treatment team. He cites this as a potential concern should problems arise requiring appropriate feedback. He describes this concern or problem as not insurmountable. Third, Dr. Hediger reports concerning episodes of anger, irritability, or frustration when Mr. Tomajin's needs are not met. Though these features have improved as Mr. Tomajin has been exposed to programs, his concern is that these behaviours have not been tested or challenged in the community. They, as well as disappointments and boredom, could put him at risk for relapse to stimulant abuse.

[19] As Mr. Tomajin is not on any antipsychotic medication, Dr. Hediger opines that the only way to gauge his risk of relapse to psychosis is through the passage of time. Certainly, he is at highly elevated risk of psychosis if he relapses to substances. Dr. Hediger does not believe that Mr. Tomajin is a proximate risk to members of his family and believes that he would most certainly behave and abstain in the short term. However, he would prefer to see Mr. Tomajin's reintegration and his resiliency to be tested, before discharge, to a less restrictive but somewhat supervised and supported setting, such as the CTC (Coast Cottages) program, for at least a short period of time. He also

recommends that Mr. Tomajin continue to participate in drug and alcohol counseling once he is discharged from hospital.

[20] Mr. Tomajin's daily living skills are adequate to the extent that he did not require placement in the pre-discharge learning environment of the Hawthorn unit. He has attended occasional placements from hospital with good feedback and has also participated extensively in a job preparation and readiness program. He is highly motivated to work but, given his overall presentation, may have a tendency to lose interest or enthusiasm over time. That is the boredom component mentioned above. For those reasons, Dr. Hediger recommends a further period of six months in detention, during which Mr. Tomajin would be provided with overnight visit leaves, on an adjustment basis, to CTC.

[21] Mr. Tomajin filed his relapse prevention plan indicating that he has completed at least ten programs during his two years on the Elm ward. He was able to outline his daily and weekly activities in some detail. He says that on Saturdays he uses unescorted leisure outings for six hours and on Sundays he visits with his family, though he has not yet stayed with them overnight. He has been in another work placement since January and says that he has participated in other vocational and voluntary placements as well as a job readiness and search program.

[22] Mr. Tomajin describes his relationship with his family really good. If he is permitted to reside with his family he plans to seek part time work so as to be able to contribute to rent and household expenses.

[23] Mr. Tomajin says that he has been entirely abstinent since 2011. He freely admits his extensive alcohol and crystal meth history which he accepts was an addiction. He understands that a relapse to alcohol or substances could trigger an onset of illness and agrees to abstain. He was able to describe his pre-index offence symptoms and says that he has not experienced anything amounting to psychosis since at least December of 2013.

[24] Mr. Tomajin testified that his family has forgiven him for the grave index offence and that alcohol or drugs are not used in his household.

[25] Under cross examination of Mr. Tomajin, Mr. Hillaby was somewhat less than impressed with his relapse prevention plan filed. He labeled it a distraction or a red herring and as demonstrating little in the way of understanding of the illness.

[26] Mr. Tomajin's sister was called to testify on his behalf. She was able to describe the layout and residence of her basement apartment which her own family shares with her brother's family. She was unable to provide a cogent explanation of her dilatory pattern of response to inquiries by the treatment team. Frankly in terms of considering her a psychosocial resource in monitoring Mr. Tomajin's mental stability in the community, her evidence did not at this stage inspire confidence.

POSITION OF THE PARTIES

[27] The Director was seeking a 6-month custodial disposition on the same terms and conditions. The representative of the Attorney General supported the Director's position. Mr. Reyes, on behalf of Mr. Tomajin, was seeking a conditional disposition delayed by one month.

ANALYSIS AND DISPOSITION

[28] The Board is required to make an independent decision to determine whether Mr. Tomajin is a significant threat to the safety of the public. If he does not pose such a threat he is entitled to absolute discharge. If he does pose a significant threat to the safety of the public we must then determine what disposition is necessary and appropriate under s. 672.54.

