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

SHANE ANTHONY METCALFE

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
March 13, 2019

BEFORE:
ALTERNATE CHAIRPERSON: I. Friesen
MEMBERS: Dr. P. Constance, psychiatrist
Dr. K. Polowek

APPEARANCES:
ACCUSED/PATIENT: Shane Anthony Metcalfe
ACCUSED/PATIENT COUNSEL: D. Nielsen
DIRECTOR AFPS: Dr. W. Widajewicz, Dr. A. Kolchak
DIRECTOR'S COUNSEL: A. Harlingten, D. Lovett, Q.C.
ATTORNEY GENERAL: M. Donnelly

INTRODUCTION AND BACKGROUND

[1] On December 13, 2018, the British Columbia Review Board (the Board) commenced a hearing to review the Director's decision to restrict the liberties of Shane Anthony Metcalfe on November 15, 2018. On March 13, 2019, the Board found the restriction to be reasonable, concluded that the accused continued to meet the Board's jurisdiction and made a 12-month custodial disposition.

[2] Mr. Metcalfe, a 49-year-old man, was found not criminally responsible on account of mental disorder, NCRMD, on September 6, 2012, for an assault on his psychiatrist during his involuntary admission under the *Mental Health Ac*t. The accused was angry when his doctor decided to have him transferred to tertiary care after he was noncompliant with treatment in the community. He lunged across his doctor's desk and punched him in the head numerous times, even after he had become unconscious. The doctor required numerous stitches.

[3] Since he has come under the Board's jurisdiction, Mr. Metcalfe has experienced difficulty gaining full access into the community. Attempts to place him in the community have resulted in almost immediate returns to FPH after relapses to substance abuse, failure to comply with supervision, and elopement. While at FPH, attempts were made to move the accused through the cascading system of privileges, but these plans invariably derailed after the accused engaged in aggressive or threatening behaviour toward staff, resulting in his return to a more restrictive unit in the hospital. Mr. Metcalfe has no insight into his illness, refuses to align himself with his treatment team, is argumentative, entitled, dismissive, threatening and aggressive toward staff. He is unmanageable, both in the hospital and in the community. Mr. Metcalfe has a well-established history of aggressive behaviour and violence and targets persons close to him. He has been violent against those who attempt to exert control over him such as caregivers and police.

[4] Mr. Metcalfe's psychiatric history has been outlined in previous reasons and will not be repeated in detail here although all of the evidence on record has been considered. He has a history of mental illness going back to 2003 when he was diagnosed with a psychotic disorder NOS, substance abuse and possible anti-social personality disorder. He was diagnosed with paranoid schizophrenia following admission to hospital in 2005.

[5] After his last return to FPH, the Board noted that further inquiry into Mr. Metcalfe's personality style might provide insight and strategies to assist him to reduce his problematic behaviour and mitigate his risk to the public to as to enable him to live in the community.

[6] In the spring of 2018, the Director commissioned a report from Dr. Teeft dated May 31, 2018, (Exhibit 41), which theorized that Mr. Metcalfe did not meet diagnostic criteria for anti-social personality, psychopathy or schizophrenia. The report concluded that Mr. Metcalfe's presentation is most consistent with an underlying paranoid personality style as well as a substance abuse disorder. It was noted that Mr. Metcalfe experiences psychotic episodes as a result of environmental stress, with or without substance use. His cognitive deficits exacerbate his complicated diagnostic picture. The practical effect of the new diagnosis was that neither psychosocial education nor anti-psychotic medication was likely to reduce Mr. Metcalfe's problematic behaviours or assist him to develop insight.

[7] As a result of Dr. Teeft's report, the Director requested an early hearing to "revisit risk from a clinical perspective in light of new information" by letter dated June 12, 2018, (Exhibit 42). In June 2018, Mr. Metcalfe's anti-psychotic medications were reduced and by July 2018, he was receiving a sub-therapeutic dosage. By September 2018, Mr. Metcalf's anti-psychotic medications were completely eliminated.

