Translated from the original French

Social Affairs Section

Designated as a Review Board within the meaning of ss. 672.38 *et seq*. of the *Criminal Code*

Date: April 1, 2021

Neutral citation: 2021 QCTAQ 0429

File: SAS-Q-142145-0712

Presiding Administrative Judges:

PAULO GOUVEIA

GÉRARD COURNOYER

LIONEL LAMBERT

J.M.
Accused

and

PERSON IN CHARGE OF THE CIUSSS A (CENTRE A)

and

DIRECTOR OF CRIMINIMAL AND PENAL PROSECUTIONS

and

MTRE STEPHEN ANGERS

REASONS FOR DISPOSITION

RENDered on October 14, 2020

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1. The Social Affairs Section of the Tribunal administratif du Québec, designated as a Review Board for mental disorder (hereinafter the Board or the RBMD) for the purposes of the *Criminal Code*[[1]](#footnote-1)(*Cr. C.*), conducted a review at the request of the accused[[2]](#footnote-2) on March 12, 2020, and held a first hearing, further to the judgment of the Court of Appeal of Quebec allowing the appeal.[[3]](#footnote-3)

# **I. VERDICTS BEFORE THE BOARD**

## **i. Current verdict**

1. On March 12, 2019, J.M. (hereinafter the **accused**) was found not criminally responsible on account of mental disorder on the following charge:
* having engaged in conduct with the intent to provoke a state of fear in justice system participants (ss. 423.1(1)(b) and (3) of the *Criminal Code*).[[4]](#footnote-4)
1. With respect to the **offence**, according to the disposition information,[[5]](#footnote-5) on April 23, 2018, the accused, who was dissatisfied with a lawyer from the office of the Director of Criminal and Penal Prosecutions (hereinafter the DCPP), contacted the office of the DCPP to ask whether they had received a complaint he had sent to the office of the director, Mtre Annick Murphy, concerning the lawyer, M.L.
2. At the end of the conversation, the accused said that if the lawyer concerned by the complaint came to his house, he would arrest him. He also referred to the death of that lawyer at the time of the arrest.
3. On April 27, 2018, the accused sent a complaint against M.L. to the office of the Quebec Ombudsman. The complaint was sent to an officer who was charged with communicating with the accused to provide him with certain information.
4. A few days later, the officer called the accused. He explained his complaints to her. Dissatisfied with the answers he was given, the accused uttered the threat that if necessary, he would resolve the situation and [translation] “shoot the lawyer and the judge”, adding [translation] “that he had a loaded weapon with two bullets in it”.[[6]](#footnote-6)
5. Following his arrest and during his trial before the Court of Québec, he denied having made the alleged comments and the threats. He even presented an alibi defence.[[7]](#footnote-7) The court of justice found the accused guilty of the index offences underlying the NCR verdict.[[8]](#footnote-8)
6. When the court of justice made its disposition, it ordered the accused’s detention without the possibility of outings and subject to certain conditions.[[9]](#footnote-9) He had to:
* Keep the peace and be of good behaviour.
* Follow the recommendations of the treatment team.
* Not communicate, directly or indirectly, with Judge G.L. or Mtre M.L.
* Not be found at their domicile or workplace.
* Accordingly, not be found at a courthouse, unless required in the interests of justice or with the permission of the Chief Justice of the Court of Québec, the Superior Court of Quebec, or the Court of Appeal of Quebec; and in the event of his release, register his presence with a special constable upon his arrival.
* Not possess firearms pursuant to s. 109 of the *Criminal Code*.
1. Dissatisfied with the verdict of not criminally responsible on account of mental disorder, the accused brought proceedings to contest the verdict before the Court of Appeal of Quebec.[[10]](#footnote-10)

# **ii. Previous verdict**

1. In 2007, the accused received a first verdict of not criminally responsible (hereinafter **NCR**) on account of mental disorder, in connection with five counts of having used forged documents.[[11]](#footnote-11) He was discharged absolutely by the Review Board in February 2009.[[12]](#footnote-12)

# **II. THE BOARD’S PREVIOUS DISPOSITION**

1. On June 10, 2019, the Review Board for mental disorder held a first hearing following the 2019 verdict and reduced the conditions of the order rendered by the Court of Québec, ordering the accused’s detention subject to several conditions, including that attempts be made to integrate the accused into a living environment that met his needs.[[13]](#footnote-13)
2. The Board also ordered an assessment of his social functioning for the next hearing.
3. Last, the Board ordered that a review hearing be held within six months of its disposition.

# **III. SUBSEQUENT PROCEEDINGS**

1. The accused filed an appeal from that disposition.[[14]](#footnote-14)
2. On October 18, 2019, the Court of Appeal rendered a judgment reversing the Board’s disposition of June 10, 2019, and referred the file back to the social affairs section of the Tribunal administratif du Québec, acting as a Review Board in respect of a person found not criminally responsible on account of mental disorder, so that it could hold a new hearing.[[15]](#footnote-15)
3. Following that judgment rendered by the Court of Appeal of Quebec, the Board held the first hearing on [...], 2019.[[16]](#footnote-16)
4. On December 23, 2019, the same panel ordered an assessment of the accused’s dangerousness due to the existing impasse and the need to obtain such an assessment before the next hearing. It also ordered that the status quo be maintained, that is, strict detention at the current hospital.
5. On February 17, 2020, at the accused’s request, the Board held a case management hearing and ordered that an assessment be conducted by Dr. Sylvain Faucher, a psychiatrist associated with Institute A, within thirty (30) days, that is, on or before March 18, 2020. The assessment report was to be submitted forthwith to the accused, the Board, and the person in charge of the designated hospital.[[17]](#footnote-17)
6. On March 6, 2020, the Board was required to order an extension of the deadline to conduct the assessment and file the report for thirty (30) days as of March 18, 2020. It also ordered that if the assessment was not received by that extended deadline, the assessment of the accused’s dangerousness would have to be conducted by Institute B.[[18]](#footnote-18)
7. Ultimately, Dr. Faucher could not conduct the assessment,[[19]](#footnote-19) and steps were taken with Institute B.[[20]](#footnote-20) The assessment took place by videoconference due to the circumstances of the COVID-19 pandemic.[[21]](#footnote-21)
8. It is also important to note that on [...], 2020, the Supreme Court of Canada dismissed[[22]](#footnote-22) the accused’s appeal[[23]](#footnote-23) from the judgment of the Court of Appeal of Quebec, rendered on [...], 2019.
9. On June 29, 2020, the multidisciplinary psychiatric consultation report on the risk of violence, prepared by Dr. Gauthier, Arnaud Sepulveda, and Dr. Bouchard, was filed in the record.[[24]](#footnote-24)

# **IV. THE BOARD’S ROLE**

1. The Board must determine whether the accused poses a significant threat to the safety of the public due to his mental condition, and, if necessary, decide which measures should be taken to control this threat and allow his reintegration into society.
2. A significant threat to the safety of the public is defined in the *Criminal Code*[[25]](#footnote-25) as a risk of serious physical or psychological harm to members of the public, including any victim or witness to the offence, or any person under the age of 18, resulting from conduct that is criminal in nature, but not necessarily violent. A minuscule risk of grave harm will not suffice, nor will a high risk of trivial harm.
3. To determine whether the accused poses a significant threat, the Board may examine a broad range of evidence, including, but not limited to, the circumstances of the offence on which the verdict is based, the accused’s current medical condition, any treatment plans, the accused’s plans for the future, community support services, and the recommendations of the accused’s treatment team or of the experts who examined him.

# **HEARING**

1. The hearing was held during the pandemic in such a way as to limit contact and the risk of spreading the COVID-19 virus.
2. The accused, counsel for the person in charge of the designated hospital, the *amicus curiae*, the attending physician, the occupational therapist, and the criminologist participated in the hearing, which was held over five sessions,[[26]](#footnote-26)via videoconference.
3. The Board members attended in the Montreal offices of the Tribunal administratif du Québec.

# **RESPECTIVE POSITIONS OF THE PARTIES**

1. The attending physician recommends detention subject to certain conditions.[[27]](#footnote-27) Counsel for the person in charge of the designated hospital and counsel for the DCPP support this recommendation. The *amicus curiae* suggests a discharge subject to certain conditions. The accused asks for an absolute discharge. He also submits other “remedial” applications.[[28]](#footnote-28)
2. For the reasons provided at the hearing and for those set out below, the Board orders the accused’s discharge, subject to certain conditions.

# **BACKGROUND**

# **V. STATUS AND PERSONAL INFORMATION**

1. On a **personal level**, the accused is 56 years old. He is single and has no children. He has five sisters and three brothers. He has owned a home for over twenty years. The accused worked as a machinist in the past but has been unemployed since about the year 2000. His income comes from social security and the Régie des rentes du Québec.[[29]](#footnote-29)

# **VI. PSYCHIATRIC HISTORY**

1. The Board understands that the accused’s **psychiatric history** dates back to December 1997, when he suffered a traumatic brain injury in a car accident.
2. He was assessed in psychiatry for the first time in January 1998 by Dr. Pierre Mailloux for somatic delusions. Dr. Mailloux diagnosed him with simple schizophrenia.[[30]](#footnote-30)
3. He was reassessed in March 1998. At that time, the accused reported the presence of coenesthetic hallucinations. His thoughts lacked coherence, and his affect was flat. He was again diagnosed with schizophrenia.
4. He was also hospitalized that month. He was diagnosed with undifferentiated schizophrenia with a history of traumatic brain injury.
5. He was hospitalized again in May 2000 and diagnosed with undifferentiated schizophrenia and head trauma with psychomotor impairment. A conflict with an electrician (in terms of stress factors) was also noted.
6. He was then hospitalized in October 2000, in the context of an assessment for the Court. He was again diagnosed with undifferentiated schizophrenia. A combination of medications was used and seemed to permit a notable improvement of his clinical state. He was found fit to stand trial.
7. He was re-hospitalized in April 2001 after he stopped taking his medication, with a similar portrait to that during his hospitalization in March 1998. His condition improved when he resumed taking his medication. He was diagnosed with paranoid schizophrenia.
8. In 2007, he was found unfit to stand trial. He was hospitalized from late August until mid-November of that year for a new assessment of his fitness to stand trial, with a recommendation for a treatment order. At the end of his hospitalization, he was found fit to stand trial and not criminally responsible, with a recommendation that he continue to receive psychiatric follow-up care. The psychiatric diagnoses made were paranoid schizophrenia and adjustment disorder with anxiodepressive mood.
9. In about 2008, he seems to have started receiving psychiatric follow-up care from Dr. Fabrice Pelletier, who accepted the psychiatric hypothesis of a persecutory-type delusional disorder with a differential diagnoses of paranoid schizophrenia associated with a history of traumatic brain injury with loss of consciousness.
10. In November 2008, the accused underwent a neuropsychological assessment. The assessor found that he had objectively verifiable cognitive deficits that are likely a consequence of his psychiatric illness, causing slowness in his thought process and an interpretive way of thinking. The conclusion was that the accused is unable to tolerate stress, and it was suggested that a concussion may be related to the psychiatric symptoms.
11. Finally, in December 2018, in the context of an assessment for the Court, it was admitted that he was no longer receiving psychiatric follow-up care and was no longer taking any medication on a regular basis.

# **VII. CRIMINAL RECORD**

# **i. Prior convictions**

1. The accused’s criminal record includes a conviction in 2001 for criminal harassment committed in 1998.
2. In 2002, he was convicted on two counts of failure to comply with a probation order.
3. In August 2015, the accused was found guilty of possession and use of forged documents for offences committed on December 14, 2014.
4. In December 2015, he was convicted of distributing child pornography and fraudulently personating another person with intent to cause disadvantage to the person being personated or another person. The offences were committed on or about April 12, 2015. The accused received a sentence of 12 months’ imprisonment and a 3-year probation order, with supervision for the first 2 years.

# **ii. Other**

1. The accused was declared a [translation] “quarrelsome litigant” for the first time in 2007[[31]](#footnote-31) by the Court of Québec, and a [translation] “vexatious litigant” in 2009 by the Court of Québec, Criminal Division. He was again declared a [translation] “quarrelsome litigant” by the Superior Court in 2017, and by the Court of Appeal[[32]](#footnote-32) in 2018.
2. Steps taken to obtain an order to authorize care had not been finalized on the date of the decision.

# **Preliminary issues**

1. In preparation for the hearing scheduled for July 28, 2020, the accused presented several applications and even served a notice of breach of fundamental rights and freedoms. Before starting the hearing and during it, the Board addressed the following issues.

# ***A. Representation by Mtre Bachand, application for representation, and appointment of an* amicus curiae**

1. On July 13, 2020, Mtre Audrey Bachand presented a notice of intent to cease representing the accused.[[33]](#footnote-33)
2. She stated that it had become impossible for her to continue to represent him because there was no longer a relationship of trust between them, and because the accused had expressed the desire to represent himself.
3. In view of the tardiness of this notice, the Board requested Mtre Bachand’s presence at the hearing.
4. At the hearing, Mtre Bachand reiterated her application on the same grounds. The accused did not contest the lawyer’s application. In fact, all parties agreed that in the circumstances, Mtre Bachand should be authorized to cease representing the accused.
5. The Board was nevertheless concerned by the fact that the accused was not represented and insisted on proceeding on his own.
6. Before the Court of Appeal of Quebec in May 2019, the accused requested that counsel be appointed to him. The minutes of the hearing indicate that the panel was informed that the accused had confirmed having taken several steps with legal aid in the district but received no response. He informed the Court of Appeal that he did not have the means to retain the services of counsel but that he was admissible for legal aid.[[34]](#footnote-34)
7. The Court of Appeal of Quebec finally agreed to hear submissions on the appointment of an *amicus curiae*.
8. In a judgment rendered on [...], 2019, Simon Ruel J.A. stated that [translation] “the appellant is clearly not in a position to adequately ensure his representation, considering his condition, the complexity of the case, and the importance of the issues”.[[35]](#footnote-35)
9. In view of the hearing before the Court of Appeal, the Court appointed Mtre Paul Skolnik as *amicus curiae*.[[36]](#footnote-36)
10. On July 28, 2020, before this panel, the accused submitted that he intended to represent himself.
11. It is clear that one of the principles of our criminal law system is that even an accused has the right to represent himself or herself and cannot be compelled to retain counsel or to seek a legal aid lawyer.[[37]](#footnote-37) In addition, the accused also has the right, subject to certain conditions, to revoke the mandate of counsel.
12. The Board understands that an accused who chooses to proceed in this manner assumes the risks of doing so.[[38]](#footnote-38)
13. The Board notes the particular situation of the accused in this case, who has been declared quarrelsome and/or vexatious by various courts four times in twelve years and who allegedly suffers from a mental disorder characterized by persecutory-type delusions regarding the medical and legal systems. In view of this choice, the RBMD is concerned about its duty to ensure the unrepresented accused’s right to a fair trial.
14. It is undeniable that the Board has a duty to assist the unrepresented accused during the trial, but in the particular circumstances of this accused, this task could quickly become very complicated, considering the accused’s beliefs resulting in pathological distrust.
15. The Board has an inquisitorial role and must gather all the relevant evidence necessary to make the “appropriate” disposition, but it also has the duty to ensure the fairness of the process and the sound management of the hearing.
16. To determine the other circumstances in which the legislature permits the appointment of counsel to ensure compliance with the rules of natural justice, the Board turns to the *Criminal Code*, the case law, and the commentary.
17. With respect to the issue of the right to counsel, the *Criminal Code* provides that “[t]he accused or any other party has the right to be represented by counsel”.[[39]](#footnote-39)
18. Section 672.5(8) of the *Criminal Code* provides that “[i]f an accused is not represented by counsel, the court or Review Board shall, either before or at the time of the hearing, assign counsel to act for any accused (a) who has been found unfit to stand trial; or (b) wherever the interests of justice so require”.
19. This section gives the Board the power to appoint counsel to represent an incapable accused on its own initiative. The RBMD is of the view that this section also permits it to appoint counsel in the event that the accused chooses not to be represented.
20. The Court of Appeal for Ontario has ruled on the scope of section 672.5(8) of the *Criminal Code* in the case of an NCR accused on a few occasions*.*
21. In *Starson*,[[40]](#footnote-40) the Review Board converted the role of counsel previously appointed to the accused to *amicus curiae* when the accused indicated that he did not want to be represented by counsel but that he agreed to have counsel remain and assist him as an *amicus curiae*. The Court of Appeal was of the view that with the assistance of *amicus curiae*, the Board could fulfill its duty to ensure that it had the evidence necessary to make its decision.
22. In 2006, in *Lepage*,[[41]](#footnote-41) the Court of Appeal for Ontario questioned why the Board had not appointed an *amicus* *curiae* for the hearing of an NCR accused. With respect to the Review Board’s jurisdiction to appoint an *amicus curiae*, Juriansz J.A. stated the following on behalf of the Court:

In my view, the words of s. 672.5(8) do not preclude the Board from appointing amicus curiae when the interests of justice so require. I would not adopt an unduly technical approach to the question. Certainly, amicus curiae appointed by the court have no solicitor-client relationship with the accused, and may be described as counsel to the court. However, the role of amicus curiae is not strictly defined and continues to evolve. One of the roles of amicus curiae has been recognized as being an assistant to the court when “there is a failure to present the issues (as, for example, where one side of the argument has not been presented to the Court)”: Clark et al. and Attorney-General of Canada (1977), 1977 CanLII 1084 (ON SC), 17 O.R. (2d) 593 (H.C.J.). When NCR accused are involved, there is an elevated possibility that all issues may not be presented.

1. In 2011, the Court of Appeal for Ontario had to consider the meaning of the terms “wherever the interests of justice so require”.42 This time, the Court explicitly recognized that the Review Board has the power to appoint *amicus* *curiae*, even where the accused expresses his or her wish not to be assisted by counsel.
2. As for the “interests of justice”, the Court noted that it is up to the Review Board to determine whether a fair hearing may be held without the accused being represented by counsel. The Court of Appeal set out a non-exhaustive list of factors that the Board may take into consideration:

including the wishes of the NCR accused, the mental state of the NCR accused and his or her capacity to participate in the hearing without the assistance of counsel, the history of the proceedings, the nature of the issues likely to arise, and the impact of any delay in obtaining counsel. There may well be other factors. No factor is determinative. In the end, the Board should assess the totality of the circumstances in arriving at its decision.

1. In *Runnalls*, the Court of Appeal for Ontario issued the warning that because NCR accused are among the most vulnerable in the legal system and their freedom is in question during each review, it is important for Review Boards to carefully examine whether the interests of justice required the appointment of counsel or of an *amicus* *curiae*.
2. In 2013, the Supreme Court of Canada ruled on the appointment of a “friend of the court” in *Ontario v. Criminal Lawyers Association of Ontario* [*CLA*].[[42]](#footnote-42)
3. According to this judgment, courts have the power to appoint an *amicus* *curiae* when they require his or her assistance to ensure the orderly conduct of the proceedings.
4. The highest court stated that once appointed, the *amicus curiae* is bound by a duty of loyalty and integrity to the court.
5. The Supreme Court clearly stated that *amicus curiae* cannot take on the role of defence counsel.
6. It noted that while trial judges are obliged to assist unrepresented litigants, they are not permitted to give them strategic advice. A friend of the court cannot exercise a power that the court itself does not have the right to exercise.
7. Three years later, the Court of Appeal for Ontario reiterated that the Review Board has the duty to assess whether the *amicus curiae* it appointed was an adequate substitute for the accused’s own counsel. In *Conway (Re)*,[[43]](#footnote-43) a friend of the court was appointed, but the Board refused the accused’s request for an adjournment so that he could retain counsel. The Court of Appeal again referred to its judgment in *Lepage*.
8. In 2017, in *Murray (Re)*,[[44]](#footnote-44) the Court of Appeal found that the Review Board did not limit the friend of the court from playing the important role of presenting issues favouring the accused that otherwise might not be raised.
9. As for the role of the *amicus curiae*, in *R. v. Imona-Russel*,[[45]](#footnote-45) the Court noted that although an *amicus* cannot give the accused strategic advice, an *amicus* may, in appropriate cases, assist in cross-examination and the presentation of evidence.
10. Authors Barrett and Shandler opine that the Review Board for mental disorder has the power to appoint *amicus curiae*:

Accordingly, section 672.5 (8) of the Criminal Code permits the Review Board to either appoint counsel to represent the NCR offender or to appoint amicus curiae if the offender refuses legal representation. [[46]](#footnote-46)

1. Taking into account these teachings of the Court of Appeal for Ontario and the commentary, the Board relies of the accused’s mental condition, his designations as a quarrelsome or vexatious litigant, the history of the file, the two applications for leave to appeal the verdict, the nature of the issues that are likely to be raised, and the accused’s wishes to conclude that it is appropriate to appoint an *amicus curiae*.
2. The Board also takes note of the fact that the two other parties raised no objection in this respect.
3. In view of the Supreme Court’s judgment in *CLA*, the Board orders that Mtre Stephen Angers be appointed as *amicus curiae*. It notes that his mandate is to analyze the evidence, prepare for the hearing, meet with the accused, and assist him in a technical or administrative manner for the hearing, if necessary.