[29] Dr. Hediger noted substance use was the major contributing factor to the psychosis present at the time of the index offence. Substance use remains the main risk factor. There was a considerable length of time when Mr. Tomajin wasn't using drugs and yet he remained psychotic.

[30] Mr. Tomajin has not used substances since the index offence. He has maintained abstinence while at FPH even though there has been use on his unit and the hospital grounds. Mr. Tomajin does not want to return to substance use.

[31] Dr. Hediger and Mr. Tomajin disagree on the potential for relapse to substance use. Dr. Hediger opines the risk could increase as Mr. Tomajin experiences life challenges, anger, or relationship problems. Dr. Hediger is of the opinion these challenges are bigger than what Mr. Tomajin acknowledges, and he bases this on Mr. Tomajin's lengthy history of substance use dating back to his teens.

[32] Boredom and anger are also risk factors for relapse to substance use. There has been improvement in his ability to tolerate frustration and anger within the contained

environment of the hospital. Dr. Hediger is not able to say with certainty how Mr. Tomajin will do in the community. An incident in which Mr. Tomajin smuggled cigarettes into the institution in January 2017 was pointed to as a recent example of his continued vulnerability to boredom and impulsivity.

[33] It was Dr. Hediger's *viva voce* evidence that Mr. Tomajin was virtually non-functional prior to the index offence. He led a disorganized and drug-based lifestyle. He needs to commit to and persist with plans and goals. Dr. Hediger recommends that Mr. Tomajin be tested in a supervised setting such as the CTC before taking up residence with his family.

[34] Mr. Tomajin has completed all the programs he needs. He has regular and frequent community access including unaccompanied day leaves. He has not had overnight leaves as he does not yet have the required privilege level. It is Dr. Hediger's intention to apply for level 6 privileges and then refer Mr. Tomajin to CTC.

[35] The team has concerns about the lack of timely and informative feedback from the family respecting Mr. Tomajin's behaviour while on leave at home. The family home is a basement suite with 3 bedrooms where 8 people live. While Mr. Tomajin has visited the home for short periods on day leave, he has yet to be tested on overnight leaves. There continue to be concerns regarding how the family dynamics will play out in such a crowded and busy home.

[36] No party contended that Mr. Tomajin did not present a significant threat. Dr. Hediger's risk assessment was unchallenged.

[37] Counsel for Mr. Tomajin submitted that the team's plan for placement at CTC was too onerous as he had not yet been referred and there was a long waiting list. A delayed conditional of one month would allow for his family to prepare the living situation.

[38] We conclude that Mr. Tomajin remains a significant threat of relapse to substance use and psychosis if released into the community upon an absolute discharge. Therefore he is a significant threat to the safety of the public and is not entitled to an absolute discharge.

[39] Since we have concluded that Mr. Tomajin must remain within our jurisdiction, we are required for s. 672.54 of the *Criminal Code* to make the disposition that is necessary

and appropriate in the circumstances. The majority of the Board concludes that the necessary and appropriate disposition is a custodial disposition reviewable in six months.

[40] Although we have considered all the evidence on the record, for the purpose of these reasons we only recite that evidence which is necessary to our decision.

MR. WALTER, DISSENTING

[41] On the evidence received in the course of this hearing a persuasive argument could, in my view, be made that Mr. Tomajin no longer satisfies our jurisdictional threshold. This is not, however, the basis of my dissent. Rather, I disagree strongly that the same evidence either reasonably, or in law, justifies his ongoing detention. Mr. Tomajin is entitled to be discharged subject to conditions.

[42] As the evidence has, in the main, been summarized above, I simply highlight the important aspects and my perspectives or interpretations, in summary form.