[8] Dr. Wiehahn outlined his diagnostic impression:

> In essence, his personality style and his cognitive deficits together with the type of treatment offered through the forensic psychiatric services are a poor match. These differences in opinions and motivations are most striking during a conditional discharge order. In essence, Mr. Metcalfe perceives any level of supervision as intrusive and as professionals wanting to control him or obtain information to use against him…The core of substance use treatment is psychological interventions, which is unfortunately is a true Achilles heel for Mr. Metcalfe in terms of cognitive functioning and personality structure…Therefore, Mr. Metcalfe will have great difficulties abiding by the expectations on a conditional discharge order. On the other hand, being on a custody order, there is very little left for him at the hospital to learn as he struggles to process information offered to him. (Exhibit 43).

[9] A second opinion given by Dr. Widajewicz opined that the proper diagnosis is paranoid personality disorder and alcohol induced paranoid state and not schizophrenia or thought disorder (Exhibit 44).

[10] The Director concluded that the usual process of reintegration has not worked for the accused and has resulted in repetitive cycles of ups and downs in terms of privileges and access to the community. Based on the new perspective occasioned by the diagnostic change, the Director concluded that the proper course of action was to facilitate the accused's departure from the forensic system through absolute discharge. If the accused committed further offences in the community, it was proposed that he would be better served in the criminal justice or mental health systems.

[11] A long, complicated and perplexing series of inquiries ensued, including 4 hearing dates between September 2018 and March 2019. By the time of the first hearing, the accused had been returned to Ash 2 unit from pre-discharge Hawthorne unit because of his aggressive and intimidating behaviour toward staff.

[12] The first hearing commenced on September 13, 2018 and continued on November 8, 2018. The Director sought absolute discharge at both hearings. The evidence regarding diagnosis and risk was murky and conflicting. Dr. Wiehahn opined that the accused's risk of causing physical harm did not reach even a moderate level although his likelihood of engaging in verbal threatening was "moderate to high". Dr. Widajewicz disagreed with the diagnosis of paranoid personality style but agreed that the accused was not schizophrenic. He testified that the accused did not meet the criteria for a verdict of NCRMD and was suffering from a drug-induced psychosis. The accused contributed to the unwarranted NCR verdict because he lied to his doctors. He opined that the accused "has some strange thoughts and overvalued ideas" that may come across as threatening. He diagnosed the accused as having delusional disorder with paranoia and underlying antisocial personality traits. Dr. Widajewicz did not perform a formal risk assessment but he concluded that the accused's risk was driven by substance abuse combined with his anti-social personality type and history of non-compliance with supervision. He opined that the accused had "learned his lesson" about assaulting psychiatrists. Regarding future risk: the accused was likely to become threatening and could perhaps take it further. Dr. Widajewicz

said that the accused should be absolutely discharged and if he were to reoffend, he ought to face the consequences in the criminal justice system.

[13] By the time of the November hearing, the accused had only been off medications for a period of 2 months. The Board was told that while the majority of individuals with a primary psychotic disorder will relapse within 12 months, a full 12-month observation period was not necessary in Mr. Metcalfe's case and that he was ready for absolute discharge. The conflicting diagnoses and risk assessments that differed significantly from previous assessments, caused the Board to make the following observations:

> The Board could not reconcile the discordant evidence of Drs. Wiehahn, Teeft and Widajewicz regarding Mr. Metcalfe's primary psychiatric diagnosis. In particular, the Board could not reconcile the new diagnosis of paranoid personality disorder and revisions to the risk assessment with the body of evidence in the record.
>
> …the Board highlights the need for the Director to provide psychiatric evidence that is concordant and clear. When confronted with conflicting evidence regarding foundational facts such as the Accused's primary psychiatric diagnosis, the Board is unclear how to understand the risk assessment evidence being presented. (Exhibit 45b)

[14] At the end of the November hearing, all of the parties agreed that the accused ought to receive an absolute discharge. Despite the united positions of the parties, the Board found evidence of significant threat in the evidence on the record, and refused to grant absolute discharge. Even though the Director had characterized a potential conditional discharge disposition as the "worst case scenario", the Board nevertheless granted the accused a conditional discharge, effective November 8, 2018.