# ***B. Application to summon witnesses*[[47]](#footnote-47)**

1. On July 13, 2020, the accused requested that M-S.F.C., J.S.B., and Dr. Marie-Frédérique Allard be summoned.[[48]](#footnote-48)
2. The accused had acted in a similar manner in preparation for the last hearing before the RBMD.[[49]](#footnote-49)
3. In a letter addressed to the accused dated May 21, 2019, Mtre Claude Turpin, the coordinating judge of the RBMD at the time and alternate chairperson at the first hearing, informed the accused that it was important for him to understand that [translation] “the Board cannot reassess the offences alleged against you or the verdict of the Court of Québec”.[[50]](#footnote-50)
4. An examination of the file reveals that in a letter dated February 20, 2020, the accused requested a complete expert assessment of witnesses M.-S.F.C. and J.B.S., whom he claims submitted contradictory versions. He claimed that the investigator in the file, S.B., even stated that no offence had been committed.[[51]](#footnote-51)

# **(i) M.-S.F.C. and J.S.B.**

1. The accused previously stated that M.-S.F.C. and J.S.B. could not testify in view of the positions they held, like the Quebec Ombudsman, for example.[[52]](#footnote-52)
2. Regarding the testimony of M.-S.F.C. and J.S.B., the accused himself stated that the purpose of the summons concerned credibility. The Board cannot revisit the index offences underlying the NCR verdict.

# **ii) Dr. Marie-Frédérique Allard[[53]](#footnote-53)**

1. It is important to note that psychiatrist Dr. Allard attended the hearing in December 2019 and informed the Board that the accused refused to meet with her for the purposes of assessment.[[54]](#footnote-54)
2. During his brief stay in the forensic unit in May 2019, the accused still refused to see her again.
3. She stated in her assessment dated June 10, 2019, that [translation] “since the verdict of not criminally responsible due to mental disorder was rendered (in March 2019), the accused no longer wishes to have contact with me. The accused categorically refuses all conversation”.[[55]](#footnote-55)
4. On December 4, 2019, the Board also asked the accused if he agreed to meet with Dr. Allard. The accused refused. He repeated the arguments he had raised against Dr. Allard. He clearly indicated that he did not want to be assessed by her.
5. He has previously suggested that Dr. Allard was in a conflict of interest.[[56]](#footnote-56)
6. Taking these facts into account, the Board did not see the relevance of summoning this person.
7. A person has the right to determine whether a witness’s testimony is useful to him or her, but it is then up to the Board to assess the relevance of the witness’s testimony.[[57]](#footnote-57)
8. As for the summons of Dr. Allard, the Board does not see how her testimony could be useful to the assessment of the threat posed by the accused at this time, considering that this physician has not assessed the accused since at least May 2019.
9. Further to the panel’s suggestion, the accused nevertheless filed the transcript of Dr. Allard’s testimony before the Court of Québec.[[58]](#footnote-58)

# **iii) S. B.**

1. In a letter dated July 10, 2020, the accused requested that the investigator be summoned [translation] “to assert the mitigating factors concerning the presumption of dangerousness on questions of law raised by the person in charge of Institute B, for the purpose of presenting the statements made on the transcripts previously filed before the RBMD.”[[59]](#footnote-59)
2. When questioned by the Tribunal on the reasons underlying this request, the accused insisted that it was to assert the mitigating factors concerning dangerousness.
3. The Board refused to summon this witness for the same reasons that it refused to summon the witnesses M.-S.F.C. and J.S.B.
4. Moreover, the Board is of the view that the filing of the transcript of S.B.’s testimony by the accused in the context of the incident that took place in April 2018 addresses the accused’s concerns and that S.B.’s presence is not required.
5. The members of this panel do not see how the investigator could enlighten them on the danger that the accused poses to the safety of the public in 2020.
6. After questioning the accused, the Board refused the summons requested. The purpose of the attempt to summon the three witnesses was primarily to challenge the guilty verdict rendered by the Court of Québec and the NCR verdict.
7. As for the possibility for the accused to question or contest the merits and legitimacy of the verdict rendered by Morand J. of the Court of Québec on March 12, 2019, the Review Board for mental disorder does not have jurisdiction to review that judgment.
8. The Court of Appeal for Ontario reiterated that the Review Board also does not have jurisdiction to review the issue of whether the accused was suffering from a mental disorder at the time of the offence.

The appellant misunderstands jurisdiction. The Board is a statutory body. Its jurisdiction over the appellant comes from the relevant provisions of the Criminal Code: see s. 672.45(1.1) and s. 672.47. That jurisdiction is not affected by assertions by the appellant, or even medical evidence to the effect that the appellant does not and never did have a disease of the mind.

In any event, the concept of “disease of the mind” is a legal one that is relevant to a determination of whether a person should be held accountable for a criminal act. That determination is made by the court in the criminal proceeding. The concept has no application to the inquiry under s. 672.54 which is concerned with the safety of the public and the “mental health” of the “accused” as it relates to the risk, if any, posed by the “accused” to the public.[[60]](#footnote-60)

1. In addition, on May 1, 2019, the Chief Justice of the Court of Appeal of Quebec refused leave to appeal the judgment on guilt but authorized the accused to appeal the judgment finding him not criminally responsible, which necessarily included the order of detention in a hospital.[[61]](#footnote-61)
2. At page 4 of the judgment dated [...], 2019, the Court of Appeal stated:[[62]](#footnote-62)

[translation]

In his memorandum, the appellant revisits the conviction, even though he was not granted leave to appeal that judgment.

1. The appearance of all the witnesses has a common objective, that is, to question the lawfulness of the determination of guilt by Morand J. or to challenge the physician’s opinion on the accused’s responsibility for the offences, which are already subject to a judgment that now has the force of *res judicata*.
2. It is clear that the Review Board does not have jurisdiction to re-examine the verdict of not criminally responsible.
3. In *Guthrie v. British Columbia (Adult Forensic Psychiatric Services)*, 2019 BCCA 430 (CanLII), the Court of Appeal for British Columbia noted that even in the context of an appeal of a disposition rendered under section 672.54 of the *Criminal Code*, the Court of Appeal does not have jurisdiction to reconsider the lawfulness of the verdict.

Mr. Guthrie on this appeal challenges the accuracy of the evidence relied on by the Board, regarding the conduct that led to his wife dying.

If what Mr. Guthrie seeks is to have this Court reopen his criminal trial verdict of NCRMD, we do not have jurisdiction to do so on this appeal.

1. Finally, in *Staetter v. British Columbia (Adult Forensic Psychiatric Services)*,[[63]](#footnote-63) a case that resembles this one somewhat, the Court of Appeal of British Columbia was categorical in this regard:

His complaint today about process seems to also be a complaint that he was not allowed to subpoena witnesses which relate to his view of the issues underlying the index offences. I do not see any error by the Board in not allowing him to in effect challenge the facts regarding the underlying offences and to subpoena witnesses. The Board’s role is not to reconsider the underlying criminal trial that led to the verdict of NCRMD.

1. In addition to the test of reliability, the summoning of a witness depends on relevance.[[64]](#footnote-64) On the issue before the Board, however, the testimony of these four persons is not relevant with respect to the issue of the accused’s dangerousness at the time of the hearing.

# ***C. Applications to add the Quebec Ombudsman and the DCPP as impleaded parties, and addition of the DCPP as an impleaded party****[[65]](#footnote-65)*

1. By letter dated July 10, 2020, the accused stated that he was representing himself and sought the addition of the Quebec Ombudsman and the DCPP as impleaded parties for the hearing scheduled for July 28, 2020.
2. To decide this issue, the Board examined section 672.5(4) of the *Criminal Code*, which reads as follows:

The court or Review Board may designate as a party any person who has a substantial interest in protecting the interests of the accused, if the court or Review Board is of the opinion that it is just to do so.

1. With respect, the Board does not see how the Quebec Ombudsman has a substantial interest in the proceeding to protect the interests of the accused. It is important to recall that it is an employee of that body who reported the accused’s conduct giving rise to the offence underlying the NCR verdict.
2. In addition, it is not that body who seeks to be granted such status, but rather the accused.
3. The interests of justice, including that of promptly determining whether the accused’s mental condition continues to justify restrictions on his liberty, do not require that the Board grant the Quebec Ombudsman party status.
4. The director of criminal and penal prosecutions was already a party to the hearing on the date of the application.

# ***D.* *ARTICLE 76 C.C.P.***[[66]](#footnote-66)

1. On July 14, 2020, the accused served a notice of infringement of his fundamental rights and freedoms, in accordance with section 112 of the *Act respecting administrative justice.*[[67]](#footnote-67)
2. To address the accused’s application, the Board takes into consideration the fact that he requires authorization to file a proceeding before the Tribunal administratif du Québec in accordance with the orders rendered by the Honourable Raymond W. Pronovost J.S.C., on February 15, 2017.[[68]](#footnote-68)
3. In that judgment, the Quebec Superior Court declared the accused a quarrelsome litigant and issued an order in his regard stating the following:

[translation]

PROHIBITS the [NCR accused] from filing, directly or indirectly, any proceeding before an administrative tribunal or any administrative body subject to the Superior Court’s superintending power, without first obtaining the prior written authorization of a member responsible for that administrative tribunal or a person responsible for the administrative body.[[69]](#footnote-69)

1. On July 27, 2020, Mtre Sylvain Bourassa, president of the Tribunal administratif du Québec, refused to grant leave to file that proceeding.[[70]](#footnote-70)
2. The Court of Appeal’s judgment in *Starz (Re)*[[71]](#footnote-71) is also applicable to the notice in question. The Court acknowledged that if an accused does not specify the alleged *Charter* violation or does not submit any evidence in support of the alleged violation, it is open to the Board to dismiss the application without a hearing.
3. In his notice, the accused did not provide specific facts to support any of the alleged infringements.
4. Accordingly, the Board will not rule on the allegations in the notice or on any remedy sought by the accused on the basis of the *Canadian Charter of Rights and Freedoms*.

# **VIII. LEGAL ISSUES RAISED DURING THE PROCEEDINGS**

# ***A. The accused’s right not to testify***

1. During the session held on August 25, 2020, the accused informed the Board that he might choose not to testify at the hearing. His position was that if he did not testify, he would not be required to answer any questions from the parties.
2. The *amicus curiae* agreed with this position and opined that only the members of this panel could question the accused.
3. Mtre Angers argued that the accused has the fundamental right not to testify, even if the accused is before the Board and that the rules of evidence and procedure are therefore more flexible.
4. The Board told the parties that it wanted to reflect on the issue, considering that the members have an inquisitorial role and powers under the *Inquiries Act*.[[72]](#footnote-72)
5. The undersigned nevertheless explained to the accused the importance for the Board to gather all relevant, necessary information to make an informed decision. Information was provided to him regarding the fact that he could make submissions on the evidence only and that, during his arguments, he could not attempt to introduce elements that had not already been entered into evidence.
6. The accused immediately expressed his intention not to testify. He added that he wanted to keep more time to present his arguments.
7. The Board warned him that it was his responsibility to properly assess the evidence before making such a decision.
8. Following the adjournment of the hearing and its resumption on August 27, 2020, the Board accepted the position of the *amicus curiae* and of the accused that the accused could not be forced to testify or to answer the questions of the parties and of the members of the panel.
9. The issue of an accused’s compellability to testify before the Board has not been the subject of much debate before other Review Boards for mental disorder or the appellate courts of this country.
10. From the argument of the *amicus curiae*, Mtre Angers, the Board understands that he is of the view that the accused has the absolute right not to testify and that, in fact, the accused was in a way expressing his right to silence. This way, the result is that the other parties cannot claim that the accused must submit to cross-examination.
11. While the Board arrives at the same conclusion as the *amicus curiae* in its decision, the intellectual reasoning differs.
12. In *Winko*,[[73]](#footnote-73) the Supreme Court of Canada had to rule on the issue of whether section 672.54 *Cr. C*. infringed sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* (*Charter*). The Court answered in the negative.
13. The Court acknowledged that Part XX.1 was drafted with the protection of the accused’s constitutional rights in mind. It stated:

At all times, this process must take place in an environment respectful of the NCR accused’s constitutional rights, free from the negative stereotypes that have too often in the past prejudiced the mentally ill who come into contact with the justice system.[[74]](#footnote-74)

1. It is indisputable that an accused facing a trial before a criminal court has the right to silence. Section 11(c) of the *Canadian Charter of Rights and Freedoms* provides that any person charged with an offence has the right not to be compelled to be a witness in proceedings against that person in respect of the office.
2. Nevertheless, *Winko* clearly establishes that once the person has received an NCR verdict, he or she is then subject to a special procedure.[[75]](#footnote-75) He or she has a special status, being spared the full weight of criminal responsibility, while being subject to the restrictions necessary to protect the public. It should be recalled that although the accused has not been acquitted, the accused has also not been convicted.
3. Considering that the accused is no longer facing charges when appearing before the Review Board, the members of this panel do not think we can refer to the possibility for the accused to exercise his right to silence during a first hearing or a review hearing, because this right, set out in section 11(c) of the *Charter* protects him in the context of “proceedings against” him for an offence.
4. The accused is no longer the subject of proceedings against him for an offence. He could even plead autrefois acquit in subsequent proceedings. The Board is of the view that the proceeding created by Part XX.1 cannot be considered “proceedings against” him. It is important to keep in mind that during a hearing concerning the NCR verdict:

The proceeding before the court or Review Board is not adversarial. If the parties do not present sufficient information, it is up to the court or Review Board to seek out the evidence it requires to make its decision. Where the court is considering the matter, it may find in such circumstances that it cannot readily make a disposition without delay and that it should be considered by the Review Board. Regardless of which body considers the issue, there is never any legal burden on the NCR accused to show that he or she does not pose a significant threat to the safety of the public.[[76]](#footnote-76)

1. Accordingly, the Board does not find it appropriate to claim that the accused has the right to silence on the issue of his dangerousness, during a first hearing or a review hearing.
2. While the panel understands the importance and relevance of the accused’s testimony in the context of its mandate to assess the threat that he represents to the safety of the public, the members do not agree that the Board’s powers of inquiry permit it to compel the accused to answer questions. The Board clearly has the obligation and the duty to assess the threat that the accused poses to the public, but it does not think that Parliament has given it the power to disregard the accused’s right not to participate in the presentation of the evidence.
3. The Board finds support for its position in the wording of the provision set out in s. 672.5(10) *Cr. C.* Pursuant to that provision, the Board may permit the accused to be absent during the whole or any part of the hearing on such conditions that it deems proper or cause the accused to be removed and barred from re-entry for the whole or any part of the hearing where the accused interrupts the hearing so that to continue in the presence of the accused would not be feasible or if the Board is satisfied that failure to do so would likely endanger the life or safety of another person or would seriously impair the treatment or recovery of the accused.
4. Because the legislature has included a provision permitting the Board to proceed *in absentia* of an accused, an inference may be drawn to the effect that the accused’s testimony is not absolutely essential to rendering an informed decision. In fact, the Supreme Court in *Winko* stated that “[t]he court or Review Board has a duty not only to search out and consider evidence favouring restricting NCR accused, but also to search out and consider evidence favouring his or her absolute discharge or release subject to the minimal necessary restraints, regardless of whether the NCR accused is even present”.[[77]](#footnote-77)
5. The panel does not agree with the British Columbia Review Board[[78]](#footnote-78) that we can infer from the accused’s silence during the first hearing or the review hearing that he acquiesces at least to some degree to the evidence submitted. The Board has the duty to consider and weigh the evidence, regardless of the accused’s level of cooperation.
6. Section 672.43 of the *Criminal Code* provides that, at a hearing held by a Review Board to make a disposition or review a disposition in respect of an accused, the chairperson has all the powers that are conferred by sections 4 and 5 of the *Inquiries Act* on persons appointed as commissioners under Part I of that Act.
7. Sections 4 and 5 of the *Inquiries Act* provide:

4. The commissioners have the power of summoning before them any witnesses, and of requiring them to

(a) give evidence, orally or in writing, and on oath or, if they are persons entitled to affirm in civil matters on solemn affirmation; and;

(b) produce such documents and things as the commissioners deem requisite to the full investigation of the matters into which they are appointed to examine.

5. The commissioners have the same power to enforce the attendance of witnesses and to compel them to give evidence as is vested in any court of record in civil cases.

1. Authors Barrett and Shandler note that “the chairperson’s powers mirror those of a judge in a civil case and includes the power to compel the attendance of the accused and other witnesses, as well as the power to compel the production of documents or other material deemed necessary to properly consider and make dispositions under section 672.54 of the *Criminal Code*”.[[79]](#footnote-79)
2. Unlike the judge in civil matters, the chairperson of the Review Board for mental disorder does not have the power to sanction the conduct of a person who acts in contempt of court. The *Criminal Code* does not grant such power to administrative judges acting as members of the Review Board.
3. It is our humble opinion that the chairperson of the Review Board for mental disorder is vested with the powers of a court of record in civil matters solely during a hearing of the Review Board to compel witnesses to appear and to file documents or other exhibits.
4. The chairperson of the Board may therefore compel the accused’s presence for the purpose of an appearance,[[80]](#footnote-80) but cannot force the accused to respond.
5. In this regard, Barrett and Shandler write:

While there is power to compel an accused's attendance before the Board, the accused cannot be compelled to testify. The inability to compel an accused's testimony does not preclude the Board from asking questions of the accused, it simply lacks the power to compel answers.

1. The authors suggest that this inability to compel the accused’s testimony is nevertheless consistent with procedure and the notion of trial fairness.
2. In *New Brunswick Review Board v. Boucher*,[[81]](#footnote-81) the New Brunswick Court of Appeal had to determine whether section 672.43 of the *Criminal Code* vests upon the chairperson the power to enforce the attendance of the accused to give evidence at Review Board hearings. Although the Court of Appeal’s judgment was rendered in the context of a hearing on the accused’s fitness to stand trial, this panel is of the view that it applies in regard to NCR accused hearings.
3. The Court wrote:

… although they are broad, the powers of the chairperson of Board do not include the power to compel an accused to give evidence at its hearings. The principles set out by McLachlin, J., in Winko v. Forensic Psychiatric Institute (B.C.) et al., [1999] S.C.J. No. 31; 241 N.R. 1; 124 B.C.A.C. 1; 203 W.A.C. 1 (S.C.C.), at paragraphs 61 and 62, were formulated carefully following a detailed analysis of the provisions of Part XX.1 of the Code. Still, one cannot infer therefrom any express or implied support for the case of the appellant. In fact, they include an exhortation to respect the constitutional rights of the accused in the context of any hearing held under Part XX.1. The right not to be compelled to give evidence is obviously part of these constitutional rights.[[82]](#footnote-82)

1. Finally, although Twaddle J.A. of Court of Appeal of Manitoba wrote the following passage in an appeal from a judgment rendered in the context of a confinement order, the Board considers it relevant:

I would be surprised indeed if the Board ever thought it necessary to compel a patient to testify. It is unthinkable to me that the Board, enquiring as to whether there are sufficient grounds on which to detain the patient on an involuntary basis, would threaten the patient with a loss of liberty for a failure to answer questions.[[83]](#footnote-83)

1. Moreover, the panel is of the view that it would be inappropriate to attempt to compel the accused to answer questions given that he is alleged to suffer from a mental disorder, he is already in detention, and the law does not explicitly or implicitly provide this power.