DIAGNOSIS

[43] Dr. Hediger's diagnosis, after a period of exploration and uncertainty, is now one of a substance induced psychotic disorder and substance use disorder, both in remission. Although Mr. Tomajin continued to demonstrate psychotic symptoms after arrest and in an environment of enforced abstinence, that is the current diagnosis. Dr. Hediger has not seen positive or active symptoms since Mr. Tomajin's admission to FPH or even before the verdict. He shows no negative symptoms or disorganization, even though he has not been, and is not treated with antipsychotic medication.

[44] It is reasonable to conclude then, that Mr. Tomajin's psychosis was likely the product of his extensive use of crystal methamphetamine at times in combination with alcohol.

[45] Mr. Tomajin has never been psychotic except in the context of drug use. Dr. Hediger would not predict the risk of relapse to symptoms, absent drug use.

SUBSTANCE USE

[46] Given the diagnostic analysis, the key factor that would render Mr. Tomajin a threat at this time, would be his relapse to drug use. In combination, crystal meth and alcohol equate with a high risk of psychosis and aggression.

[47] However, despite his earlier addiction, Mr. Tomajin has, on all evidence, been entirely abstinent since the index offence despite “ample” opportunities to access substances even in hospital. He has shown no evidence of any cravings. He has good insight into the risks associated with a relapse to substance abuse. His professed intention to abstain is considered “credible” and is “accepted”. Admittedly it remains untested in the community. This is in my view a potent and insurmountable argument against further detention at this time.

[48] Mr. Tomajin has not yielded evidence that he suffers from a personality disorder or even traits. Therefore this is not an area of attention from the perspective of risk prediction.

DR. HEDIGER’S IMPRESSIONS

[49] Mr. Tomajin’s behaviour has been settled, co-operative, and not concerning throughout his admission to FPH. He is entirely treatment compliant.

[50] Mr. Tomajin is open, non-guarded, and disclosive. He has good rapport with his treatment team.

[51] Mr. Tomajin has engaged fully and to good effect in numerous programs. At one time, Dr. Hediger advised him that he needed to genuinely “engage”, beyond merely attending programs. Mr. Tomajin responded positively and implemented that advice. He has never resisted any advice from his treatment providers.

[52] Mr. Tomajin is described by Dr. Hediger as “remarkably high functioning and capable”; as a “quick learner”; as “conceptually and cognitively adept”.

[53] Mr. Tomajin has participated in vocational placements with good feedback. He has also completed a job readiness program and is considered “highly motivated” to work.

[54] Dr. Hediger has no concerns that Mr. Tomajin poses a risk to members of his family who offer to accommodate him. He has had extensive access to the community and his family visits have been problem free.

[55] In summary, Dr. Hediger’s evidence is that Mr. Tomajin has done “extremely well”. He is “extremely happy” with his patient’s progress.

RESIDUAL CONCERNS

[56] In somewhat vague terms, and although Mr. Tomajin has already been connected to an outpatient team, Dr. Hediger recommends detention and placement at CTC, on visit leaves before conditional discharge to the community. One of Dr. Hediger's concerns is that, based on his history, Mr. Tomajin's risk to relapse to substance use may be heightened due to stress, such as might be occasioned by intra-familial relationship problems or dynamics. Dr. Hediger believes that Mr. Tomajin may be overconfident in his ability to deal with such challenges. Therefore his reintegration should be "tested" in a supervised environment. In my view awaiting placement at CTC, which is not even available at this time, would not serve as a meaningful testing ground for such undetailed, amorphous issues.

[57] Dr. Hediger also has concern about the responsiveness of Mr. Tomajin's family, as exemplified by the timeliness of their response to calls seeking their feedback following his visits, which were characterized as problem free. Dr. Hediger says, however, that this concern is not "insurmountable" and he considers Mr. Tomajin's family a source of good support.

[58] Finally, Dr. Hediger identifies past examples of Mr. Tomajin demonstrating anger or irritability when frustrated, impatient or when his needs were not met. However, he also characterizes Mr. Tomajin's frustration tolerance and anger issues as "much improved". He also adds that the "anger issue" has been "exhausted" in an inpatient setting. I take that to mean that this will only be meaningfully tested in an outpatient environment.