[15] The Board further "recommended" that the Director obtain an independent risk assessment providing a detailed review of the underlying clinical facts and assumptions that support the revision of Mr. Metcalfe's primary psychiatric diagnosis, the role of alcohol and substance use in Mr. Metcalfe's history of violence and psychotic episodes, and a detailed analysis of the evidence that supports the position that Mr. Metcalfe will remain sober,

stable and violence free if he is unfettered by the legal supervision of the Board. The Board also suggested that the Director obtain a neurocognitive assessment if warranted.

[16] Seven days later, the Director restricted the accused's liberties (ROL). The Director concluded that an appropriate community residence could not be found and refused to release the accused into the community. (Exhibit 46).

EVIDENCE AT THE HEARING

[17] The ROL hearing occurred on two dates, commencing on December 13, 2018 and continuing on March 13, 2018. At the December 13, 2018 hearing, Counsel for the Director sought a three-month custodial disposition. The Director declined to provide the Independent Risk Assessment requested by the Board, taking the position that Drs. Wiehahn and Widajewicz had already provided sufficient assessments of risk.

[18] Dr. Widajewicz testified that the accused was upset after the hearing on November 8, 2018, because he believed he would be absolutely discharged given the position of all of the parties. He engaged in problematic behaviours and made repeated telephone calls to the Ombudsman, the Queen and the RCMP, leaving intimidating messages on RCMP answering machines. When police arrived at FPH, the accused told them he had been wrongfully detained. The hospital placed restrictions on the accused's telephone calls.

[19] The treatment team was not prepared for conditional discharge and had difficulty finding an appropriate placement in the 7-day period after the order. The accused could not be placed with his mother because no community assessment had been undertaken. The accused was willing to reside in a hotel room, but this was not considered appropriate. Attempts were made to place the accused at a tertiary care facility, but he was not accepted because of his ambivalent stance regarding substance abuse, his significant risk for flight as well as his unwillingness to engage with treatment.

[20] Dr. Widajewicz testified that the accused should be briefly kept in hospital for his own safety. He opined that the accused could be kept for a week or two at the hospital and then should be discharged. He testified that Mr. Metcalfe is not psychotic but may appear that way because of his inappropriate use of words. Dr. Widajewicz testified that the accused does not pose a physical threat to the public unless he is using substances, which

he has promised not to do. Dr. Widajewicz testified that the accused agreed to take Abilify, but did not provide any details regarding the reintroduction of this medication. Dr. Widajewicz continued to advocate for absolute discharge, and that the accused does not pose a significant threat presently or in the short term. Dr. Widajewicz said the accused is "not much different than many other individuals with personality disorder at corrections who perceive society as hostile and the rules as infringing on their freedom. Being incarcerated would in my opinion mange his risk better as he could help him learn from unpleasant detention if he becomes violent again". Dr. Widajewicz opined that the accused would do well in a small town in BC where he would fit in better than in an urban environment.

[21] Ultimately, the matter was adjourned after the Director introduced a community assessment written in February 2017. Counsel for the accused objected to its admission and required the attendance of the writer for the purpose of cross-examination. The matter was adjourned. After the adjournment, the accused continued in detention until another date could be found. In the meantime, the Board made an order under the *Inquires Act* requiring that the Director provide an Independent Risk assessment and an update to the February 2017 community assessment.

[22] On March 13, 2019, the matter was reconvened. Dr. Widajewicz remained as treating psychiatrist and Dr. Kolchak provided an independent risk assessment (Exhibit 51). A new community assessment was provided by C. Ambrosio dated January 14, 2019 (Exhibit 50).