# ***B. The amicus curiae’s application to expand his role***

1. During the hearing held on July 28, 2020, concerning the appointment of the *amicus curiae*, and following the submissions of all the parties, the Board appointed Mtre Stephen Angers as *amicus curiae*.
2. His mandate is to analyze the evidence, prepare for the hearing, meet with the accused, and assist him in a technical or administrative manner at the hearing, if necessary.
3. During the hearing held on August 27, 2020, Mtre Angers submitted that he could help the accused prepare his arguments.
4. Following the submissions of Mtre Tourigny, counsel for the person in charge of the designated hospital, and of the *amicus curiae*, the latter undertook to submit authorities on the role and duties of the *amicus curiae* before the next date.
5. On September 1, 2020, Mtre Angers provided the Board with a copy of a judgment rendered by the Court of Québec on the role of the *amicus curiae*.[[84]](#footnote-84)
6. On September 4, 2020, Mtre Angers provided the Board with written arguments and authorities in support of his position that the Board may expand the role of the *amicus curiae* to permit him to assist the accused in the preparation of his arguments.
7. On September 21, 2020, the Board asked the parties to provide it with their written comments concerning the possible application to the accused’s case. The Board received the respective positions of counsel for the person in charge of the designated hospital and of the friend of the court on September 23 and 24, 2020.
8. On September 25, 2020, following the submissions of all the parties, the Review Board took note of the *amicus curiae*’s discontinuance of his application to assist the accused in the preparation of his submissions.

# **IX. EVIDENCE AT THE HEARING**

# **Report of Dr. Chantale Bouchard, Dr. Charlotte Gauthier, and Arnaud Sepulveda**

1. On June 29, 2020, the multidisciplinary psychiatric consultation report on the accused’s risk of violence was filed in the record. An actuarial tool, the HCR-20, was used in the assessment of the risk of hetero-directed violence.
2. The Board notes that according to the HCR-20 v.3, there is a risk of hetero-directed violence when “[a] person engaged in an act (or omission) with some degree of wilfulness that caused or had the potential to cause physical or serious psychological harm to another person or persons” (Douglas et al. 2013).[[85]](#footnote-85)
3. The Board was informed that Dr. Chantale Bouchard, forensic psychiatrist, Dr. Charlotte Gauthier, fifth-year resident in psychiatry, and Arnaud Sepulveda, criminologist, held a meeting with the accused by videoconference for the purposes of the assessment on May 15, 2020.
4. According to the report, the limits of confidentiality, that is, the fact that the report would be submitted to the Board, were explained to the accused, who apparently provided free and informed verbal consent. It is reported, however, that later during the meeting he said that his remarks were [translation] “protected statements”, invoking a limited scope of his remarks before [translation] “the Court”.
5. The report also indicates that at the very end of the meeting, the accused stated that because of a sedative he had taken the day before for a physical medical exam, he was not feeling entirely like himself.
6. The authors of the report state that the sources consulted were clinical file summaries external to the ClUSSS (reports of the Review Board for mental disorder, psychiatric assessments, admission notes, psychiatric progress notes, assessment of social functioning, and progress notes of the treatment staff, that is, the nurses and other case workers).
7. The professionals at Institute B (hereinafter [Institute B]) report that the accused remains vague about medication. They state that he shows signs of distrust towards the members of the team. He does not seem to want to take a position on the issue of the diagnosis. Accordingly, he refuses to speak about his psychiatric history, although he often brings up past events himself, but denies it when the assessors mention it to him. He is often evasive and seems to choose his words carefully to avoid providing answers that could be used [translation] “against” him. He does not answer certain questions on the pretext that he [translation] “doesn’t have his file in front of him”.
8. They note that he is hesitant to discuss subjects other than those he considers to be strictly part of the assessment of dangerousness, that is, very specific elements (prior violent acts and hetero-aggressive thoughts). When more anxiety-provoking subjects are addressed, he can quickly become tense, interpretive, and projective, asking if they present [translation] “a risk of violence” and asking to comment on the dangerousness of various people. Most often, he changes the subject and raises issues of legal procedure, which he describes in great detail. When they try to make him refocus and get back to the question posed, he becomes somewhat irritable and says that he is in the process of answering the question.
9. During the assessment, the accused criticized the assessors for [translation] “causing him to regress” by constantly revisiting past events, whereas he is trying to move on. He changed the subject back to his previous legal cases several times.
10. The Board finds the following passages of the report significant:

[translation]

… we note the presence of a systematic delusion of persecution in connection with the legal system and with [translation] “an individual” whom he perceives as being the source of his difficulties, an overwhelming concern with legal proceedings, overinvested versus delusional thoughts in connection with pedophilia, to which he does not provide access. We also note significant defence mechanisms of psychotic denial, rationalization, and intellectualization. He has no insight. He does not believe that he has a psychiatric disorder. His judgment appears altered in the long term as he considers it reasonable and justified to act on his delusional beliefs.[[86]](#footnote-86)

1. Dr. Bouchard accepts the diagnosis of a persecutory-type delusional disorder. In her view, he has possible premorbid cluster A personality traits (schizoid and paranoid).
2. The assessors are of the view that the accused has a history of issues with violence and antisocial behaviour.
3. According to this report, the accused refuses to speak about his past criminal convictions.
4. Dr. Bouchard, Dr. Gauthier, and Mr. Sepulveda are of the view that in general, the accused seems to have had few significant relationships since childhood.
5. They note that his past risk factors include a history of major mental disorder, problems related to a personality disorder, and traumatic experiences.
6. They also refer to his history of problems responding to treatment or to supervision. They submit that the accused says that he has had adverse effects from the medication every time and that he refuses to take it again. More specifically in regard to antipsychotics, they note that he says they can cause those who take them to have issues with violence.
7. They acknowledge that the accused has not actually received psychiatric follow-up care or taken his medication regularly for about 10 years.
8. The professionals assert that the accused has recently had problems with insight. According to the report, when confronted, the accused acknowledges that an assault can be verbal, but he denies having ever committed verbal assault.
9. The Board notes that the accused seems to have conceded during the meeting that intimidation may be harmful to others and associated with violence.
10. As for the offence and the criminal convictions on charges of distribution of child pornography and identity fraud for facts dating back to April 2015, for which he was convicted of having fraudulently personated another person for the purpose of causing disadvantage to the person being personated or another person, he does not acknowledge the facts:

[translation]

Regarding the charges of intimidation of a justice system participant on which he was convicted and found not criminally responsible for facts that occurred in April 2017,[[87]](#footnote-87) he denies the validity of the evidence presented in Court, being of the opinion that it is a conspiracy against him.

Regarding the charges of uttering threats to cause death or bodily harm for facts that occurred in April 2018, he states that he acted in self-defence, thereby denying the criminal and violent scope of his act.[[88]](#footnote-88)

1. Finally, the professionals at [Institute B] indicate that the accused says he was declared to be a [translation] “quarrelsome litigant” by the Court of Québec in 2007 and a [translation] “vexatious litigant” by the Court of Québec in 2009 solely because of technical errors made in preparing his cases without the assistance of counsel.
2. They note that when questioned about his mental disorder, the accused denied the validity of the diagnoses in the record and the presence of symptoms of his mental disorder. Finally, he said that he does not need psychiatric follow-up care. The accused has certain paranoid perceptions about the psychiatrists who have assessed him over the years.
3. The report also states the following:

[translation]

He has recently had emotional, behavioural, and cognitive instability issues. By the symptoms described above, the accused shows cognitive instability, with psychotic defence mechanisms at the forefront that alter his ability to perceive reality as it is. He also sometimes displays behavioural instability, that is, unpredictable acts in connection with his delusional beliefs. His emotional instability manifests especially as irritability, even anger, when the accused is confronted with the presence of a psychiatric illness or his past criminal acts.[[89]](#footnote-89)

1. The three professionals recommend that the accused be subject to an order of strict detention or an order of detention including conditions for outings. They submit that he could continue to receive the same services as in the months prior to the assessment, with adapted multidisciplinary care (psychiatric, psychological, and social).
2. They nevertheless admit that when the accused benefitted from conditional outings in the past, they appear to have gone well overall. He spent his time doing handyman work at his house and helping his mother, which, he says, [translation] “refocussed his thoughts”, and he spent less time working on his computer, fixated on his legal proceedings.
3. The assessment revealed that his family may also have a certain shared distrust of the legal system, according to the record.
4. The physicians and the criminologist opine that [translation] “in the absence of a legal context such as a court order for care, it seems extremely probable that the accused will continue to refuse to take medication”.[[90]](#footnote-90)
5. They are of the view that issuing a treatment order could represent a source of significant stress for the patient, due to his paranoid thoughts concerning both the medication itself and the entire medical community and justice system.
6. They submit that the accused may also experience the end of the current legal proceedings as a loss given his paranoid anxiety, for which his quarrelsomeness may be a defence strategy.
7. They identified the following risk factors: [translation] “the mental disorder, the lack of insight, and the impulsiveness, which underlie the accused’s violent dynamic and his problems responding to the treatment and supervision”.[[91]](#footnote-91)
8. They recommend regular support provided by a person he trusts and who has some knowledge of mental health issues, until the accused adjusts to his new routine, to his new circle, and to the various stressors to which he will be exposed. The submit that a return to pharmacological treatment and regular psychiatric follow-up care should be urged.
9. The Board also notes the following passage of the report:

[translation]

The charges of intimidation of a justice system participant (April 2017) and of uttering threats (April 2018) are rooted in a context of destabilization of his clinical condition related to the cessation of psychiatric follow-up care and his medication. They did not ultimately result in a hetero-aggressive physical act, but were accompanied by the persistence of paranoid thoughts towards the persons concerned. In the absence of medication, **these thoughts may persist over time and may in the future become associated with a risk that the accused will engage in violent conduct again.**[[92]](#footnote-92)

[Emphasis added.]

1. Last, the final opinion provides the following:

[translation]

In light of the information gathered through the HCR-20 v.3, we are of the view that for the next six months in the institution, **assuming that conditions for outings are granted without appropriate risk management strategies**,the accused represents **a moderate risk of violence. If the accused were to act violently in the next six months, the violence displayed would likely be more psychological than physical with a low risk of serious physical harm. At the time of the accused’s assessment, we are of the view that there is a low risk of imminent violence.** The risk of imminent violence should be assessed when necessary with a tool meant for that purpose, such as the Dynamic Appraisal of Situational Aggression (DASA). If risk factors for self-harm and/or suicide arise, that risk must be assessed by a mental health care practitioner competent to do so. The next assessment of the accused’s risk of hetero-directed violence should be conducted in approximately six months or if significant changes are noted on a clinical level or in terms of orientation (release, incarceration, hospitalization, change in living environment in the community, pharmacological treatment, etc.).[[93]](#footnote-93)

[Emphasis added.]

*The accused’s objection to the references in the multidisciplinary assessment to the information arising from Dr. Marie-Frédérique Allard’s application to authorize care dated June 3, 2019.*

1. Before Dr. Chantale Bouchard’s testimony, the accused objected to the references in the multidisciplinary assessment to Dr. Marie-Frédérique Allard’s application to authorize caredated June 3, 2019. He submits that Dr. Bouchard could not rely on Dr. Allard’s analysis considering that the expert assessment conducted for the purposes of the order to authorize care remains pending before the Superior Court. He says that the expert assessment of Dr. Bouchard and of Mr. Sepulveda is a mere carbon copy of Dr. Allard’s opinion.
2. The Review Board dismisses this objection for the following reasons.
3. In fact, Dr. Allard’s report expresses agreement with the remarks made in Dr. Allaire’s report.[[94]](#footnote-94)
4. In addition, it is important to consider that Dr. Bouchard used the word [translation] “including” in her footnotes when referring to Dr. Allard’s report.
5. It is difficult to distinguish the information that appears in the application to authorize care and the information that comes from other sources.
6. Even if the Board could disregard this information, it appears elsewhere in the administrative record.
7. For example, at note 9 on page 15 of 21, Dr. Bouchard specifically refers to the hospitalization at the CSSS A in the context of the assessment of his fitness to stand trial and of his criminal liability that took place in October 2000.
8. The objection is dismissed, because the references that the accused invokes are facts that the Board considers relevant and that it could take into account for the purposes of analyzing the issue of dangerousness. It is up to the Review Board to determine the probative value to ascribe to these elements. The Board has an inquisitorial role. All reliable facts relevant to this issue may be presented.[[95]](#footnote-95)
9. Finally, the multidisciplinary assessment was filed further to the Board’s request as a result of the panel’s observation in December 2019 of the situation of therapeutic impasse.

# ***Testimony of Dr. Chantale Bouchard***

1. She confirmed that despite the fact that her report dates back to June 2020, her conclusions remain relevant. She stated that the accused’s mental condition has not changed since then.
2. She insisted that there is no [translation] “table” included in her report. The table is the result of a multidisciplinary assessment based on the HCR-20 tool.
3. When asked whether she gave the accused a warning before starting the assessment, she confirmed that she had. She admitted, however, that the accused said that his answers were protected statements. She maintains that the assessors obtained the accused’s free and informed consent.
4. Dr. Bouchard confirmed that she had access to the report prepared by Dr. Allard in support of the application for an order to authorize care, pending before the Superior Court. She nevertheless consulted the file summaries provided to her.
5. When asked whether her assessment report is based on pre-constituted elements not entered into evidence, she answered that her clinical opinion is based on her clinical judgment. She specified that it is the result of the history of the accused’s illness, the symptoms he presented, and the mental examination that the three assessors conducted. She stated that she does not issue an opinion if she is not sure.
6. As for whether she is of the view that the accused poses a risk, she said that, according to the report, he represents a moderate risk of violence.
7. Regarding the reference in the report to the low risk of imminent violence, the physician explained that the word [translation] “imminent” refers to the risk that the accused will commit violent acts against the assessors at the precise time of the assessment. She acknowledges that at the time of her analysis, the accused was not under medication.
8. Asked whether the risk [translation] “incurred” in fact comprises physical violence of a criminal nature, the physician insisted that this is not what she stated in her report. She said that it is more a risk of psychological harm.
9. She used the following terms in her explanation: [translation] “psychological, it’s often, it could be harassment; it could be threats; it could be of a criminal nature”.
10. She admits that the team of assessors relied on historical factors.
11. She denies that her questions during the assessment essentially concerned previous files.
12. She confirmed that she did not have access to Dr. Sylvain Faucher’s opinion concerning the accused’s dangerousness.
13. Dr. Bouchard explained that when she assesses personality, she concentrates on the person in front of her and not on the other persons involved. For her, the word [translation] “personality” refers to the way a person behaves in the long term. According to her, it is not something that arises from an interaction.
14. She opined that certain character traits, in certain defined contexts, can result in greater distress or difficulties in functioning.
15. She conceded that an individual who makes a legitimate complaint is not doing anything dangerous. She does not consider that to be a risk factor.
16. Asked whether a diagnosis of persecutory delusional disorder could be reconciled with the fact that criminal acts were actually committed against the accused, the physician answered in the affirmative.
17. The psychiatrist recognizes the Merck Manual as an authority in medicine.
18. Confronted with the definition of delusional disorder proposed by psychiatrist Carol Tamminga, Dr. Bouchard said that it was her diagnosis.
19. She submits that the fact that the accused suffers from a delusional disorder does not mean that he cannot have been the victim of a criminal offence. She said that it is important to remain vigilant so as to distinguish the two.
20. She explained that to do so, she conducted a psychiatric examination and a careful review of the records. The team then applied the scientifically recognized framework for the risk of violence.
21. As for whether she took into account the mitigating factors of provocation and discrimination in her assessment of the risk, she said that they took all of the clinical factors into account, in accordance with the analytical framework, the HCR-20.
22. She confirmed that they considered the fact that the accused claims to have been the victim of offences.
23. She admits, however, that they did not repeat the whole story in the assessment report. She believes that the breaking and entering at the accused’s residence in 2019 was mentioned in the report.
24. She maintains that she considered the mitigating factors, even if they are not discussed extensively. The team limited itself to what was requested by the RBMD.
25. As for the risk of violence, she acknowledges that the team was concerned with only the acts that the accused committed and not those of which he was a victim.
26. She said that she did not have access to analysis report SQ-503-150413-002.[[96]](#footnote-96)
27. She insists that the report she co-authored contains an accurate account of the meeting and the statements made by the accused.
28. She submits that the assessment of the risk fluctuates over time. An individual may not be dangerous, but the progression of untreated mental illness may cause an aggravation of the risk factors.
29. She confirmed having noted in the previous reports of Dr. Élise St-André and Dr. Marie-Frédérique Allard [translation] “that there was no dangerousness”.
30. When asked whether a person involved in a file could assess an accused’s risk of dangerousness at the same time, the physician stated that the question seemed moot to her.
31. She insisted that she would not assess someone if doing so would put her in a conflict of interest. She said that she is aware of the importance of remaining neutral and objective.
32. As for whether she conducted an investigation into the events that could be considered abuse, Dr. Bouchard answered that she prepares clinical assessment reports; she does not conduct police investigations.
33. When the accused asked her if the risk that an individual presents is the result of a combination of multiple factors and their circumstantial association with an identified group of individuals, the physician answered that the assessment of risk indeed takes a multitude of factors into account.
34. The physician conceded that the assessment takes into account a scale with a group of individuals identified by studies, for comparative purposes.
35. She notes that certain forms of stress may cause an individual to be at greater risk.
36. As for whether psychological distress is a symptom of mental illness, she answered that it depends. In her view, psychological suffering can cause an illness, if there are complications. She submits that distress is experienced psychologically, but also manifests in biological changes.
37. When asked what questions she asked him to determine his level of introspection, she said that all the assessments conducted and all the documents consulted allowed her to conclude that the accused has no insight with respect to his psychiatric condition. She noted that the accused says he is not sick and does not want treatment. She recalls having asked him if he thought he had a psychiatric disorder and needed treatment.
38. She admits that crying because everything is mixed up in a person’s mind is not a delusional symptom of a psychotic disorder. In her view, it is a sign of sadness. She submits that emotions are complex and numerous.
39. She maintains that we must not be limited by what we can see. It is necessary to ask questions and analyze [translation] “the situation” as a whole.
40. Asked whether persons who exercise their right to defend themselves constitute a danger to the public, she said that wanting to do so is a natural human reaction. She insisted that the assessment of risk implies a trajectory, a history, a context, and several clinical factors.
41. She acknowledged that stress and relational factors may also contribute to the threat to the public.
42. In response to the accused’s question as to whether she took into account Dr. Marie-Frédérique Allard’s testimony before the Court of Québec to the effect that he does not have schizophrenia, she referred the accused to the [translation] “sources consulted” section of her report.
43. She insists that she referred to Dr. Mailloux’s opinion and that the accused told her about that physician’s retraction of the diagnosis.
44. She explained that Dr. Mailloux’s report is from a private file, which was not provided to her. She did not have access to or consult the retraction.
45. She admitted that the accused told her about a decision of the Tribunal administrative du Québec that did not recognize a traumatic brain injury suffered in 1997, but said that she did not consult the document.
46. She said that during the assessment, the accused mentioned that it may sometimes be appropriate to commit a criminal act against someone who has committed a criminal act. She denied the accused’s suggestion that he explained to her that Officer S.B. testified that everything took place in a context of self-defence.
47. She agreed that the accused referred to that officer at length when he spoke about the legal steps taken in regard to the file.
48. She said that she sometimes asks for clarification during cross-examination, because the questions are of a legal nature. Out of concern for thoroughness and precision, she wants to be sure that she has properly understood before providing an appropriate response.
49. She informed the members of the panel that multidisciplinary assessments are never recorded.
50. As for whether the accused told her that when he was answering, he was using another person’s answers, the physician said that she did not recall that.
51. With respect to the error regarding the date of the offence, she referred the Tribunal to Mr. Sepulveda, because she submits that he wrote that part.
52. She was not aware that a witness at the criminal trial stated that the alleged words of the threat were never uttered. She acknowledged that the accused told her that there are other explanations for what happened. She said that it has been documented that the accused [translation] “often had other versions”.
53. She acknowledged that she did not consult the transcripts of the criminal trial.
54. When asked what she meant when she asked the accused during the assessment if he felt betrayed, she answered that she wanted to know how he felt.
55. In her view, the mental disorder is the main risk factor, apart from the absence of treatment. She says she is convinced that if the accused was under pharmacological treatment, he would feel relief. He would be less overwhelmed by his thoughts about injustice, and he could resume his life outside the institution.
56. When asked if she was aware whether he had stopped taking his medication at the time of his past offences, she answered that it is clear in the file that the accused was not taking his medication. She added that the accused is categorical about the fact that he does not need medication.
57. Regarding whether he was undergoing treatment at the time of the incidents in 2000, the physician insisted that the accused said that he was not taking medication, or that he took medication for very brief periods and then ceased pharmacological treatment due to the side effects he was experiencing.
58. She confirmed that the assessment lasted an hour and a half. Her contact with the accused was by videoconference.
59. She explained that the word [translation] “delusion” is defined as a false belief that is not supported by reality.
60. As for whether the psychological illness is mental or biochemical, she said that they are two sides of the same coin.
61. When asked whether she had proof that the accused had undergone changes in his neurotransmitters, she explained that the basis of psychiatry is clinical diagnosis. There is no specific test. Medicine is not an exact science.
62. She admitted that she cannot identify the exact cause of a mental illness.
63. The information does not allow her to understand why the accused reacted in a certain way at the time of the offences or whether he was the victim of abuse.
64. When asked whether she noticed a relaxation of the psychomotor system, she answered that she is not a neurologist. Regarding concentration, she stated that the accused is very concentrated and oriented in time and space. She noted that the team did not conduct a mental assessment of the higher functions. She said that the accused has already undergone a neuropsychological assessment, which revealed certain difficulties. She suggested that it could be relevant to redo it.
65. She confirmed that the accused is quite interested in the legal process.
66. She maintained that the delusional disorder is well established and confirmed by several psychiatrists. She bases her diagnosis on the fact that the accused has persecutory delusions related to an individual known to be the source of this problem. The accused is overwhelmingly concerned with legal procedure.
67. In her view, he has overinvested as opposed to delusional thoughts about pedophilia, to which he does not give access. He has a significant defence mechanism of psychotic denial, rationalization, and intellectualization, as well as an isolated affect. In other words, it is her understanding that he suffers from delusional thoughts.
68. She added that it is not possible to isolate a single event from his past.
69. His diagnosis is quite stable. Nevertheless, everything seems well crystalized. These delusional thoughts appear to have been present for a long time.
70. She confirmed that the fact that the accused helps his relatives seems to be corroborated. She acknowledge that the outings he was able to go on seen to have gone well.
71. She has been a psychiatrist since 1997. She practises only clinical psychiatry. She has been working at Institute B since January 2006. She also worked for Correctional Service Canada for 10 years.
72. She has prepared three to six expert assessments a week since 2006. She mostly prepares reports on criminal liability for the courts of justice.
73. She did not record all of her time spent reading the documentation in this file. She had many discussions with the criminologist and the resident.
74. She had never heard about Dr. Faucher’s report. She was not aware the Mr. Dubeau, occupational therapist at the designated hospital, prepared a report. She does not know Dr. Delagrave. She was aware, however, that the accused was assigned a new physician.
75. She confirmed that it is possible for a psychiatrist involved in the file after her to call her, to ensure some continuity.
76. She noted that this file is nevertheless particular, because the request came from the Review Board for mental disorder.
77. She repeated that the imminent risk of physical violence is low, despite the absence of medication.
78. Her recommendation takes into account the fact that the accused is hospitalized. In the event of a change in the situation, such as the start of pharmacological treatment, the members of the team could reconsider their position.
79. She is not the attending physician and cannot act as a substitute for him or her. Only that professional will be able to integrate the clinical recommendations.
80. She could form an opinion on the frequency of outings, which will be developed in the context of a clinical discussion.
81. She conceded that, in the accused’s case, outings helped him think about other things. In general, she is of the opinion that the family is in favour of managing such outings. The accused seems to have had occasional contact with his mother and his two sisters.
82. With respect to psychological treatment, she believes that it is important for the accused to find meaning in his life, to keep busy, and to acquire a sense of self-worth.
83. The assessment team listed the various therapeutic modalities, but they remain subject to the attending physician’s assessment and evaluation in accordance with the accused’s progress and needs.
84. She stated that with respect to the offence, the accused repeated that he did not want to revisit the trial and that he wanted to stay in the moment. At the same time, he constantly referred to events from the past, according to her reading of his difficulties.
85. The accused was defensive. He refused to answer several questions.
86. Her reading of the entire file leads her to think that there is a sort of fire that the accused broods over and that he is constantly ruminating.
87. She said that it is possible that the most recent trigger was that the accused made a complaint and that, once again, he felt as if no one heard him.
88. Last, she submitted that the paranoid anxiety could respond to medication. She thinks that the accused has a history of depressive symptoms. She thinks that he could become depressed with treatment, hence the importance for the start of treatment to be properly supervised.