[59] In summary, Dr. Hediger acknowledges that Mr. Tomajin's progress will only be really known when he is back in the community. He says that Mr. Tomajin realistically "could be actively" returned to the community "at this time". He functions at such an advanced level that he does not even require the pre-discharge learning and assessment environment of Hawthorne unit.

ANALYSIS

[60] Having found that an accused continues to pose a significant threat to public safety, the Board must reconsider the evidence against the criteria set out in s.672.54 *CC*:

> **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.

[61] In **Ranieri (Re)**, 2015 ONCA 444, the Ontario Court of Appeal commented on the amended wording of s.672.54:

> This court noted in ***Re Osawe***, 2015 ONCA 280, at para. 45, FN 3, that since the amendment, the Board has held that "the necessary and appropriate disposition" is also the least onerous and least restrictive disposition (citing ***Re Ahmed-Hirse***, [2014] O.R.B.D. No. 1876, at para. 36). Indeed, in her factum, the Attorney General, referring to the legislative history of Bill C-14, acknowledges that the amendments to s. 672.54, as well as related amendments, are clarifications as opposed to modifications of the law, and that the prevailing jurisprudence still applies (par 20).

[62] More recently, in **McAnuff (Re)**, 2016 ONCA 280, par 22, the Court emphasized:

> 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.

[63] On my assessment of the evidence Mr. Tomajin is, in all respects, ready for discharge.

[64] As he is not medicated, Mr. Tomajin does not require the close supervision available at the CTC to ensure treatment compliance.

[65] The expert evidence is that the critical risk factor in this case would be the accused's relapse to substance abuse as the trigger, or doorway to possible psychosis. Mr. Tomajin has been entirely abstinent. His commitment to abstaining is not suspect. I therefore believe that his response to stress and its impact on his apparent desire to remain drug free is best, and perhaps only meaningfully tested under conditional discharge with the supervision and support of an experienced outpatient treatment team. It is simply not believable that Mr. Tomajin could, under such circumstances, slip into drug use and psychosis to an extent which endangers others without detection and early return. Such monitoring is part of the very purpose of an outpatient treatment team. Mr. Tomajin says he would continue substance counselling in the community.

[66] Regarding the responsiveness of his proposed family environment, Dr. Hediger considers this as the ultimate or eventual destination and a source of positive support for Mr. Tomajin. Discharge to this environment sooner, rather than later, would provide an opportunity to engage in meaningful psychoeducation and learning for all, without any unacceptable exacerbation of risk whatsoever. Again this is an activity which is entirely suited to an outpatient team.

[67] I have already commented on the residual issue of frustration tolerance.

[68] In my opinion, in having already connected Mr. Tomajin to an outpatient team even before having identified or secured a bed at CTC, Dr. Hediger may in fact be communicating that his patient is ready for discharge. The majority of his evidence supports that conclusion. It is my belief that Dr. Hediger may be supporting that position for institutional considerations which appear, despite the promises of "program re-design", to continue to impose a lockstep, risk-averse approach to reintegration planning at FPH.

[69] In this case the hospital's position and the majority decision are inconsistent with the requirement to ensure that restrictions on an accused's liberties are proportionate to the risk to public safety: **Saikaley**, 2011 ONCA 136, par 7; **Winko** at par 70. There exists in this case no reason to delay discharge in order to test any aspect of the accused's compliance or risk management.

[70] In my opinion the position of the Director and the decision of the majority, continuing Mr. Tomajin's detention out of an abundance of caution, places a legally unreasonable onus on the accused. Mr. Tomajin is entitled to, and his risk is manageable under, conditional discharge. It also violates the *Code's* presumption in favour of least

restriction and relies on detention as the default option of first resort. Sadly, at a time when outpatient placement opportunities appear in short supply, it is a poor use of scarce resources.

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