[23] The Board was told that Mr. Metcalfe's mental health has been deteriorating for many months, although it was not clear when this became apparent or should have become apparent to his treatment team. On December 4, 2018, the Director requested a second opinion from Dr. Kolchak. Dr. Kolchak concluded that the accused was psychotic and as a result, on December 5, 2018, Mr. Metcalfe was given an involuntary dose of antipsychotic medication. Since that time, Mr. Metcalfe's mental health has been improving, although even after 3 more injections, and maintenance at a therapeutic level, he is not yet at baseline. The injections are supplemented with oral anti-psychotic medication at night. Mr. Metcalfe continues to suffer from significant thought disorganization and displays delusional and grandiose ideation. On January 11, 2019, he was referred to Dr. N. Druhn for further psychological assessment and diagnostic clarification. The referral was

ultimately withdrawn “due to active symptoms of thought disorder that would likely affect the validity of neuropsychological screening results”.

[24] Dr. Widajewicz testified that he has changed his opinion and he now diagnoses the accused with schizophrenia. He changed his mind after observing a dramatic change in Mr. Metcalfe’s presentation when he was without medication. He couldn’t sleep, became more disorganized, as well as paranoid and delusional. It was over this time period he called the RCMP. The accused’s late onset of mental illness and previous high functioning in the community made diagnosis difficult, but suggests a good prognosis.

[25] Dr. Widajewicz testified that the risk picture has changed. Mr. Metcalfe’s lack of insight into his mental illness prevents him from understanding his need for medication compliance. If absolutely discharged, Mr. Metcalfe would likely return to substance abuse, become non-compliant to medication and develop grandiose, and paranoid ideas. He is particularly at risk of responding violently to police officers or mental health officers who might attempt to impose legal restrictions on him.

[26] Mr. Metcalfe ‘s mental health has improved since November 8, 2018. He enjoys privileges at level 5 and recently has enjoyed 3 unescorted outings in the community per week. The treatment plan is to place him at Hawthorne unit and then at CTC when a bed becomes available. The accused has provided several clean urine screens. Dr. Widajewicz reports that the accused has not received treatment for substance abuse because he has had never shown any interest. He is now interested and has connected to an AA program in the community. Dr. Widajewicz reiterated that the accused could potentially be transitioned to CTC within a two-month period.

[27] Dr. Kolchak gave a less optimistic risk assessment. After giving his opinion to the Director that Mr. Metcalfe was psychotic and required medication in early December 2018, he was subsequently asked to provide an independent risk assessment in January 2019. He opined that the accused meets the threshold of significant threat because he presents a multitude of risk factors. In addition to the index offence, Mr. Metcalfe has 2 convictions for violence and he has had up to 40 previous interactions requiring police attendance. He is habitually non-compliant with supervision. He often engages in impression management. He minimizes psychotic symptoms and tries to normalize them. The accused has no insight into the index offence and does not recognize that his actions

were wrong. He continues to justify his violence and maintains that anyone would do the same. He has poor insight into his illness and has not developed the skills to manage future frustrations without engaging in verbal or physical aggression. He perceives other people's actions in a paranoid manner. He continues to exhibit grandiosity and believes rules do not apply to him. For example, he eloped in 2017 just because he wanted to and felt he could get away with it.

[28] Dr. Kolchak opined that the appropriate diagnosis is schizophrenia or schizoaffective disorder. He does not agree with a separate diagnosis of personality disorder but says that personality features ought to be considered subsumed within the primary diagnosis. He maintains that substance abuse treatment is necessary to manage the accused's risk to the community. The accused's relationship with his mother has soured and she is not likely to be a good resource in the future. In his opinion, the mental health resources in small BC towns are not sufficient to manage Mr. Metcalfe's complex mental health needs.

[29] Dr. Kolchak is not the accused's treating psychiatrist but if he were, he would treat the accused's mental illness more aggressively. Treatment with clozapine may provide some benefit but it is unknown if there are any medical issues that may contraindicate the use of that medication. While the accused's mental health may improve with more aggressive treatment, total regression of his illness is unlikely. Dr. Kolchak advocates for a robust reintegration plan once the accused is ready.