# ***Testimony of Arnaud Sepulveda***

1. The criminologist testified at the hearing. The following points summarize his observations.
2. He stated that he has a master’s degree, which he completed in 2018.
3. He has been practising at Institute B since late May 2019. He completed a six-month internship at Institute B during his master’s degree.
4. He occasionally works at the violence risk assessment clinic (VRAC). It was in that context that he prepared the report concerning the accused – a multidisciplinary assessment of the risk, based partially on the HCR-20.
5. He explained that he was trained to use this tool by an accredited assessor, recognized by the creators of the tool.
6. His involvement in the file consisted of participating in the assessment, which ended with a videoconference meeting, with Dr. Bouchard and Dr. Gauthier in attendance.
7. He said that they each had their relevant questions prepared for the purposes of conducting the assessment. He subsequently drafted a part of the report. The two physicians drafted the other part. The three of them communicated with each other. Then they had clinical discussions to make sure that their opinions were consistent and that they would be able to prepare the report.
8. Before that meeting, which lasted one hour and a half, they had to read the all the files sent to them by the designated hospital. They received all the prior decisions of the Review Board and the psychiatric assessment. All of the sources are indicated in the report.
9. As someone with a master’s degree in criminology, the added clinical value he brings to the assessment is specifically with respect to risk. The HCR-20 is a risk assessment tool based on semi-structured judgment.
10. He confirmed that in this case, the team’s final opinion was that there is a moderate risk of violence.
11. He submitted that it is important to establish a working definition of risk. He referred to a danger or threat that has not necessarily been carried out or occurred. The risk cannot be precisely foreseen. It is not certain that the event will occur. They came to the conclusion of a general risk, fluctuating over time, that is also contextual. The risk will depend on the measures implemented. The assessment of the risk is valid for only the following six months if the conditions remain the same.
12. He listed the conditions they considered, including the fact that the accused is detained. They took into account the fact that he was granted the liberty of outings without a risk management strategy, that is, before applying their recommendations.
13. They also found that at the time of the assessment, the accused did not represent an imminent risk. The risk was characterized as low. The criminologist nevertheless explained that by imminent risk, he is referring to a risk of violence in the next hours.
14. As for the types of risk, they identified a psychological rather than physical risk.
15. Mr. Sepulveda acknowledged that the risk of serious physical harm, for example the offence of aggravated assault, is low.
16. He stated that the concept of psychological violence refers to threats, harassment, or intimidation.
17. He suggested that when risk management strategies are implemented, they tend to decrease the risk.
18. The team found that the factors that could influence the risk in the short or medium term were the accused’s mental disorder, lack of insight, and impulsiveness.
19. He said that the mental disorder manifests in paranoid thoughts. He candidly admitted, however, that this is not his area of expertise.
20. He went on to state that for the dynamic of violence, his team tries to contextualize the violent act. He added that there can sometimes be more than one dynamic.
21. He testified that the context of the accused’s case includes diagnoses of several untreated mental illnesses. In that context, the acts may occur again.
22. He is aware that the accused was declared a quarrelsome litigant in the past. He submits that this [translation] “concept” helps him in his analysis of dangerousness because quarrelsomeness can be associated with a sort of defence mechanism against the emptiness experienced in the face of paranoid anxiety. He said that according to Dr. Bouchard, if they were able to treat the accused, his quarrelsomeness could improve.
23. In his view, the purpose of the report is to determine the risk of re-offending.
24. He specified that they came to the conclusion as a team that, in the context described, there was a moderate risk that the accused could commit another violent act in the next six months.
25. When questioned about the subject of his master’s thesis, he said it was about women committing violent acts in connection with several factors that he identified in the literature at the time, in particular personality disorders, post-traumatic stress, and substance abuse. His master’s degree allowed him to join the Order of criminologists, which authorizes him to conduct this assessment.
26. He acknowledged that this is his first professional experience in criminology.
27. He admitted that he drafted a large part of the report.
28. The physicians drafted the diagnostic impressions and a section titled [translation] “recent symptoms of major mental disorderand clinical factors”.
29. He drafted one part alone and other parts , such as [translation] “recent problems with insight and instability”, jointly with others.
30. He said that he did not have a chance to read Dr. Delagrave’s report.
31. In the context of his analysis, he examined the accused’s previous and current situation, but from a criminological perspective, it is necessary to add a more prospective vision.
32. He explained that the final opinion is guided by the assessment tool, that is, the twenty (20) factors that position and clarify the clinical judgment, on the basis of their presence or absence and their relevance. Factors that remain unclear are noted as being present or partially present.
33. He said that the reference to [translation] “semi-structured judgment” refers to the category of the tool.
34. He acknowledged that he drafted the section titled [translation] “future living conditions problem”.
35. He submitted that if a treatment order were issued, it could be a source of significant stress for the accused and cause a temporary deterioration of his clinical condition, which would need to be closely monitored.
36. When questioned as to whether he thought that the fact that the accused was in strict detention was favourable from a criminological perspective, he said that the factors they identified as underlying the accused’s dynamic of violence are [translation] “untreated”.
37. In his view, work is required to try to decrease the accused’s risk of re-offending and to implement appropriate risk management measures.
38. From a criminological perspective, it is necessary to work on the criminogenic factors that are currently problematic and that remain in the same state as when he committed the offence. In his view, there has been no change, and the risk is the same.
39. He said that the report identifies two components: the therapeutic and pharmacological component to correct the situation, and the reintegration into society component.
40. He admits that in view of the strict detention and the absence of treatment, the professionals are at an impasse.
41. The risk determined is a very short-term risk.
42. He concedes that when referring to risk, a clear prediction cannot be made. It is only possible to characterize the main factors in the dynamic of violence, before coming to a conclusion.
43. He said that the assessment of the accused’s risk was the last report he prepared. He is now working on another unit.
44. Although the assessment took place on May 15, 2020, the report was finalized only on June 18.
45. He said that in the interim, he had other files for other types of assessment but not for a VRAC assessment. He said that every week, he conducted between three and five assessments similar to that of the accused.
46. He usually prepares a first report, intended solely for the physician, for which he does an initial “screening” or identification of the relevant elements. The physician then meets with the patient once or twice more and then prepares his or her report.
47. When questioned as to whether telling a case worker about one’s thoughts can constitute violence, the criminologist conceded that thoughts are not criminal. The information is nevertheless relevant to the assessment of risk because it permits an understanding of how the accused responds to things and on what basis he relies to make decisions. In this regard, it is possible to refer to [translation] “violent thoughts”, which is relevant to certain tools as an acute clinical factor, for example.
48. He remembers that when the accused answered these questions, he said that he was answering as Officer S.B. did during his testimony before the Court of Québec.
49. He added that the team explained to the accused that the files before the Court of Québec did not concern them.
50. He explained that since the professionals of [Institute B] had been mandated by the Review Board for mental disorder, he was not there to [translation] “redo the trial” during the assessment.
51. He said he wrote the section of the report that states [translation] “he asserts on the one hand that he does not condone violence, and on the other that committing a criminal act against someone who committed a criminal act may sometimes be justified”, but noted that it is important to also read the rest of the paragraph, which states that [translation] “when confronted with this second statement, he retracted it immediately and then accused us of altering and re-interpreting his remarks”.
52. The witness said he asked the accused what could have provoked the breaking and entering. He insisted that the accused said it was the lawyer.
53. The accused then told the witness to talk to the lawyer and added that [translation] “it was up to the police officer to do his job”.
54. The criminologist acknowledged that during his discussions with the accused, the latter indeed referred to the *Criminal Code*. The accused expressed serious suspicions as to whether the lawyer who was subjected to the threats and intimidation may have been responsible for the breaking and entering at his home.
55. The witness nevertheless admitted that the accused did not say that it was the lawyer who entered his home in 2019, but that the police officer should provide evidence of it.
56. He noted that in the final opinion, the risk of physical violence of a criminal nature is not excluded, although on a balance of probabilities, he leans more toward psychological violence.
57. He disputes the fact that these questions essentially concern the previous record. He maintains that the tool includes various items, including ten (10) historical factors and some more recent factors.
58. With respect to the recent issues concerning insight, he says he asked the accused if he thought he had a mental health problem. He also asked if he thought he needed medication or if he thought that there was a connection between medication and risk.
59. As for the symptoms of a major mental disorder, he acknowledged that it was actually Dr. Gauthier who was responsible for this part.
60. When asked whether the accused referred him to his lawyer in response to the question about the existence of a mental illness, the witness referred the Board to a paragraph of his report indicating that the accused said he wanted to remain in the present and that he did not wish to express an opinion on the need for medication.[[97]](#footnote-97) The criminologist noted that the accused often repeated that answer.
61. Mr. Sepulveda said that the fact that the accused did not want to express an opinion may be added to all the information gathered for the purpose of making conclusions.
62. In response to a question from the accused, he answered that on a balance of probabilities, if the accused’s prior offences were set aside, his opinion would no longer be valid. That explains the use of the tool with a structure that he must comply with.
63. As for the accused’s criminal record, the criminologist insisted that he relied on the court ledger. He believes that it includes only the files resulting in a conviction or a verdict of not criminally responsible.
64. He said that when he accesses the court ledger, he does not obtain the details of the offences on which the person was either acquitted or convicted. He is not necessarily aware of the circumstances, but he can sometimes make the connection with the information set out in the files he is given.
65. He acknowledged that the tool does not take into account mitigating factors such as provocation or discrimination.
66. He maintained that the fact that a person is a victim himself or herself may be considered under the item titled [translation] “history of traumatic experience”.
67. He confirmed that all the factors set out in the tool were considered.
68. He said that the duration of the meeting was reasonable. He suggested that the meeting may have lasted just over an hour and a half.
69. He claimed that the HCR-20 tool is very effective. It allows him to do very complete, consistent, and intelligible work.
70. The witness explained that after meeting with the accused, all the data collected was analyzed. The three professionals identified the most important factors and the general dynamic surrounding the violent acts.
71. He repeated that the work is done together as a team. Each member is given time to reflect. Afterwards, they consult each other during several meetings, to discuss the report before drafting it. They go point by point.
72. The tool is presumed to have been designed in such a way that the assessors should come to the same final score. Dr. Bouchard, Dr. Gauthier, and he all came to the same conclusion, namely, that the risk is moderate.
73. He is of the view that the fact that the accused denies the validity of the charges of violence on which he was convicted means that the patient has potential deficiencies in insight into the dynamic of violence.
74. He acknowledged that some patients may have defence strategies, such as not answering or denying. Such conduct may provide information to the assessors on that person’s understanding of violence. It is also possible that the person feels justified in defending themselves.
75. He insisted that the risk factors that existed at the time of the offence are still there. His paranoid thoughts concerning the persons in question remain present. The absence of medication is one of the important aspects explaining the dynamic of the accused’s commission of the offence. In addition, the accused feels justified in acting on beliefs that are delusional but that he believes to be true.
76. He explained that if the accused deems his acts to be reasonable and explainable in the context of a mental disorder, he cannot exclude the possibility that the accused could act the same way during one of his outings.
77. He added that the accused may experience the end of the current legal proceedings as a loss, given his paranoid anxiety.
78. Quarrelsomeness may be one of his defence strategies. The witness said that an illustration of this seemed to be occurring during the hearing.
79. He thinks that as we approach the end of the proceedings, the motions may become increasingly numerous. He opines that this is the means the accused uses to deal with his paranoid anxiety.
80. He notes that the accused can use various strategies. He sometimes presents legal motions. However, when the stressor becomes more significant, he can make threats in a moment of frustration.
81. The number of times he has committed violent acts, the frequency of those acts, and their type are all reassuring factors, according to the witness.
82. He acknowledges that the fact that the destabilization of the accused’s clinical condition, related to the cessation of psychiatric follow-up care and of his medication, did not result in a hetero-aggressive act is reassuring. In the past, there have been periods of calm with respect to acts committed by the accused, despite the absence of pharmacological treatment.
83. He said he received very little details concerning outings. He understands that during these periods of release, the accused took care of his mother and did handyman work at his house. He spent less time in front of the computer working on his court proceedings.
84. The criminologist stated that the risk management strategies include psychiatric follow-up and pharmacological treatment. He currently sees no progress in this regard. The situation is the same as it was at the time of the meeting held on May 15, 2020.
85. He said it appears that the accused responded well to treatment in the past.
86. He was unable to express an opinion on the accused’s reaction if he were to run into the electrician again.
87. He said that the treatment team could explore whether it would be counter-productive for the accused to share a living environment with other people who have the same doubts.
88. He said that appointing a social worker could be helpful for family discussions and interactions.
89. Mr. Sepulveda said that he worked approximately thirty hours to prepare the report.
90. He is of the view that so long as the accused does not work on the factors, in particular his mental disorder, introspection, and impulsiveness, there is a distinct possibility that he could re-offend.
91. When asked whether he could add three additional factors of the dynamic of violence, he said stress, the management of emotions, and social skills.
92. He explained that he referred to the statutory and penal files because the accused refused to discuss his previous offences. These files are categorized under another item, that is, problems related to other [translation] “antisocial behaviour”. He admitted, however, that this is not central to his report.
93. He said that the purpose of using the scientific tool is to come to a conclusion that does not depend solely on the assessor, but on the facts.
94. Last, he said he does not remember having refused the accused’s offer to send him the transcripts.

# **Dr. Delagrave’s report dated August 18, 2020**

1. His report states that the accused has been housed at the current hospital since December 21, 2018. He was transferred to the treatment and rehabilitation unit on May 29, 2019.
2. The report indicates that to his knowledge, the accused has not had any psychiatric follow-up care and has not taken any medication for about 10 years.
3. The physician notes that the accused suffered traumatic brain injury in December 1997 in an automobile accident.
4. Dr. Delagrave notes that relationships with both Dr. Laforme and Dr. Morin-Simard were difficult. The accused can be irritable and demanding.
5. According to the physician, the patient is primarily preoccupied by the [translation] “preparation of his defence before the RBMD” and by the application for an order to authorize care.
6. Because he refused to meet with and talk to Dr. Morin-Simard several times, the patient was transferred to him on April 27, 2020.
7. Dr. Delagrave said that he met with the accused a few times and that the meetings went well in general.
8. He described the accused’s cooperation as minimal. He remains generally polite, and the conversation invariably, and in a circular manner, comes back to the fact that he does not consider himself to be ill, but that he is the victim of injustice and that the legal system is against him.
9. According to the physician, the accused sometimes makes unpleasant remarks, especially about the patients and staff of the department. He does not utter direct threats, however. He reported that the accused has not engaged in any direct or indirect acts of violence or threats.
10. The accused has little contact with his peers or the staff on the unit, other than for utilitarian purposes.
11. He claimed that no therapeutic alliance has developed between the accused and any worker or his physician. He said that the accused absolutely refuses to consider them as his physicians and says that he has an attending physician, Dr. R. H., a gastroenterologist who provides him with follow-up care for Crohn’s disease. The accused agrees to take the medication prescribed by this physician.
12. On only a few occasions, he took PRN (*pro re nata*)[[98]](#footnote-98) Seroquel for anxiety. He categorically refuses the antipsychotic medication he was prescribed to take daily.
13. He is of the view that the accused cooperates, but in a defensive matter. He added that the accused has been slightly verbally aggressive a few times.
14. He said that the patient has always remained very closed about his personal life, but he readily agrees to discuss his legal problems.
15. He noted that the mental examination revealed a thought process characterized by circularity with perseveration of thoughts that are primarily persecutory and of delusional intensity. Long-term judgment is impaired with respect to his perception of the legal system and the problems he has been having with that system for several years.
16. The physician described the accused as being totally anosognostic and having no insight into his mental illness. He firmly believes that he does not need medication.
17. In his view, the diagnosis is a delusional disorder with a lesser possibility of paranoid schizophrenia, and cognitive sequelae further to traumatic brain injury in 1997 contributing to the negative exacerbation of his psychiatric condition. With respect to his personality, the accused has a premorbid cluster A personality with mainly schizoid and paranoid traits.
18. He referred to the assessment of dangerousness conducted at Institute B in June 2020.
19. He claimed that the treatment order could also cause the accused significant stress, with the possibility of an increase in anxious, thymic, psychotic, auto-aggressive, or hetero-aggressive symptoms.
20. He submitted that the accused continues to pose a threat to the public.
21. Last, he recommended that the accused remain detained at the current hospital, subject to certain conditions.

*Objection based on ss. 657.3(6), 657.3(7), and 672.21 of the Criminal Code.*

1. During the reading of Dr. Delagrave’s report, the accused raised an objection based on ss. 657.3(6), 657.3(7), and 672.21 of the *Criminal Code*.
2. Following the submissions of each party, the Review Board concluded that the accused’s objection must be dismissed.
3. The sections that the accused refers to do not support his assertions.
4. Section 657.3 *Cr. C*. is found in the part of the *Criminal Code* titled “Evidence on Trial”. Subsection 657.3(6) *Cr. C*. refers to the prosecution.
5. It is our humble opinion that the role of the person in charge of the designated hospital cannot be likened to that of the prosecution.
6. In addition, the provision in question prohibits the production of evidence provided to him or her under paragraph 3(c) without the consent of the accused. Paragraph 657.3(c) requires an accused who intends to call a person as an expert witness to give thirty days’ notice.
7. The Board is of the view that the information concerning the accused’s psychiatric history is relevant and constitutes a factor that the Review Board may consider during its analysis of whether the accused poses a significant threat to the safety of the public on the day of the hearing.[[99]](#footnote-99)
8. The Court of Appeal responded to a similar argument presented by the accused, specifying that Dr. Allard could consider the patient’s medical history for the purposes of her own assessment.[[100]](#footnote-100)
9. The psychiatric history subject to an objection by the accused included the psychiatric assessment for somatic delusions from January 1998 by Dr. Mailloux, referring to a diagnosis of simple schizophrenia. His objection to this reference could not be maintained. The accused filed a retraction by Dr. Mailloux, dated July 2, 2009,[[101]](#footnote-101) referring to an assessment by the same physician.
10. In addition, it is clear that Dr. Delagrave consulted the accused’s medical files with respect to the hospitalizations at [Center B] in March 1998, at [Center B] in May 2000, at the CSSS A, site A, in October 2000, and at the CSSS A, site A, in April 2001.
11. The accused did not refer the Board to any “protected statement” within the meaning of section 672.21 of the *Criminal Code* among the elements concerning these hospitalizations.
12. The paragraphs concerning the assessment of the accused’s fitness to stand trial on August 20, 2001, the assessment of his criminal liability in April 2004 on the forensic unit of the CSSS A, and the hospitalization at the CSSS A from August 29 to November 14 2007 for the assessment of his fitness to stand trial contain no protected statements within the meaning of section 672.21. The Board makes the same observation with respect to the psychiatric follow-up care provided by Dr. Pelletier around 2008 and the neuropsychological assessment in November of that year.
13. It should be noted that under section 672.21(3), a protected statement is admissible for the purpose of making a disposition.
14. Last, it should be noted that the accused did not object to the filing of the reports on the basis that they contained information covered by professional secrecy, contrary to the submissions he made during his arguments on the merits.

*Objection to Dr. Delagrave’s testimony*

1. At the start of Dr. Delagrave’s testimony, the accused objected, specifying that Dr. Delagrave is not a psychiatrist but a physician and cannot opine on a diagnosis of delusions. According to the accused, only a psychiatrist is entitled to do so.
2. Counsel for the person in charge of the designated hospital suggested that he ask the physician questions to establish his expertise.
3. The witness explained that he has been a physician for 40 years. He has been practising exclusively in psychiatry since 2002. He was able to refine his knowledge of psychiatry by taking courses offered by the hospital and by continuing medical education.
4. He is also in contact with psychiatrists who act as consultants with respect to treatment, with whom he works on a daily basis.
5. He has several patients who are under the jurisdiction of the Review Board for mental disorder. He said that he is often called upon to appear before the Board and to opine on dangerousness. In his practice, he has had to testify in the context of applications to authorize care.
6. After hearing the parties’ submissions, the Review Board for mental disorder recognized that Dr. Delagrave could enlighten it on the accused’s mental condition.
7. The Board understands that certain general practitioners practise exclusively in psychiatry[[102]](#footnote-102) and are thus called upon to make submissions before the Review Board as to the progress of NCR accused.[[103]](#footnote-103)

# ***Testimony of Dr. Delagrave***

1. Next, the physician testified at the hearing and added the following observations.
2. He stated that he has met with the accused once a week since the start of the follow‑up sessions. The meetings are held on the treatment and rehabilitation unit. He responds to the accused’s requests. He said that the meetings are rather brief and not very productive.
3. He indicated that since he has known the accused, his situation and conduct have been quite stable.
4. He notes that topic-driven discussions are characterized by a certain circularity and contaminated arguments concerning the testimony of a physician or an injustice or ambiguities that the accused perceives.
5. The meetings usually come to an end at the accused’s initiative, in an appropriate manner.
6. The physician stated that he relied on the background for the diagnosis. He was able to observe the delusions first-hand by analyzing the accused’s conduct.
7. He explained that with delusional disorders, the subject of the delusion is not always implausible or incompatible with a certain reality.
8. What he observed is above all related to the accused’s background, which the accused constantly revisits. Dr. Delagrave describes the intensity as delusional.
9. He emphasized that the accused prefers not to hear the explanation for the diagnosis.
10. The accused has absolutely no insight in regard to his illness. The accused is not aware that he has an illness or that his behaviour is pathological.
11. The physician claimed that the accused tends to revisit the past and engage in circular reasoning.
12. He does not think that the accused fully understands the mandate of the Review Board for mental disorder.
13. He said that [translation] “there is excessive behaviour that confirms the accused’s illness”.
14. He said that the accused is not open to his recommendations. The accused says he is not dangerous.
15. Dr. Delagrave stated that he explained to the accused that the purpose of his recommendations were to allow him to resume a more normal life with more independence, in a manner that is safe for the various workers involved and for society.
16. When questioned as to whether he was of the view that the accused was potentially dangerous, the physician answered in the affirmative. The key to controlling this dangerousness remains pharmacological treatment.
17. The physician emphasized that the accused’s illness is not easy to treat. It responds to psychoeducation and to various approaches. Pharmacological treatment would control the intensity of the delusions and the behaviour.
18. He said that we can expect the accused to become more anxious and stressed if the treatment order is obtained. He considers the supervision suggested to be appropriate.
19. He admitted that if ever pharmacological treatment was not available, psychosocial treatment would be appropriate. It would be particularly helpful in terms of monitoring, observing, and supporting the accused.
20. In his view, the accused’s dangerousness resides primarily in the fact that he has no insight. The accused channels his energy into the legal process, which is socially disturbing, but not dangerous *per se*.
21. The physician added that if the accused were deprived of his ability to channel his energy, delusional elements would surely remain very present, and his attention could be directed to the workers. He submitted that there could be an increase in the accused’s stress and the intensity of his suffering, with greater risk that he could re-offend.
22. He is of the view that the accused’s thoughts are characterized by pathological reasoning. There is perseveration.
23. Dr. Delagrave readily admits that the accused does not pose a particularly high risk of physical violence. The risk is more psychological, on the level of harassment.
24. He suggested that the accused be entitled to outings, with accompaniment, on a slow and gradual basis. He thinks that outings could help the accused focus his attention on something other than his own case.
25. He does not think that the accused would focus his attention on other people. In the current context, he does not think that the risk to anyone is imminent or likely in the short‑term.
26. In his view, without treatment and without insight, the accused could have a tendency to act impulsively on his delusions.
27. He said that, at this time, his actions have to do with legal aspects. However, there could be a transfer to more physical actions that are directed more towards people.
28. He acknowledged that during outings, there has been no evidence of more significant decompensation, acting out, or an increase in symptoms or dangerousness.
29. In his view, we should not expect a dramatic increase in insight, despite the fact that outings may result in some improvement or a reduction in the intensity of suffering.
30. He confirmed that the accused was at home and had contact with his family at the time of the offence, but emphasized that he had not been receiving follow-up care for a long time.
31. **During cross-examination**, the physician insisted on the fact that greater anxiety will not result from the treatment, but potentially from the accused’s reaction to being treated against his will.
32. He is not able to draw a parallel between pharmacology and the accused’s criminal record. What is certain, however, is that the accused has had a mental health problem for some twenty years and that it has led to many hospital stays and consultations, not always in the context of illegal acts.
33. He opined that taking medication before or after the offence changes nothing about the diagnosis or history.
34. He stated that the primary diagnosis is a delusional disorder. He believes that the traumatic brain injury in 1997 probably contributed to the deterioration of the accused’s mental condition, regardless of whether or not the Tribunal administratif du Québec decided to recognize a connection with the accident.
35. He admitted that the accused is sometimes able to accept court decisions.
36. He stated that the accused has made insulting comments about other patients and rather crude remarks about certain workers, but conceded that he was never placed in isolation.
37. The physician confirmed that he never saw the accused wandering around and yelling endlessly. He said that his behaviour is generally appropriate. The patient goes about his activities and spends most of his time working on the computer.
38. He said that every time he has had an interaction with the accused, the latter never considered or questioned the relevance or the legitimacy of his actions.
39. He added that since the accused has been hospitalized, he has spent an incalculable amount of time on a proceeding that has been pointless for many years and that led to his hospitalization.
40. When asked what questions he asked the accused to determine if he had any insight, the physician answered that he did not remember the specific questions. He remembers asking him why he was hospitalized following the acts he was accused of.
41. He specified that when he used the word [translation] “anosognostic”, he meant [translation] “lack of awareness of suffering from an illness”. In the accused’s view, the elements of the delusion are completely real, and he has no perspective on them.
42. He insisted that the accused said he has no mental illness, although he does not remember the circumstances or the exact words.
43. He submitted that the fact that the accused defends himself is part of the behaviour that springs from his illness, even though the fact that someone defends themselves does not mean that they have a mental illness.
44. He corrected the accused, noting that legal complications are not a complication of the illness, but rather a symptom.
45. He said that when the accused focuses on other things, he does not get involved in his legal proceedings.
46. He admitted that everything went well in a structured context with planned, supervised outings, even though the accused was not under pharmacological treatment.
47. He reiterated that the accused is likely to commit other dangerous acts.
48. According to him, antipsychotics are a recognized treatment in the event of a diagnosis of delusional disorder. They have fairly good, partial effectiveness, which varies from person to person. They are not the only solution.
49. He acknowledged that in the short-term, the dangerousness is not imminent. It is moderate. As for physical violence, he conceded that the risk is rather low.
50. He believes that the accused has a chronic illness that is following its course. He cannot issue a very favourable prognosis.
51. He said that the accused spends a lot of time on his activities. According to the physician, that may represent a certain social violence, because there is an associated redundancy. He channels his energy and that minimizes his abilities and his violent acts towards others.
52. He stated that the occupational therapist has almost daily contact with the accused.
53. He admitted that strict detention is not necessarily productive and that outings favour the accused’s reintroduction into society. He submitted that, depending on the accused’s progress, he could be granted longer outings.
54. He said that at the monitoring stage, the treatment team conducts verifications in an attempt to have the best possible idea of the accused’s progress and use of his time.
55. He said that since late 2018, the accused has not been able to develop a relationship of trust with any physician, except his family doctor. He nevertheless emphasized that in delusional disorder cases, it is often difficult to establish a therapeutic alliance.
56. He explained that the accused is convinced that he is doing the right thing. He opined that the way the accused behaves confirms the diagnosis.
57. Dr. Delagrave said that the possibility of consulting a psychologist to resolve the impasse was discussed with the accused, but he is not very open to it, as he does not see the purpose of treating an illness that he does not have.

# **Social worker Amélie Doucet’s report dated November 27, 2019**[[104]](#footnote-104)

1. Olivier Dubeau, the occupational therapist assigned to the accused, referred to this report during his testimony on September 25, 2020.
2. The Board accepts the following facts from the report filed in November 2019.
3. The social worker met with the accused following the decision of the Review Board for mental disorder rendered in June 2019, ordering that an assessment of social functioning be filed before the next hearing.[[105]](#footnote-105)
4. The report states that at the start of the meeting, when the accused was asked for his consent, he stated that he was neutral with respect to the assessment.
5. She noted that the accused disagrees with his mental health diagnosis.
6. According to the social worker, the accused asserted that the person in charge of the designated hospital was being a nuisance to him and that he wanted to present his case, which he identified as a social debate.
7. She noted that the accused felt a sense of injustice with respect to the judgments rendered in his proceedings and was asserting his position before the various courts.
8. The accused admitted that he is more withdrawn in his social interactions due to the pending legal proceeding. She indicated that he spends his time working on his legal proceedings.
9. She noted that when he was able to go on outings, he would work on his house, doing maintenance (handyman work) and helping his sisters and his mother. The accused also has a nephew with whom he has contact. The social worker noted that the two men help each other when needed.
10. She said that the accused would like to have a job again. He says that he would be proud if he was able to achieve this objective.
11. She stated that he showed interest in starting a non-profit organization to help unrepresented people assert their rights.
12. She noted that during outings accompanied by his pivot worker, the accused used the services he needed independently. He showed openness and was polite with the people he had to interact with in that context. The occupational therapist observed the accused’s efforts to take himself in hand.
13. She identified certain risk factors, including social isolation due to a poor social circle and the accused’s failure to recognize his illness, although she does not think the accused will ever develop any insight. In this regard, she is of the view that the accused’s questioning of authority, the health and social services system, and the diagnoses is such that his cooperation with care and services is limited.
14. The report establishes that the accused benefits from his relationship with his mother, which he describes as significant, as well as from the relationships of mutual assistance he has with his sisters and his nephew, and thereby maintains active social participation.
15. In addition, according to this assessment, the accused has clear life plans for when he is discharged from the hospital. These plans show his interest in getting involved socially and resuming certain social roles that are harder for him to assume during his hospitalization.
16. Last, she confirmed that the accused has been showing some openness towards the staff members since November 2019. She recommended pursuing individual follow-up with the occupational therapist during the hospitalization.

# **Dr. Laforme’s progress notes, dated November 22, 2019**[[106]](#footnote-106)

1. Dr. Lucie Laforme filed progress notes in view of the hearing that was to be held on December 4, 2019. The Board accepts the following from that document.
2. The physician thinks it would be good for the patient to occupy himself with something other than preparing his defence on his computer.
3. She stated that in the summer of 2019, the accused had asked her to extend his outings, and the medical team even gave him the privilege to go alone to his appointment with his family doctor.
4. The physician confirmed that his weekend leaves seem to have gone well.
5. Nevertheless, the notes include the information that on August 28, 2019, the accused hit the guitar of another patient, because he did not want to hear him play anymore. He was told not to be arrogant with the staff. He responded that the staff was harassing him psychologically.
6. It is also noted that the accused was more fragile during the week when his pivot worker, occupational therapist Olivier Dubeau, was on holiday, even though he had been granted permission to go on more outings during that period.
7. The notes indicate that on August 30, 2019, the accused became angry in the dining room. He was upset and threw his tray into the garbage and a bit on the floor.
8. Following that period, the accused was reluctant to meet with this physician.
9. It appears that on October 23, 2019, the accused found out that he would be returning to strict detention further to the judgment of the Court of Appeal. Dr. Laforme noted that the accused was quite frustrated and exclaimed, [translation] “that’s what everyone wanted”.
10. Dr. Laforme noted that since May 28, 2019, little progress had been made in terms of medication. The accused still refused to take psychiatric medication.
11. No therapeutic relationship was established with the accused, and following certain frustrations, the patient no longer wanted to see her.
12. In her view, his behaviour was inappropriate, haughty, and impolite, but he did not show any significant aggressiveness.

# **Transcript of Dr. Marie-Frédérique Allard’s testimony**

1. On August 27, 2020, the accused filed the stenographic notes of Dr. Allard’s testimony before the Court of Québec. The accused wanted to call the physician to testify at this hearing before the Review Board for mental disorder.
2. On March 12, 2019, the forensic physician[[107]](#footnote-107) testified before the Court of Québec, further to the filing of her assessment.[[108]](#footnote-108) The following points summarize her testimony.
3. In 2001, she assessed the accused’s fitness to stand trial, and she prepared a report for the Court.[[109]](#footnote-109)
4. She said that it is quite normal for a physician to see the patient again to redo the same assessment. It is often with respect to different charges.[[110]](#footnote-110)
5. She consulted the medical records. She also reviewed the assessments of Dr. St‑André, Dr. Fabrice Pelletier, and Dr. Lacerte over the years. The accused provided Dr. Mailloux’s documents to her. She reviewed all of these documents.
6. It is rare for her to meet with someone on the day the offence was committed. Accordingly, she relies on collateral information, sometimes on what was said to the Court, on several other documents, and also on what she sees, even if it is several months later, to form her opinion.[[111]](#footnote-111)
7. She did not have access to the trial transcripts. [[112]](#footnote-112)
8. The accused received a guilty verdict. She therefore assumed that the facts alleged against him were well founded.[[113]](#footnote-113)
9. Dr. Mailloux seems to acknowledge that he may have been mistaken, that is, that the diagnosis was not simple schizophrenia.[[114]](#footnote-114) Dr. Allard said she agrees with Dr. Mailloux that the diagnosis is not schizophrenia, but rather paranoid delusional disorder.[[115]](#footnote-115)
10. The accused underwent a neuropsychological assessment in 2008.[[116]](#footnote-116)
11. It is normal to question a patient about significant events in his or her life, whether or not they were difficult.[[117]](#footnote-117)
12. When the physician conducts any psychiatric assessment, she needs to understand the person’s life story and to see the elements that could have triggered the illness or made it worse.[[118]](#footnote-118)
13. In her view, someone who repeatedly makes threats or harasses is dangerous because such conduct can have an impact on the victim.[[119]](#footnote-119)
14. In hindsight, some of the behaviour that she observed may be likened to a certain dangerousness.[[120]](#footnote-120)
15. The illness became established, and the legal problems arose out of the illness.[[121]](#footnote-121)
16. Without medication, it is unrealistic to think that the accused could become aware of his mental health condition.
17. He has sought medical attention on his own initiative at certain times.[[122]](#footnote-122)

# **Transcript of S.B.’s testimony**

1. On September 25, 2020, the accused filed the stenographic notes of the testimony of S.B., a witness whom he wanted to call before the Review Board.
2. S.B. testified before the Court of Québec on September 20, 2018. The following points summarize his testimony.
* Lieutenant Detective L. summarized the case for him;
* Certain emails form J.B.S. were included. J.B.S. worked for the office of the Director of Criminal and Penal Prosecutions;
* According to the witness, [translation] “the accused’s tone changed; he said that he’d had enough and that if L. returned to his home, he would arrest him himself, and that if the arrest did not go well and L. died as a result, that would be the DCPP’s fault”;[[123]](#footnote-123)
* The officer added, [translation] “the way I perceived it, indeed, if I can go a bit further, I perceived it to mean that if Mtre L. went … which was unlikely, but well, if he went to the accused’s home, the accused would be entitled to arrest him, and if the arrest did not go well and Mtre L. died as a result, well, that would not be his fault, it would be a form of self-defence. That is how B.S. explained the facts to me and that is also how I understood it, and I took the time to ask questions to properly understand that this is the way it was said”;[[124]](#footnote-124)
* The witness J.B.S. said in an email that he had heard death threats. According to the police officer, for J.B.S., they were death threats;
* The officer stated, [translation] “on April 24, 2018, I was in charge of the file; I noticed differences between the threats reported by the witness in his email versus his written statement. When I communicated with him, he explained to me that he did not remember the exact words, but that the remarks were much more to the effect that if Mtre L. returned to the accused’s home, he would arrest him himself, and if the arrest did not go well and Mr. … Mtre. L. -- sorry – died as a result, that would be the fault of the DCPP”;[[125]](#footnote-125)
* The officer added, [translation] “on April 24, 2018, I communicated with Mtre L.; he is comfortable with the decision and is not concerned for his safety”;[[126]](#footnote-126)
* He prepared a file closure report on April 25, 2018. The investigation was put on hold.