[30] Mr. Metcalfe testified that he would be willing to try to live at CTC "as long as there are no substance abusers" there. He told the Board that he can get a "little nosey" and that could cause trouble for other people. He would have to "abide by the rules and turn them in". Mr. Metcalfe wants to take a Private Investigator course and pursue investigation as a career. Other options include law enforcement and science.

[31] Mr. Metcalfe does not like Abilify and calls it "garbage". It makes him feel "loopy". He is willing to take oral medication but does not like injections.

[32] The accused testified that his relationship with his mother is "love/hate". He should have given her more space when they lived together.

[33] Mr. Metcalfe does not wish to live in Trail. It is a “dirt hole” with “lots of radiation” in the area. There are lots of “missing body parts and people”. Mr. Metcalfe does not wish to go to AA.

[34] Mr. Metcalfe testified that he has lied to a lot of people. He fabricated stories for Dr. Kolchak to see how far he could push him. He said that Dr. Kolchak is “overzealous” and “not good for me”. He said he “lied to him…its bollocks…I could have got out months ago”. He said he “doesn’t like the guy” and that is not a sin.

[35] When asked about the index offence, the accused agreed the assault was not a good idea, but argued that the victim had misidentified him as a drug dealer. He minimized his actions, advising that it was less serious because he didn't “kill him”. He gave him 3 – 4 good punches, which were not that hard. He stated that the doctor “didn’t have the decency to take off his glasses” when he saw the accused coming around his desk to assault him.

[36] Mr. Metcalfe agreed that he has a mental problem right now but that he is “correcting it”. It could be a “light, mild psychosis”. He believes he is under a lot of surveillance right now.

ANALYSIS AND DISPOSITION

Restriction of Liberties

[37] The Board concluded that the restriction of liberties of November 15, 2018 was justified. The hospital was unprepared for the conditional discharge and there were no appropriate plans in place. The treatment team attempted to organize a placement, but given the accused’s prior problematic response to supervision, an appropriate placement could not be found within 7 days.

[38] On November 8, 2018, the accused had not taken anti-psychotic medication for months and his mental health deteriorated to the point that he was a danger to the community. Soon after learning that he had not received the absolute discharge he expected, the accused became aggressive and left threatening messages for authority figures in the community. His mental health deteriorated further until he was given

involuntary medication less than a month later. He was in no position for discharge into the community. The Director appropriately restricted his liberties.

Significant threat

[39] The Board's decision making is governed by s. 672.54 and s. 672.5401 of the *Criminal Code* which provide:

> **672.54** When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:
>
> > **(a)** Where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;
> >
> > **(b)** by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
> >
> > **(c)** by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.
>
> **672.5401** For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public — including any victim of or witness to the offence, or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent.

[40] The Board must determine whether the accused poses a significant threat to the public safety as defined in s. 672.5401. The Board must consider both the interests of individual liberty as well as the paramount consideration of the protection of the public. The jurisdictional test as articulated in ***Winko v. British Columbia (Forensic Psychiatric Institute)***, [1999] 2 S.C.R. 625:

> [T]he threat posed must be more than speculative in nature; it must be supported by evidence: *D.H. v. British Columbia (Attorney General)*, [1994] B.C.J. No. 2011 (QL) (C.A.), at para 21. The threat must also be "significant"; both in the sense that there must be a real risk of physical or psychological harm occurring to

> individuals in the community and in the sense that this potential harm must be serious. A miniscule risk of grave harm will not suffice.
> Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. *(Par. 57)*