# **Olivier Dubeau’s report dated November 29, 2019**

1. The report of occupational therapist Olivier Dubeau was also filed.
2. It indicates that since June 2019, he has been the pivot worker responsible for the accused’s follow-up care on the unit. The file was assigned to him so that he could prepare an intervention plan.
3. He states that he provided support for the accused in his legal proceedings on several occasions. He visited the accused at his home many times. He accompanied him to city hall, to purchase automobile parts, and to the local employment centre.
4. He saw the accused for 4 to 12 hours a week.
5. It appears from the report that the accused does not acknowledge having a mental health problem. The accused believes that his concerns about the police, the legal system, and the health system are justified by his current legal situation and committal to custody.
6. The occupational therapist confirms that the accused sees his mother regularly. He also has a positive relationship with his sister and his nephew, with whom he has a positive relationship of mutual assistance.
7. The occupational therapist says that the accused prefers that an *amicus curiae* be involved in his case, considering his recent experience with one.
8. He says that the accused does not like the psychiatrist from the forensic medicine unit.
9. The occupational therapist explained that shortly before November 2019, the accused started making jokes occasionally and being more appropriate in his behaviour with the team.
10. The most developed connection remains with him, despite the utilitarian aspect of their meetings.
11. He says that during his outings, the accused put some of his affairs in order.
12. While hospitalized, the accused spends the majority of his time preparing documents and other legal aspects. He does not have an expertise in the legal system, but he was able to prepare applications and file documents. He was able to represent himself in court and control his mood.
13. Mr. Dubeau reports that on the unit, he was observed listening to music and watching television, when he is not taking care of his legal affairs.
14. He notes that the accused also prepares applications for the other patients. He has a need to assert his rights and to defend himself against what he considers to be injustice.
15. According to the worker, the accused cooperates with medical follow-up care for his physical health.
16. The occupational therapist identifies the project in which the accused is most invested as setting up a small business repairing machinery/automobiles in his shed.
17. The report contains the following passages: [[127]](#footnote-127)

[translation]

The way he channels his frustration is to make complaints and seek remedies. He displays problematic disruptive behaviour, however, when he is not able to express himself or does not have control over a situation of which he claims to be a victim …

He tends to perceive events, especially those that concern him, as being elements of his persecution. He quickly attributes them to the justice system, which is his primary scapegoat.

1. He states that the patient is able to engage in exercises to question [translation] “automatic thinking” when the situation is not directly related to him.
2. He concludes that the accused has great potential for independence, which he seeks to maximize.
3. According to him, the patient is nevertheless quick to feel attacked, wronged, or unjustly treated by various people. He submits that the accused then reacts logically from this initial erroneous perception of persecution. In addition, he notes that the primary mode of channeling is to use the standard and legal structures available to him. He says that the accused was able to remain calm in situations that provoked him.
4. Last, he maintains that the accused’s return home will allow him to diversify his activities and put constructive energy into tasks that he considers positive.

# ***Mr. Dubeau’s testimony***

1. The witness confirmed that, as the pivot worker, he accompanied the accused in various activities outside the hospital, including with the city and the police and for construction work that needed to be done at his home. He also accompanied the accused to various shops in the region during his outings from the hospital.
2. The witness said that he was very often in the background, because he did not want to cause the accused to be identified as a psychiatric patient.
3. The accused organized his activities on his own. Everything went very well. The accused carried out negotiations with the various parties. The time spent on this was normal.
4. He noted that the accused had several ongoing renovation projects. He had to finish the garage in the back yard and repair a floor and a door. He witnessed the progress of the work over the course of their meetings during the summer, until early fall. The accused carried out these projects efficiently.
5. Mr. Dubeau reported that the city was pressuring the accused to finish the construction work on the garage.
6. He said that the accused accepts help to address, and ideally resolve, his legal situation.
7. The occupational therapist admitted that the accused refuses to discuss his mental health problem with him.
8. He maintained that the accused dealt with his legal problem in an acceptable manner, i.e., there was no excessive behaviour.
9. When he accompanied the accused, he always complied with his time commitments. The accused even showed flexibility on several occasions, to allow the social members of the team to adjust.
10. He remembers that when the accused received the judgment of the Supreme Court of Canada, he stayed in his room for a day. He subsequently returned to being the person that he spent time with, day after day.
11. Regarding the Merck Manual, the witness said that the first time he heard about it was when he was with the accused, who showed him an excerpt from it. The witness said that he was familiar with certain manuals, but not this one.
12. Mr. Dubeau said that the purpose of accompanying the accused was to form a relationship with him, so as to be able to manage complications. When questioned as to whether they were able to put an end to the complications, the witness answered that the accused is still hospitalized. He conceded that the accused did indeed manage complications but that he was not able to put an end to them.
13. As for the accused’s reintegration into society, he is of the view that it was initiated in 2019, when the accused was able to go on outings. They were unable to complete this phase of treatment, however.
14. The accused was able to go on outings lasting up to three consecutive days. His reintroduction into his home went well. Mr. Dubeau confirmed that he visited the accused at his home and that [translation] “things were going well”.
15. He submitted that, despite the circumstances, the accused tries to take advantage of his outings as much as possible to set up projects for his reintegration and for living at home. The patient shows a high level of independence in his daily and domestic activities. His purchases are well organized.
16. Mr. Dubeau said that since he prepared his report, the treatment team has held various follow-up meetings. He confirmed that progress has been made. In his view, the [translation] “automatic thinking” has in fact been questioned.
17. Regarding contact with the other patients on the unit, since early summer 2020, the accused uses the time given to him to find music for other patients and to advocate for them. He often comes to the defence of the vulnerable people on the unit.
18. The accused’s judgment is biased in regard to daily life and inherent dangers. The occupational therapist assessed the concept of safety, in life and at home.
19. His role is to ensure that people can use their abilities to their full potential in their life projects.
20. He conceded that there is no connection between his work and pharmacology.
21. When questioned about the accused’s concerns, the witness said that they were more prominent in recent months. The patient expressed a great desire to be able to return home to help his mother and his nephew and to complete his renovations, the work, and the projects he has started, including the construction of the garage and the repair of a vehicle.
22. He acknowledged that the accused does not require much stimulation to direct him to his concerns.
23. Mr. Dubeau stated that the legal proceedings in which the accused invests himself are a way of channeling his emotions. He did not observe any excessive behaviour with respect to the legal proceedings during the many times he accompanied the accused.
24. He said that the initiatives taken by the accused are actions proposed in the context of disputes. The accused was implementing his various projects. From what he saw, it was not [translation] “misbehaviour”.
25. He said that the accused was indeed able to outline a strategy and adjust it in accordance with the various actions that needed to be taken if the results initially sought were not achieved.
26. The occupational therapist said that he does not work with the global assessment of functioning scale. The tool he uses is the autonomy scale. They are not identical.
27. With respect to social functioning, the accused is able to manage his relationships within his circle. On several occasions, the occupational therapist observed the bond between the patient and his mother and sister. He witnessed the interactions between the accused and various merchants and other members of society, such as a security guard at the courthouse.
28. He noted that the report of the social worker assigned to the file, Amélie Roy Doucet, is based on his observations, given that he was the only one who accompanied the accused on all his outings.
29. Mr. Dubeau confirmed that, while he accompanied the accused, he did not witness any conduct by him that could pose a danger to the safety of the public.

# ***Cross-examination of Mr. Dubeau***

1. He stated that he has held his position since 2009. He obtained a bachelor’s degree in occupational therapy from the Université de Montréal in 2008.
2. He explained that his role is to assess a patient’s level of independence with respect to the patient’s return home, their property management, and their response to safety issues, and to issue recommendations on the methods and means to be implemented to try and improve beneficiary’s situation.
3. He conducts assessments of mental health functioning. His assessment focusses on the functional aspect, that is, in the broad sense of all the activities that a person may perform in their everyday life.
4. He admitted that, as an occupational therapist working in mental health, he does not assess a person’s dangerousness. He can take note of particular elements that emerge and pass that information on to the physician.
5. He admitted that he intervenes more with respect to the gathering of information. He reports what he sees, even though the physician has other sources.
6. He confirmed that there is specific training available to assess dangerousness in mental health and assessment tools that can be used. He acknowledged that he has not completed such training.
7. He has completed training on the risk of suicide. That training was not focussed on dangerousness to others.
8. He confirmed that as of the moment the accused arrived on the treatment and rehabilitation unit, he tried to establish contact with him and document how he acted and interacted.
9. It was agreed with the physician that the cognitive-behavioural approach would be used. He explained that there is no psychologist on the unit. Over time, he used this approach to work with the accused, while helping him in his activities.
10. This approach was put in place to challenge the various scenarios of [translation] “automatic thinking”. His role was to raise doubt for the accused about other hypotheses on how the situation was progressing. He tried to get him to reflect and question himself.
11. He reported that the accused was able to engage in the exercise in regard to everything external, that is, general life situations. When it came to family scenarios, he would eventually formulate other hypotheses and adhere to them. It was much more difficult with respect to scenarios concerning him directly. There were certain scenarios regarding which he remained steadfast in his positions.
12. He prepared his report further to a request from Dr. Lucie Laforme. The document is based on the various interactions he had with the accused from June to November 2019.
13. In his view, the accused channels his energy by making complaints or initiating legal proceedings. Nevertheless, he admitted that, in the event that he cannot make a complaint or if he sees that the complaint is not justified, he can become provocative with the person concerned, so as to elicit a counter-reaction from them. He observed such behaviour on four occasions.
14. He submitted that he recently observed a sort of well-entrenched weariness in the accused in regard to the entire legal system. He has witnessed a change in intensity. The accused used other methods to calm himself down. He will even isolate himself to avoid a confrontation. He is creating a repository of music. He sometimes uses it as a pastime, even when things are not going so well.
15. He confirmed that sometimes, when the accused is dealing with a member of society in a position of authority, he seeks to prove his point or say certain things to that person.
16. The occupational therapist defined the term [translation] “provocative” as displaying a certain insistence or repetition in one’s questions. He acknowledged that a person dealing with the accused could feel targeted.
17. He submitted that the accused has already shown that he is able to quickly return to himself after a confrontational situation.
18. Mr. Dubeau said that he is no longer the accused’s only person of trust on the unit. The situation has evolved. The accused interacts with the social workers, the people in his office, and his interns.
19. He admitted that it is a bit more laborious with the intervention officers, but it is going rather well with the staff in general.
20. He maintained that the accused remains polite with the physician, although he can sometimes be more reserved or cold.
21. He said that during an intervention he had to do further to an observation, the patient accused him of having entrapped him to create the intervention. The accused can react on the basis of an initially erroneous perception.
22. During cross-examination by counsel for the DCPP, the occupational therapist acknowledged that he had never completed training allowing him to issue a clinical judgment on an individual’s dangerousness, but he emphasized that he had observed the accused on a daily basis and never saw him commit an aggressive physical act against anyone.
23. He admitted that discussing an individual’s future dangerousness would be beyond his expertise.
24. In response to a question about his knowledge of the accused’s history, the occupational therapist admitted that he had heard only the accused’s version.
25. As for the recommendations set out in his report, he maintained that they are intended for the attending physician and concern rehabilitation.
26. When asked whether he thought it was a good thing to allow the accused to assert his opinion and channel his demands in the various systems, he insisted that, in his view, if the accused’s ability to express himself were limited, that could give rise to an accumulation of emotions.
27. He conceded that he is aware that the accused was declared to be a quarrelsome litigant. In his view, the accused’s ability to submit an application helps him to channel the phenomenon, even if the application is ultimately dismissed. He denied the suggestion that he is encouraging the accused to pursue his proceedings.
28. When questioned about his recommendation that the accused could reintegrate into his home (because that could help him get out of the active framework related to the feelings of persecution), the occupational therapist explained that when he used the words [translation] “feelings of persecution”, the diagnosis had already been made by the physician. He simply wanted to submit that the more the accused revolves around these systems, which the accused considers to be persecutory in his regard, the less he will be able to be involved in his rehabilitation.
29. When asked to explain the connection between his training and the following statement: [translation] “I am nevertheless of the view that the accused will continue to invest part of his energy in activities to assert his rights, which should remain possible both in terms of his personal rights and the fact that is it an outlet to channel his problem”,[[128]](#footnote-128) the witness answered that he was referring to the accused’s ability to manage his emotions, to channeling. He acknowledged that paragraph 48 of the judgment of the Court of Appeal[[129]](#footnote-129) contradicts his suggestions somewhat.
30. He said that over the past fifteen (15) months, he has seen a significant improvement in the accused’s condition, especially in his social interaction and functioning on the unit.
31. He stated that the treatment team is composed of the physician, the nursing staff, a social worker, a psycho-educator, and himself. They have weekly meetings.
32. He said that the suggestion is to integrate the accused into his home for a few days and observe the progress.
33. He is trying to promote all positive vectors of reintegration, that is, emotional release and productivity, and to encourage something that gives the accused a role and meaning.
34. He wants to ensure that the accused resumes the cognitive-behavioural follow-up care as best as possible. He submitted that it is important to observe how the accused sees, conveys, and experiences the situation, and how he reacts.
35. He submitted that the patient calmed down after his outings. He became less weary of all environments.
36. Since he has been in full detention again, this calm has continued. He is more often in a helping relationship with other residents. He reported that the accused uses the time that he would normally have spent on his legal files to go see the others and talk to them. He is taking steps to enable another person to have access to certain activities. He seizes every opportunity to go out. He tries to avoid always being stuck in front of the computer in the living room.
37. The occupational therapist hopes that the accused can go on outings in the very near future.
38. Mr. Dubeau is not sure if the patient could get involved in volunteer work. He already helps his mother.
39. He nevertheless believes that the accused’s plan to operate a small garage is realistic.
40. The witness conceded that the accused still does not acknowledge having a mental health problem. He does a lot of research on the diagnosis, but solely for the purpose of disputing it.
41. As for the automatic thinking, he has tried to explore the way the accused interprets things.
42. He gave the example of the breaking and entering incident at the accused’s home. The patient thought that a police officer had opened the door to place something inside the home. That is the type of thinking that they were able to work on over time, more or less successfully. That one in particular worked well.
43. Mr. Dubeau recognized that one of the principles of cognitive therapy is that we feel what we think. Thoughts bring on emotions, conduct, and consequences.
44. He submitted that the accused is now able to see other hypotheses. He admitted that he is sometimes able to do the cognitive work, but does not follow through.
45. He explained that the purpose of working on thoughts is that it does not cause psychological suffering or problems. He explained that they sometimes work on a specific point. The accused learns something. After, they consider how that can help him, on his own, to conclude that there may be other circumstances and that he may have erred in good faith.
46. Mr. Dubeau said that he has a few examples where the patient reconsidered his underlying idea, but he cannot say that it is generalized. There is nevertheless a pattern that returns.
47. When questioned about the following statement he made: [translation] “The accused is quick to feel attacked, wronged, or unjustly treated by various people, for reasons that are sometimes completely out of their control. The accused then reacts, logically, on the basis of this initial erroneous perception”,[[130]](#footnote-130) the occupational therapist said that it is less contemporary.
48. He confirmed that he has spoken to the accused about the need to let go and take part in other activities.
49. He acknowledged that the accused still has hopes of clearing his name, but on the other hand, there is a sort of weariness starting to set in. He thinks that after the Supreme Court judgment, the accused realized that he had reached the end. At one point, he said, [translation] “I need to take myself in hand and do something else”.
50. Mr. Dubeau said that he spoke to the patient about the offence and the risk of re-offending. The accused is still in denial. The occupational therapist claimed that he has a poor understanding of the system, and that they were unable to make progress on this aspect.
51. He conceded that he did not discuss a plan for outings or for integration with the accused. They spoke only about potential projects.
52. The intervention plan was to work on his automatic thinking. The rest was very much limited to providing the accused with logistical help on his legal proceedings.
53. He said that other than the time the accused tried to convince a police officer of something, the occupational therapist never had any concern about what might happen to the accused. Aside from that incident, he never even thought about having to intervene.
54. He said that he never felt afraid of the accused, even when the latter was [translation] “angry” with him. He said that the patient would turn around and look out the window if he did not like where the conversation was going.
55. He said that at one point, there was an altercation on the unit. During an intervention with an intervention officer, the accused threw his tray onto the counter. It fell to the ground. According to Mr. Dubeau, the patient was not aiming for the intervention officer.
56. He said that his intervention plan was not part of a broader intervention plan.
57. He agreed that it is really quite difficult to establish a general intervention plan with this patient.
58. For him, the accused was a special case. He sometimes went out with this patient for an entire afternoon.
59. Before the accused arrived on the unit, the members of the previous team had great difficulty establishing contact with him.
60. Mr. Dubeau decided to invest a lot of time to [translation] “pierce through the wall”.
61. He explained that the purpose of accompanying the accused in his activities was to make sure he obtained a response.
62. The occupational therapist reiterated that there has been an improvement in his reaction and [translation] “automatic thinking” versus various scenarios.
63. He maintained that the accused has had problems with the more disruptive patients.
64. The witness said that he was not aware that the accused had been placed in isolation for acts of violence. He explained that placement in isolation is sometimes used for deconditioning or due to a psychotic disruption, crisis, or aggressiveness during interactions with others. Rather than causing a potential risk on the unit, the person is isolated.
65. The occupational therapist was unable to tell the Board on which date the breaking and entering at the accused’s home happened.
66. He remembers driving the accused to an appointment with his family doctor and being present during various meetings for a second opinion in other cases.
67. He confirmed that the patient took care of his appointments and external follow-up on his own. The accused provided the information to the members of the treatment team so that he could have access to transportation.
68. He insisted that the accused’s feelings of persecution are related to all the legal events, but not to the situation of systemic violence.
69. He reminded the Board that he permitted the accused to access the computers to prepare his legal proceedings further to instructions he had received to allow him to do so in order to properly prepare his defence. He was also authorized to provide the accused with access to the various materials required.

# **Exhibits filed in evidence by the accused**

1. In addition to the transcripts of the testimony, the manuals, and the notebooks, the exhibits filed by the accused also included a letter from Dr. Mailloux. The Board wishes to comment on the relevance of this exhibit.

# **Dr. Mailloux’s letter**

1. In his letter, the physician confirms that his [translation] “diagnosis of January 25, 1988, was merely hypothetical, never confirmed by psychiatric follow-up on his part, and should not be used against J.M. to establish a personal condition in a subsequent file. The state of upheaval J.M. was experiencing before his assessment in January 1988 could very well have been temporary and resolved on its own”.[[131]](#footnote-131)
2. It is important to keep in mind that this letter in over 10 years old. The information set out in it is not contemporary and therefore not relevant to the issue of whether the accused poses a significant threat to the safety of the public.

# **X. SUBMISSIONS**

1. The ***amicus curiae*** argues that s. 672.54(b) of the *Criminal Code* applies.
2. He refers the Board to the judgment rendered by the Court of Appeal for Ontario in *Amini (Re)*.[[132]](#footnote-132)
3. He submits that the Board should examine the report and the testimony of Dr. Delagrave. According to him, the report contains more information concerning the accused. Mtre Angers is of the view that the work of the two other professionals was more information-gathering. He characterizes the content of their reports as a bit heavy. He submits that Dr. Delagrave’s report is more concrete.
4. He submits that the purpose of Mr. Dubeau’s testimony is to enlighten the Court.
5. Mtre Angers believes that the occupational therapist is doing excellent work. He has a good relationship with the accused, who has a tendency to be stubborn.
6. He reminds the Board of the teachings of the Court of Appeal in *R. c. S.P.*,[[133]](#footnote-133) which state that to maintain an accused under the Board’s jurisdiction, positive evidence of dangerousness is required. He emphasizes that a hypothesis or doubt is not sufficient.
7. He points out Mr. Dubeau’s testimony to the effect that the accused has shown great improvement.
8. He cites the judgment of the Court of Appeal for Ontario in *Kalra (Re)*.[[134]](#footnote-134)
9. He submits that after reviewing Mr. Dubeau’s report, one can only note that the risk of re-offending is [translation] “lower”.
10. He acknowledges that the accused is opposed to pharmacological treatment. The significance of this aspect is set out in the reports of [Institute B] and Dr. Delagrave.
11. He submits that reference is frequently made to the accused’s quarrelsomeness. He notes that the situation has improved in this respect. Under the rules in place, the accused must seek the court’s authorization to institute legal proceedings.
12. Mtre Angers notes that the accused called only one witness. He submits that the accused is able to put things into perspective. He has made progress with respect to his awareness.
13. Mtre Angers submits that the accused’s complaints are no longer relevant. According to him, the threats against justice system participants are also no longer relevant. He says that because the accused has made progress, he is no longer preoccupied by that.
14. Mtre Angers concedes that it is time for the accused to take part in other activities.
15. He refers the Board to the testimony of Mr. Dubeau, who said that the accused had started practising relaxation activities, such as reading and walking outside, to help him manage his stress. He even goes to another room to avoid the computer.
16. The evidence establishes that the accused should take part in occupational activities that would allow him to be less isolated and not different than the others.
17. He reiterated that Mr. Dubeau testified that the accused’s reintegration into his family and into society went well.
18. The witness described the progress made with respect to [translation] “automatic thinking”. The accused has more contact with the other patients. For someone who is extremely closed-off, he now takes time to do things for others.
19. Mtre Angers admits that the case is complex, but he emphasizes that the accused has made progress. The accused wants to return to help his mother and his nephew.
20. Mr. Dubeau also testified about the patient’s ability to frame his strategy based on the needs of his situation.
21. He says it is a bit simplistic to limit Mr. Dubeau’s role to information-gathering, as the submissions of Mtre Bervin and Mtre Tourigny suggest.
22. Indeed, Mtre Angers notes that Mr. Dubeau’s role is much more significant. He introduced the cognitive-behavioural approach into the therapeutic context.
23. Mtre Angers submits that the witness Dubeau was candid and showed integrity in admitting that the accused has difficulty when he is with persons in positions of authority. He nevertheless maintained that the patient has more trust in the team’s special educators and social workers.
24. Last, he argues that, in his view, absolute discharge is not appropriate in this case. He believes that the accused must make an effort. He submits that the Board should apply section 672.54(b), with a maximum of conditions.
25. He insists, however, that the accused has made a sincere effort. He has significant issues, and he has improved. He invites the Board to adopt a more positive standpoint to encourage the accused in the effort and progress he has made.
26. He refers to the conditions put forth by Dr. Delagrave.
27. He notes that the ball is in the accused’s court.
28. He considers it [translation] “appropriate” for a prohibition against possessing weapons to be imposed and for the accused to be prohibited from communicating with the victims, in addition to the other usual conditions.
29. He submits that the accused’s situation will need to be reviewed in six months.
30. Mtre Tourigny, the **representative of the designated hospital,** says that the Board has colossal, clear, and limpid evidence before it.
31. He urges caution with respect to the probative value of the flood of documents and information submitted by the accused. He submits that the vast majority of the documents submitted should be granted no probative value.
32. The only exhibit on which he wishes to comment is D-7, the occupational therapy report, and Mr. Dubeau’s testimony.
33. Mtre Tourigny says that the report provides details of the accused’s functional performance. He reiterates that the occupational therapist’s role is to opine on the reasonableness of a return home. He notes that the occupational therapist does not have the proper training to assess the threat that a person may pose to the safety of the public. He asserts that this evidence does not allow the Board to draw a conclusion on the significant threat posed by the accused.
34. He notes that the Board must rule on the basis of only two assessments, the one prepared by Dr. Delagrave and the one prepared by the experts of [Institute B].
35. He concedes that the *amicus curiae* tried to somewhat weaken the probative value to be ascribed to the assessment of [Institute B].
36. Mtre Tourigny notes that the assessment of dangerousness was ordered by the Board. He characterizes the report of [Institute B] as extremely complete, convincing, and exhaustive. He submits that this report should therefore be given probative value.
37. Mtre Tourigny added that the fact that we are dealing with an accused who is complex does not complicate the legal nature of the proceeding.
38. He submits that the entire hearing is at the very heart of the accused’s delusion and that the entire debate is feeding into that delusion. He asserts that we must avoid obscuring the law by all of the accused’s remarks, which were often irrelevant.
39. He argues that the analysis conducted by the professionals of [Institute B] is based on a recognized tool, which permitted the identification of many background events that may serve as a guide for the Tribunal. The RBMD is justified in relying on behavioural evidence to assess the risk of dangerousness on the date of the hearing.
40. He notes that the report also indicates that problems will arise in the short term.
41. He submits that the experts conclude that the risk of violence that could arise on a psychological level falls within a psychotic dynamic of an untreated illness. They conclude that the cornerstone of the problem is the treatment.
42. Mtre Tourigny points out that the accused has refused long-term treatment for many years.
43. He insists that psychological violence is a ground on which the Board may rely as the basis of its disposition. According to the professionals of [Institute B], the accused’s behaviour allows him to soothe the intense emotions and is a defence mechanism related to his paranoid thoughts and anxiety-provoking events. The accused will face many such events in the future.
44. Meanwhile, the accused is experiencing stress. He has fallen back into his delusions. He is not receiving treatment. He is surrounded by workers whom he does not trust, and he is being questioned by the justice system.
45. According to Mtre Tourigny, these reactions must be considered risk factors, which increase the danger posed by the accused, hence the importance of monitoring his condition.
46. He submits that the accused has a serious, chronic mental health problem, with clear persecutory and paranoid aspects that include circular discourse. He displays complete anosognosia and long-term disturbed judgment.
47. He submits that the accused’s plans for the future need to be analyzed. They are not a sufficient guarantee to allow the Tribunal to conclude that there is a protective factor that will reassure the public with respect to dangerousness.
48. So long as there is no treatment order, there is a risk that the accused will refuse the support services to be implemented at his home if he is discharged.
49. As for the results of the assessments, all the experts concluded that for the next six months, the risk of hetero-directed psychological violence is moderate in the institution. Mtre Tourigny admits that they did not opine on what would happen if the accused were removed from the hospital context. He submits that the protective factors would no longer be there.
50. Mtre Tourigny emphasizes that everyone involved determined that the accused can be tense and arrogant when he is upset. During this hearing, the *amicus curiae* had to intervene to reassure the accused and ask him to watch his behaviour.
51. He reiterates that the accused continues to pose a threat to the safety of the public because when the right to bring legal proceedings is withdrawn from him, his delusional convictions persist. He is also persistent in his refusal to accept treatment, which leads him to repeat the same behaviour.
52. With respect to the alternative conclusions that the accused seeks from the Board, Mtre Tourigny argues that it does not have jurisdiction to award damages to the accused. In addition, the accused asks that the workers be assessed. This request is inappropriate, and the very fact of asking it shows that there is no improvement. So long as the accused does not receive treatment, his condition will remain the same, and the dangerousness will remain.
53. Mtre Tourigny concluded by stating that the mental health professionals prepared the ideal plan, that is, detention subject to conditions for the next six months. That disposition could allow the accused’s condition to be monitored and, if necessary, to make a gradual and safe transition.
54. He is of the view that, considering the accused’s history, it would be premature to discharge him at this time.
55. **Counsel for the director of criminal and penal prosecutions,** Mtre Bervin**,** argues that the evidence supports a total restriction of liberty.
56. He refers the Board to three factors underlying the dynamic of violence: the accused’s mental disorder, his lack of insight, and his impulsiveness. He submits that these factors are still present.
57. He notes that the accused’s family also distrusts the legal system. The accused would not be supervised by his circle if he were granted total liberty.
58. He submits that he found the occupational therapist’s report troubling. According to the occupational therapist, the accused should be allowed to bring proceedings for the purpose of channeling his stress. Mr. Dubeau submits that even an application to institute proceedings would serve the same purpose. Counsel states that this cannot be condoned, considering that the accused has been declared quarrelsome.
59. He notes that a question remains as to how the accused will manage his stress once the proceedings are over.
60. Mtre Bervin submits that it is something that must be considered, with the stress resulting from possible forced treatment.
61. He says he agrees with the analysis of the *amicus curiae* regarding Dr. Delagrave’s report and that it is a good summary of the situation.
62. He notes that the accused has not always complied with the recommendations of the treatment team.
63. He asks that the Review Board include a condition requiring the accused to inform the special constables upon his arrival at the courthouse so that he can be supervised.
64. Mtre Bervin asks the Board to take into account the occupational therapist’s report concerning the fact that the accused had a few outings during which there were no problems, even though he does not agree with the occupational therapist opining on the aspect of violence.
65. He reiterates that there are many questions that remain in regard to the accused’s behaviour before he can be granted total liberty. He notes that the risk factors must be kept in mind in the analysis of the file.
66. **The accused** submits that the level of dangerousness assessed by the persons in charge of Institute B is set out on page 21 of psychiatrist Chantale Bouchard’s assessment report. He says that at the time of the assessment on May 15, 2020, the risk of immediate violence was low.
67. He argues that at the time of the hearing, the six months referred to in the report of [Institute B] have already elapsed.
68. He submits that his detention is excessive and disproportionate.
69. He says that he knows that he will not be compensated.
70. He claims that he was assessed on the sole basis of the record by the [Institute B] team.
71. He submits that we cannot refer to a delusional disorder if there are no symptoms of psychosis. He says that according to Dr. Delagrave, the delusion includes [translation] “things that are not external”.
72. He refers to the testimony of police officer S.B. and says that the alleged words were not spoken.
73. He says that the evidence is silent as to the damage to the victims of his future wrongful behaviour.
74. He says that there is no evidence of a history of violence. He submits that they have had time to observe him for one year.
75. With respect to whether a legal proceeding before a court raises a significant threat to the safety of the public that is criminal in nature, he submits that the Court of Appeal of Quebec, by a panel including Chief Justice Nicole Duval Hesler, responded unanimously in the negative in *J.S. c. Centre universitaire de santé McGill (CUSM)*, 2016 QCCA 1085 at paragraph 29:

[translation]

Indeed, beyond the disruptive behaviour the appellant might adopt, the evidence does not support the conclusion that such behaviour would be criminal in nature. A delusion focussed on legal proceedings to recover millions of dollars is not behaviour that is criminal in nature. Moreover, if he were to adopt criminal behaviour, the evidence is completely silent as to the serious threat, as per Winko, that the appellant could cause serious physical or psychological harm to a member of the public in accordance with section 672.5401 Cr. C.

1. As for quarrelsomeness, he says that the risk of re-offending is zero on a balance of probabilities because legal conditions are imposed on him, as noted by Chief Justice Duval Hesler at paragraphs 41–52 of the judgment rendered on [...], 2019.
2. According to the accused, the “significant threat to the safety of the public” textually implies that someone suffered serious physical or psychological harm as a result of conduct that is criminal in nature.
3. He says that the evidence in the record in no way established or identified a victim that suffered serious physical or psychological harm, which implies serious property damage, a serious physical injury, or serious psychological harm. The accused submits that the Court of Appeal opined on this subject when it said that [translation] “the latter statement is not supported by the evidence, however” at page 11, paragraph 51 of the judgment dated [...], 2019.
4. The accused argues that the definition of a “significant threat to the safety of the public” in section 672.5401 of the *Criminal Code* requires not only that the “physical” or “psychological” harm be “serious” and “criminal in nature” without necessarily being violent, but also that the expected consequences be so serious as to endanger the life and safety of the victims, the witnesses, and the public.
5. He submits that the level of clinical violence was characterized as [translation] “low” by Dr. Chantale Bouchard of Institute B during her cross-examination on August 25, 2020. He refers to the [translation] “FINAL OPINION” on page 21 of her report dated June 18, 2020, which mentions a [translation] “low risk of imminent violence”.
6. He submits that this passage was not contradicted in cross-examination by criminologist Arnaud Sepulveda on August 27, 2020.
7. According to the accused, during cross-examination on August 27, 2020, Dr. Jacques Delagrave characterized the level of dangerousness as [translation] “low”. This is set out on pages 8 and 9 of his report. He also notes that there is no mention of any [translation] “violent acts or direct or targeted threats” and that the result observed is without any medication.
8. The accused notes that Dr. Delagrave also contradicted his report during cross-examination by testifying that it was not schizophrenia, contrary to page 8 of his report where he refers to a [translation] “remote possibility of paranoid schizophrenia”.
9. He claims that all of this is inconsistent with a diagnosis of [translation] “persecutory delusional disorder”, according to the position of psychiatrist Carol Tamminga, set out in the Merck Medical Manual filed as exhibit D-1.
10. He says that, because the level of dangerousness was assessed as [translation] “low” by more than three experts, the Review Board should find that he does not pose a significant threat to the safety of the public and that he meets the standards for a disposition of absolute discharge, as set out in section 672.54(a) of the *Criminal Code*,in accordance with *Winko*.
11. He submits that to refuse an absolute discharge, the Review Board must be convinced, on a balance of probabilities, that the expert evidence filed establishes both the existence and the required seriousness of the significant threat of serious physical or psychological harm to the safety of the public.
12. He states that the clinical evidence set out in Olivier Dubeau’s occupational therapy assessment report at page 8, filed as D-7, confirms that he [translation] “is not fundamentally inclined towards violence and was able to remain calm in situations that were more provoking for him”, as he has the ability to channel his energy so as to [translation] “use the standard and legal structures available to him”. The accused submits that Mr. Dubeau was the only person who saw him every day.
13. He claims that the report of [Institute B] is a carbon copy of Dr. Allard’s.
14. He submits that even without pharmacological treatment, there is no dangerousness, and that it has in no way been established that his perception of reality is distorted by a disturbed mental condition.
15. He notes that a persecutory delusional disorder alone does not involve a differential diagnosis of schizophrenia or a personality disorder.
16. He asserts that the origin and the cause were not established and that there is no clinical observation in the content of the report of [Institute B] or that of the current hospital of a significant pathological sign that would require treatment to ensure the safety of the public.
17. He insists that his mental condition is not altered. He claims that his cognition with respect to the events is appropriate. He notes that no cognitive overload was observed before the Review Board and that psychosocial functioning is not compromised.
18. In his view, reintegration is not understood as a risk factor. It is recommended, according to the occupational therapy report filed as exhibit D-7.
19. He submits that according to the testimony of the criminologist of Institute B, the tools developed to assess the risk in criminology even use prior events of which an NCR accused was a victim for the purposes of calculation.
20. According to the accused, the criminologist stated in cross-examination that if the accused did not have a criminal record, or had not been the victim of a criminal act, the assessment of risk would have no purpose. He takes this to mean that one’s attitude, personality, thoughts, and conduct on their own do not lead to an assessment of risk in criminology, in the absence of a prior offences.
21. He suggests that the time elapsed before the report was drafted, thirty-three (33) days, implies that assessments of other accused were conducted and constitutes working conditions conducive to errors and to [translation] “profiling”.
22. He argues that the report of Institute B is based on pre-established evidence from previous reports prepared by psychiatrist Marie-Frédérique Allard, who opined on an issue without conducting any clinical follow-up.
23. He submits that the assessment contains inadmissible involuntary statements. He claims that the content of previous expert reports concerning other cases was filed, although the reports themselves were never filed and the experts did not testify.
24. He suggests that the DCPP [translation] “is trying to save one of its members and that the representatives of that office have a long reach”. In his view, they have control over the representatives of the current hospital.
25. He also claims that Dr. Allard erred.
26. He argues that the evidence obtained for the purpose of the expert assessment by Institute B must be excluded under s. 24(2) of the *Canadian Charter*, because it includes previous expert reports concerning other files, which are subject to litigation privilege and professional secrecy and which contain safeguarded protected statements under section 672.21 of the *Criminal Code*, on which the experts did not testify, and that their use without consent infringes ss. 657.3(6) and (7) of the *Criminal Code*.
27. He goes on to note that the experts’ opinion is based on contested hearsay that was not adequately investigated by the police authorities.
28. He notes that the forensic medical evidence shows that there was concerted action among the physicians involved, in particular Dr. Allard, Dr. Bouchard, and Dr. Delagrave, and that they developed a firm, delusional, circular thought concerning a diagnosis of [translation] “traumatic brain injury” and [translation] “probable simple schizophrenia”.
29. He submits that the forensic medical evidence also showed that the physicians involved developed a dynamic circular thought concerning a diagnosis of [translation] “delusional persecutory disorder” even though they did not investigate the [translation] “delusion”.
30. In his view, it is prejudicial for contradictory versions originating in hearsay to be considered subsequently to allege dangerousness.
31. He emphasizes that elements of the delusion were characterized as [translation] “not implausible” by Dr. Delagrave during his testimony on August 27, 2020, before the RBMD, which is one of the two characteristics advanced by Carol Tamminga.
32. The delusion cannot be supported by the evidence, because his perception and interpretation are not erroneous.
33. He notes that the [translation] “persecutory delusional disorder” is characterized as [translation] “unspecified” according to the testimony of psychiatrist Chantale Bouchard, who stated during cross-examination that she did not know the specific cause of psychotic disorder. Dr. Bouchard thus tacitly admitted that the so-called psychiatric illness remained at the [translation] “syndrome” stage with no specific, convincing clinical sign or differential diagnosis that would support finding a dynamic mental condition justifying the need for treatment or for maintenance in the institution.
34. He submits that his psychosocial functioning is not altered according to the testimony of occupational therapist Olivier Dubeau, who stated in his report that the accused [translation] “has great potential for independence” and that his [translation] “judgment regarding situations of daily life and inherent dangers is adequate and based on a solid foundation”.
35. He concludes by asking the Review Board to render a judgment of absolute discharge under s. 672.54(a) of the *Criminal Code*.
36. He also seeks the dismissal of Institute B’s report under section 24(2) of the *Charter*, as well as the dismissal of Dr. Delagrave’s report, and in the alternative, the redaction of all references to previous files from the content of the reports of Institute B and the designated hospital.
37. He adds a conclusion recommending that the Attorney General be required to pay him a thousand dollars per day of detention and that psychiatric assessments be conducted of the various persons involved in the prosecution who are likely to still show signs of a psychological injury subsequent to a persecutory delusional disorder.