[41] The question of significant threat has been at issue since the Director sought an early hearing in June 2018. After numerous hearing dates and conflicting expert testimony, the clear and decisive evidence heard on March 13, 2019 established that the accused continues to meet the threshold level of significant threat. The accused presents a risk on various levels. He has a major mental disorder, which requires treatment with anti-psychotic medication. His illness is aggravated by his use of substances and complicated by his cognitive impairments. Mr. Metcalfe has no insight into his illness or his need for medication. He responds aggressively to frustrations, mostly with verbal aggression, but occasionally with physical violence. His ability to avoid physical violence in recent years is likely attributable to the moderating effects of his medication, sobriety, intensive supervision and the coercive effects of the on-going Review Board order. If absolutely discharged, Mr. Metcalfe would become non-compliant with medication, and would likely amplify his mental health deterioration with the use of substances. He would encounter frustrations and likely feel entitled to respond with violence as he did at the time of the index offence. Mr. Metcalfe has not developed any insight into better ways to handle disagreeable situations.

[42] The accused has a history of violence including the index offence, an offence he continues to minimize and assign responsibility to the victim. He has on occasion assaulted his mother although only one incident resulted in a criminal conviction. Another conviction for assault arose after he assaulted a female. The accused has a history of verbally threatening behaviour that falls into the definition of causing “psychological harm” to others. He intimidates staff in the hospital. Prior to going AWOL in 2017, he made numerous late night phone calls to a former acquaintance. The recipient of the phone calls interpreted them as threatening. He called police and indicated his fear of reprisals if the accused returns to live in the area.

[43] The accused has a substance abuse disorder which aggravates his aggressive and intimidating impulses. On many past occasions, when given access to the community, the accused gravitated almost immediately to substance abuse. While he tells

his treating psychiatrist that he will attend AA, he disavowed any interest in substance abuse treatment or programming while testifying before the Board.

[44] The Board accepts the opinion of Dr. Kolchak and the revised opinion of Dr. Widajewicz that the accused meets the threshold of significant threat and that the Board's jurisdiction continues to be justified.

[45] We feel it is necessary to comment on the Director's strategy to seek to transition Mr. Metcalfe from forensic responsibility to the civil mental health community and the criminal justice system. This change was occasioned by a controversial new diagnosis, but it was abundantly clear that there were no positive changes to the accused's risk profile. The only reasonable conclusion that can be drawn from the Director's change in position is that the institution wanted to push the accused out of the forensic system because he was too difficult to manage, used an inordinate amount of resources and was unlikely to ever change.

[46] This approach has been emphatically denounced by both the Ontario Court of Appeal in *R. v. Daryl Bryne Jones,* 1994 CanLII 8715, and by the BC Court of Appeal in *Warren Stewart Jones v. British Columbia (Attorney General)* [1997] B.C.J. No. 2773. Both cases featured a recalcitrant and unmanageable accused, much like Mr. Metcalfe. In the Ontario case, the Ontario Review Board bowed to pressure from the Director and ordered the accused absolutely discharged. The Ontario Court of Appeal overturned that decision. In the B.C. case, the accused unsuccessfully appealed the Board's decision to retain jurisdiction over him after his diagnosis changed.

[47] It is instructive to review comments made by both Courts of Appeal as they are apropos of the case before us.

[48] The Ontario Court of Appeal observed:

> In short, the respondent is a nuisance to the authorities in the hospital. While acknowledging that his basic condition is untreatable and that his substance abuse problems are unresolvable because of his attitude, the administrators of the hospital have sought to get rid of him. They did so in two ways: first, by proposing that he be sent to some institution other than the Brockville Psychiatric Hospital; and second, by

proposing that he be released unconditionally so that when he runs afoul of the law, as it is conceded that he will, he can be dealt with by the criminal justice system.

And:

…the question the Review Board should have asked itself is: How can we effectively supervise the reintegration of the respondent into society when he has willfully refused to abide by the conditions of release that we imposed earlier? To abolish the conditions of his release simply because he has refused to comply with them, not only sets a poor precedent to other patients on conditional release, it ignores the statutory framework under which the Review Board acts. (*emphasis added*)

And further for the majority:

In my opinion, the disposition of an unconditional discharge is unreasonable and is based upon expediency, not the best interests of the public or the safety of the public. The disposition under appeal should be set aside and the matter remitted to the Review Board. (*emphasis added*)

[49] The BC Court of Appeal cited the Ontario *Jones* case with approval. In the B.C. *Jones* case, the accused's original psychosis had remitted, but he had a continuing substance abuse disorder and he was resistant to treatment, much like Mr. Metcalfe. The Board maintained its jurisdiction on the basis that in his untreated state, he was at risk of further drug-induced psychosis and remained a significant risk to the public. In response to the accused's argument that his remission in psychosis justified an absolute discharge, the B.C.C.A. cited *Peckam v. Attorney General of Ontario et al,* (1994), 93 C.C.C. (3d) 443 (Ont.C.A.) and concluded that an accused's change in diagnosis from the time of his NCR assessment will not necessarily lead to absolute discharge. The Board must consider the overall mental state of the accused in determining whether he continues to meet the threshold of significant threat:

> Section 672.54 addresses the accused's mental condition at the time of the hearing. That hearing may occur many years after the initial finding of not criminally responsible on account of mental disorder. Nothing in the language of the section suggests that the Board must first decide whether the label attached to the accused's mental condition for the purposes of determining whether he could be

> held criminally responsible for his acts remains the operative diagnosis. Instead, the section contemplates a consideration of the accused's mental condition at the time he or she is before the Board. The original diagnosis along with the psychiatric information referable to the accused's mental state since the finding of not criminally responsible on account of mental disorder must be considered in arriving at a conclusion with respect to the present mental condition of the accused. That conclusion in turn plays a central role in the Board's determination of the appropriate order.
>
> Furthermore, the section speaks to the accused's mental condition and not to the existence of a mental disorder. The latter is defined in s. 2 of the Criminal Code as meaning a disease of the mind, and is clearly a more restrictive phrase than the phrase "the mental condition of the accused". By using the broader phrase, Parliament must have intended the Board to address the overall mental state of the accused without limiting itself to a determination of whether that condition, or at least some aspect of it, continued to fit within the confines of the legal concept of a mental disorder. (Para. 43)

[50] We conclude that regardless of the label assigned to Mr. Metcalfe's diagnosis, at the time the Director sought absolute discharge, the accused's risk factors were unchanged from previous hearings. But for the Board's resistance to the pressure of the Director and its refusal to order an absolute discharge, the accused's subsequent mental health deterioration in late fall 2018 would have happened in the community, without forensic management. Given the accused's history of aggression, lack of insight, and inability to resist substance abuse, it is not speculative to conclude that he would quickly have become a real risk of significant harm to the public.

Disposition

[51] Having concluded that the accused meets the threshold level of significant threat, the Board went on to consider appropriate disposition. Mindful of Dr. Kolchak's opinion that the accused requires prudent, slow and gradual community reintegration, the Board imposed a custodial disposition for period of one year. In order for a successful return to the community, Mr. Metcalfe requires careful management of his risk. If released into the community, he will require external controls to ensure that he takes his medication and

complies with supervision. This disposition will be reviewed within 12 months unless the Director concludes that the accused is living successfully at CTC and meets the criteria for an early hearing.

[52] We further mention that it is unacceptable for an expert to withhold information within reports and during testimony at hearings. The Board must be presented with all risk relevant information in order to make the appropriate decision and failure to do so erodes confidence that the Board can rely on the testimony presented. Specifically, the Board ought to have been told at the December 13, 2018 hearing that on December 4, 2018, Dr. Kolchak observed that the accused was psychotic, resulting in the involuntary injection. This information was not brought to the Board's attention until the March hearing, without explanation for the lapse.

[53] It is hoped that the Director will review the events of Mr. Metcalfe's case to develop strategies to avoid similar pitfalls in future cases.

Reasons written by I. Friesen in concurrence with Dr. P. Constance and Dr. K. Polowek.