# **XI. DISPOSITION**

# *Applicable principles*

1. In *Winko*, the Supreme Court of Canada confirmed that s. 672.54 of the *Criminal Code* does not create any presumption of dangerousness. It noted that the Review Board can restrict the liberty of an NCR accused only on the basis of evidence that the accused poses a significant threat to the safety of the public. According to the Court, moreover, the decision-makers cannot refuse to grant an absolute discharge because they harbour doubts in this regard.[[135]](#footnote-135)
2. This interpretation of s. 672.54 *Cr. C*. relieves the NCR accused of any legal or evidentiary burden.[[136]](#footnote-136)
3. If the evidence does not support the conclusion that the NCR accused is a significant risk, the NCR accused need do nothing; the only possible order is an absolute discharge.
4. Section 672.54 is not adversarial in the usual sense.[[137]](#footnote-137)
5. The inquiries conducted by the Review Board are necessarily broad. They will closely examine a range of evidence, including but not limited to the circumstances of the original offence, the past and expected course of the NCR accused’s treatment if any, the present state of the NCR accused’s medical condition, the NCR accused’s own plans for the future, the support services existing for the NCR accused in the community and, perhaps most importantly, the recommendations provided by experts who have examined the NCR accused.[[138]](#footnote-138)
6. It is up to the Review Board to examine all the relevant evidence presented by all parties. It has the duty to seek and assess not only the elements that support restricting the accused’s liberty, but also those that weigh in favour of an absolute discharge or a discharge subject to minimal conditions, whether or not the accused is present.
7. Fairness is thus ensured. It is clear that the accused is not always able to defend his or her own case.
8. As for the significant threat to the safety of the public, the superior courts teach that it must not be purely hypothetical. It must be grounded in the evidence.
9. There must be a real and serious risk of physical or psychological harm occurring to individuals in the community.
10. 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.[[139]](#footnote-139)
11. The existence of a significant threat must be observed at the time of the hearing.[[140]](#footnote-140)
12. Mental illness in itself is not evidence of a person’s dangerousness.[[141]](#footnote-141)
13. Thus, dangerousness must be proven by positive compelling evidence. The Board must be satisfied that there is evidence showing the existence of a significant and genuine threat. Doubt is not enough.[[142]](#footnote-142) The tendency to overestimate the potential danger associated with such an illness must be countered.
14. It is also important to note that the Review Board cannot impose or maintain conditions of release merely as a protective measure or to ensure that the accused complies with a treatment plan.[[143]](#footnote-143)
15. Section 672.55 *Cr. C*. expressly states that the Board cannot “direct that any psychiatric or other treatment of the accused be carried out or that the accused submit to such treatment”.[[144]](#footnote-144)

# *Analysis*

1. The Board must determine whether the accused poses a significant threat to the safety of the public due to his mental condition and, if need be, decide which measures should be taken to control this threat and allow his reintegration into society.
2. In light of the evidence as a whole, the Board is convinced that the accused continues to pose a significant threat to the safety of the public due to his mental condition.
3. In its analysis of the issue of the risk of dangerousness, the Board considered the evidence, in particular the multidisciplinary report of [Institute B], the report of Dr. Delagrave, and the report of Olivier Dubeau, all filed at the hearing, and the testimony heard at the hearing.
4. The Board takes the following elements into account.

# *The diagnosis*

1. The evidence on a balance of probabilities establishes that the accused suffers from a persecutory type delusional disorder with premorbid cluster A personality traits (schizoid and paranoid), as defined in the document filed into evidence by the accused:

Persecutory: Patients believe that they are being plotted against, spied on, maligned, or harassed. They may repeatedly attempt to obtain justice through appeals to courts and other government agencies and may resort to violence in retaliation for the imagined persecution.[[145]](#footnote-145)

1. According to the psychiatrist and author, “Delusional disorder does not usually lead to severe impairment or change in personality, but delusional concerns may gradually progress”.
2. The exhibit filed by the accused provides that treatment consists of the “[e]stablishment of an effective physician-patient relationship, [m]anagement of complications, [and by] antipsychotics. ... Substantial lack of insight is a challenge to treatment. If patients are assessed to be dangerous, hospitalization may be required. Insufficient data are available to support the use of any particular drug, although antipsychotics sometimes suppress symptoms”.
3. The author suggests that a long-term treatment goal of shifting the patient’s major area of concern away from the delusional locus to a more constructive and gratifying area is difficult but reasonable.
4. The Board thus understands that, despite the mental disorder, several hospitalizations since the late 1990s, and judgment that is altered by his mental condition, the accused was able to function from 2009 to 2014 as well as during his outings from June to October 2019.

# *Contemporary presence of persecutory type delusional ideas*

1. The evidence on a balance of probabilities establishes that the accused is fueled by conflict with the members of the medical and legal systems.
2. The Board notes that when there is opposition, the accused can become hostile and even intimidating. According to the witnesses heard and the documentary evidence, the accused is impulsive and can be aggressive, especially verbally.
3. It is also undeniable that he continues to have persecutory type delusional thoughts. According to the physician at the designated hospital, the accused is not prepared to comply with the recommendations made by the physicians.
4. The accused does not acknowledge his difficulties at all. In his view, it is always the fault of others, and his rights have been infringed.
5. He efforts are now focussed on preparing his actions and/or proceedings. He is very distrustful.
6. His lack of cooperation with the treatment team prevents him from receiving the treatment he needs to be safe. The accused seems impervious to psycho-education attempts.
7. Other than an openness towards his occupational therapist, the accused still believes that he is the victim of conspiracies and injustices by participants in the justice and medical systems.
8. Fifteen months later, the accused’s situation has evolved somewhat since July 2019, although his mental condition seems identical to how it was when the offence was committed and when the verdict was rendered.
9. The evidence shows that since the judgment of the Supreme Court in May 2020, the accused’s legal activities have been limited, but this change is very recent.
10. In addition, although much emphasis has been placed on the risk of legal proceedings, the index offences underlying the verdict did not take place in the context of legal proceedings *per se*. The facts took place during telephone conversations, in the context of complaints.
11. While the Review Board is aware that the requirement of obtaining leave of the chief justices of the various courts will have the effect of controlling the accused’s legal activities, his persecutory thoughts could lead him to commit an offence during an episode of anxiety.
12. Let us consider the evidence in support of these observations.
13. It consists in particular of the testimony of two experts from Institute B, the multidisciplinary HCR-20 assessment, the report and testimony of Dr. Delagrave, and the report and testimony of the occupational therapist, Mr. Dubeau.
14. The Review Board asked Institute B to assess the accused’s risk of dangerousness, in view of Dr. Faucher’s inability to accept the mandate.
15. [Institute B] decided to conduct a multidisciplinary assessment based on an actuarial tool, the HCR-20.
16. The superior courts recognize that actuarial assessments such as the HCR-20 “are … capable of predicting the likelihood of future violence, and not its nature or magnitude”.[[146]](#footnote-146)
17. However, these judgments also specify that to reach a decision on an accused’s dangerousness, the Board may consider such actuarial assessments, alongside the clinical risk assessment in a hospital report and the evidence of a treating physician.[[147]](#footnote-147)
18. Institute B’s report sets out the assessment of the accused’s risk based on the actuarial tool as well as the opinion of Dr. Bouchard, Mr. Sepulveda, and Dr. Gauthier, based on the clinical risk factors.
19. The accused objected to the consultation of psychiatric information in the context of the multidisciplinary assessment. It is important to note at the outset that the accused’s objection is tardy as it was raised after the report was filed. In addition, although the accused seems to object to Dr. Marie-Frédérique Allard’s expert assessment, Dr. Bouchard and Mr. Sepulveda did not specify exactly which reports they consulted. As a general rule, psychiatric history is admissible in evidence. The psychiatric assessments were ordered by the courts of justice. The physicians were entitled to consult the previous information for the purposes of their opinion.
20. In addition to the report and the testimony of the professionals from the national institute of forensic psychiatry, Dr. Delagrave’s testimony must be examined in the context of the report of the hospital that signed it.
21. Dr. Delagrave’s report and the multidisciplinary assessment report set out the stressors that all these professionals found increase the accused’s risk.
22. Based on several factors, the Institute B team and Dr. Delagrave are of the view that the accused continues to pose a significant threat to the safety of the public, within the meaning of section 672.5401 of the *Criminal Code*.
23. The evidence as a whole establishes a substantial long-term disturbance in the accused’s judgment, which is chronic in the case of his perception of the legal and medical systems. It also establishes a complete lack of insight. The accused does not believe that he suffers from a mental disorder or that he needs medication or follow-up care. In addition, he continues to deny the acts for which he was found not criminally responsible.
24. The accused is unable to recognize the dangerousness that may result from a decompensation of his psychiatric illness.
25. He does not understand that his attitude can cause some people to feel threatened by his actions. The psychiatric pathology from which the accused suffers causes him to have a lack of empathy.
26. The accused’s situation is identical to the one that existed in May 2018 and March 2019. It shows that the accused is unable to think about and experience anything else.
27. The evidence establishes that during the assessment, he would bring the clinicians back to his past legal cases. This shows that the accused is unable to think about anything other than these situations, even for a brief moment. He constantly ruminates on his disappointment. The resulting feelings lead to frustration and a propensity to commit an offence.
28. Returning to the accused’s position, he also raised arguments against the quality of the evidence. Essentially, he stated that the witnesses were relying on information of which they did not have personal knowledge.
29. While the Board need not respond to each argument made by the parties, it considers it important to address the issue of the use of hearsay during its hearings. The case law consulted suggests that Board members may use hearsay in the analysis of the issue of dangerousness.[[148]](#footnote-148)
30. The Court of Appeal for Ontario considered the issue of hearsay in *Conway (Re)*.[[149]](#footnote-149) It stated:

The Board has wide latitude to receive hearsay evidence, in part because its proceedings are more inquisitorial than adversarial … Of course, depending on the nature of the hearsay and its relevance to the matters in issue, some hearsay evidence will require greater scrutiny before the Board can accept it.

1. Earlier, in *Vancurenko*, the Court of Appeal for Ontario found that the Review Board may admit and consider hearsay evidence. It found that it is up to the Review Board to evaluate hearsay evidence, while remaining aware of the dangers inherent in evidence of this type.[[150]](#footnote-150)
2. Of course, the value of a physician’s testimony may be affected if it is based on [translation] “second hand” information, but these elements are part if the analysis of the probative value, if any, to be ascribed to testimonial or documentary evidence. The Review Board understands the need to conduct this analysis and make the necessary distinctions at the stage of determining probative value.

# *Probative elements in the occupational therapist’s testimony and report*

1. Despite the occupational therapist’s opinion that attempts to submit applications to assert his rights seem sufficient for the accused, the accused’s dangerousness does not reside solely in the institution of actions or the filing of legal proceedings.
2. The Board finds it relevant that the occupational therapist recognizes that the accused “displays problematic disruptive behaviour, however, when he is not able to express himself or does not have control over a situation of which he claims to be a victim”. Note that this attitude arises in a controlled environment, where the accused knows he is being monitored.
3. With respect, the Board also disagrees with Mr. Dubeau’s statement that [translation] “the accused accepts help to address, and ideally resolve, his legal situation” The members of this panel do not believe that the accused has completely integrated the principle of seeking help. They have doubts as to whether the accused truly wants to resolve his legal situation.
4. While the Board cannot comment on the accused’s initiatives regarding his legal problems before other bodies, it finds that the steps he took with respect to this hearing go far beyond the steps taken by other unrepresented NCR accused.
5. The accused is still very interpretive. A few times during the hearing, the Board witnessed his frustrations, especially towards the members of the office of the DCPP. During his arguments, he suggested that the members of that office [translation] “have a long reach”. The accused’s delusional preoccupations are focussed on the fact that he claims to be a victim of the legal system, and more specifically of Mtre M.L.
6. His attitude throughout the hearing shows that he is convinced he is the authority on the subjects of his beliefs.
7. At the hearing, during which the accused was detained in a protected environment, he showed his frustration and displeasure somewhat. In his conclusions, he even suggests that the Board has the power to order the psychiatric assessment of the case workers and persons involved in the file.
8. An element to consider is that the accused’s only witness, Mr. Dubeau, acknowledges that the accused seems to have a problem with persons in positions of authority.
9. He himself wrote in his report that the accused tends to perceive events, especially those that concern him, as being elements of his persecution.[[151]](#footnote-151)
10. While Mr. Dubeau’s testimony suggests a certain openness in regard to the accused’s mental condition, the Board finds that progress is still in the early stages.
11. Questioning the [translation] “automatic thinking”, while a first step, is in the embryonic stage. According to the evidence, the accused is able to apply this to everything external, that is, general life situations, but it is much more difficult with respect to scenarios that affect him directly. There were even some scenarios where he was quite fixed in his position. He seems to have at least started on the right path.
12. The attempt at behavioural therapy nevertheless revealed that he is not easily distracted from his need to establish the guilt of others.
13. The accused’s thinking has not changed or relaxed very much, and it remains a dominant aspect of his presentation. His intransigence has led him to develop reactions that are inappropriate to his situation and that create an obstacle to a better understanding of his situation. This has a negative impact on his quality of life.
14. The accused’s inflexibility means that there is a real risk of him developing significant stress in the future when he is confronted with unexpected events that are typical of everyday life. The evidence is conclusive that stress, in turn, has a definite impact on the accused’s mental stability.
15. It is true that Mr. Dubeau confirmed that, while accompanying the accused, he did not witness any incidents suggesting that the accused’s conduct is a danger to the safety of the public.
16. It should not be forgotten that the accused is in a very structured context at the moment. His right to go on outings lasted barely 4 months during a hospitalization that has lasted 22 months.
17. On of the elements raised by the representative of the designated hospital and by counsel for the DCPP was that the mental health occupational therapist was not qualified to assess a person’s dangerousness and did not have the training required to opine on that issue.
18. While the Board understands that the witness cannot give an “opinion” on the risk of dangerousness, it is nevertheless of the view that this ordinary witness may inform the Board as to whether he observed any dangerous conduct by the accused while he accompanied him.
19. These parties also seem to object to the witness Dubeau’s suggestion that the accused can channel his energy by making a complaint or bringing legal proceedings.
20. The Board understands that such a suggestion may appear rather questionable to lawyers, especially in the case of an accused found to be a [translation] “quarrelsome and vexatious litigant”.
21. What the Board notes in particular is that this witness also states that in the event that the accused is unable to make a complaint or sees that the complaint is not justified, he could become provocative with the person concerned so as to elicit a counter-reaction from them. The occupational therapist added that he observed such conduct on four occasions.
22. Such conduct was thus repeated, even during a period when the accused was detained.
23. The Board considers it likely, based on the accused’s history and his tendency to act impulsively, that in these circumstances, a situation could escalate due to the accused’s conduct.
24. It does not believe that the lengthy hospitalization has diminished this type of reaction.
25. Impulsivity is one of the risk factors identified by the professionals of [Institute B]. It is also confirmed by the occupational therapist’s testimony. He said that during an intervention he had to do further to an observation, the accused claimed that he had entrapped him to create the intervention. Although the worker concluded that the accused reacted on the basis of an initially false perception, the accused reacts that way even with people he has allied himself with.
26. The Board considers it probative that Mr. Dubeau himself is of the view that if the accused’s ability to express himself were restricted, it could lead to an emotional accumulation.
27. This part of the testimony confirms that there has been little significant progress in the accused’s mental condition over time. The Board is convinced that the fact that the accused felt silenced and not listened to has given rise to the excessive behaviour in the past years, which in part explains all the charges and convictions since 2014.

# *Evidence of the risk of criminal behaviour*

1. The Board is of the view that the evidence amply justifies the conclusion that the accused is inclined to engage in rash behaviour and desperate acts in the face of stress and adversity.
2. It is clear from the evidence and from the accused’s attitude and speech during the hearing that the systematic persecutory delusion regarding the legal world and various individuals is still very present. During her testimony, Dr. Bouchard compared it to a fire that the accused is stirring. In her view, the accused ruminates constantly. Occupational therapist Dubeau made frequent reference during his testimony to [translation] “automatic thinking”.
3. The evidence establishes that the accused’s conduct permits him to soothe intense emotions and acts as a defence mechanism against paranoid thoughts and anxiety-provoking events. Nevertheless, some of his actions are unacceptable and criminal and must be monitored.
4. The charges underlying the NCR verdict are based on firm and increasing threats arising from the deterioration of the accused’s mental condition. His conduct was troubling.
5. Even more troubling is the fact that the accused is unable to question his actions.
6. The persistent mental health problems are relevant considerations for the Board, but they do not determine the risk on their own.[[152]](#footnote-152)
7. It is likely that the accused will take steps that are harassing for the people concerned, but the Board notes that the significant threat to the safety of the public resides in the fact that it is plausible and probable that the accused will engage in criminal behaviour such as threats, intimidation, and harassment. Considering that, without any changes, it seems impossible for him to question himself, no measure will be able to prevent it.
8. Simply ignoring the threats altogether is never an option. Paradoxically, it could have the effect of encouraging the accused, because it would mean that he is not being taken seriously.
9. While the ultimate concern in regard to an offence is whether it reflects a violent intention or plan, the Board believes that, without structure, his behaviour will cause psychological harm in the future.
10. We must not forget that it is in part to satisfy his need for revenge that the accused tried to create circumstances that could cause M.L. and the judge who convicted him in 2015 the same feelings of powerlessness and loss that he felt. That need for revenge was not met.
11. The Board does not think that the accused has understood that recourse to violence is not the solution to his problems.
12. Psychological violence is a ground on which the Review Board for mental disorder may rely to reach its decision.
13. The Court of Appeal for Ontario’s judgment in *Saikaley (Re)*[[153]](#footnote-153) confirmed that expert evidence before the Board establishing the likelihood that the appellant would resume criminal harassment was sufficient grounds to find that the preliminary test was met.
14. During his arguments, the accused submitted that the members of the treatment team have not witnessed any hetero-aggressive behaviour during his detention, and that therefore there is no dangerousness. The Board does not accept this argument.
15. Contrary to the accused’s submissions, the Board cannot base its decision on dangerousness solely on the fact that the accused has not committed a hetero-aggressive act during his detention since December 2018. It must be kept in mind that the accused has been detained for 29 months. His illness and wrongful behaviour have been present for 20 years.
16. While the accused seems to play down all his acts, it is inaccurate to contend that he did not act aggressively or express frustration with patients or staff of the current hospital in the past year.
17. In an assessment note prepared by Dr. Lucie Laforme describing an incident that took place on August 28, 2019, she wrote, [translation] “he hit the guitar of another patient because he did not want to hear him play anymore. In view of this conduct, there was a team discussion, and weekend outings were cancelled. The patient was told not to be arrogant with the staff. He said that the staff was harassing him psychologically”.[[154]](#footnote-154)
18. Last, in his report, occupational therapist Olivier Dubeau stated that when [translation] “the accused was in an environment that could be explosive at times, he took it out on equipment, without breaking it in the end”.[[155]](#footnote-155)
19. The evidence does not clearly establish if the incident to which Mr. Dubeau was referring is the same as the one to which Dr. Laforme mentioned in her report when she said that [translation] “on August 30, 2019, the accused became angry in the dining room. He was upset and threw his tray into the garbage and a bit on the floor”, and that after that the patient was reluctant to meet with her.[[156]](#footnote-156)
20. During his testimony, Dr. Delagrave also said that the accused made insulting comments about other patients and rather crude remarks about certain workers.
21. It is clear that even if this is true, such comments alone do not mean that the accused is a significant threat to the safety of the public.
22. Persons suffering from mental illness have the right to be irritated, annoyed, impatient, and angry. The Board is simply answering an argument raised by the accused.
23. Nevertheless, these events tend to show that that, considering his propensity for [translation] “irritability”, the accused will act quickly when he is angry and/or frustrated.
24. The Court of Appeal for Ontario recently warned against giving too much importance to the absence of recent aggressive behaviour.
25. In *Krist (Re)*, 2019 ONCA 802, the Court wrote:

However, the absence of violent behaviour by the appellant does not serve by itself to eliminate the risk of significant harm to the public … the appellant’s abstention from criminal or violent acts is not singularly determinative of whether he poses a significant threat to the safety of the public …

Evidence of the potential for physical or psychological violence, such as a lack of insight into the index offences and mental illness, and concerns over discontinuing medication and substance abuse, which could result in decompensation and psychosis, like in the present case, may support a finding of significant risk to the public.[[157]](#footnote-157)

1. In this case, the accused was in detention while awaiting his trial and the verdict. He was detained by the court of justice until his hearing before the Review Board. He was in detention subject to conditions from June 10 to October 18, 2019. At the time of the last day of the hearing on October 2, 2020, his liberty had been subject to significant restrictions for over two years. During that whole period, the accused was subject to constant supervision.
2. The Board is convinced that in the absence of supervision by the treatment team, the accused would continue to have delusional beliefs. As the possibility of asserting his thoughts surrounding his rights is very restricted, he inevitably experiences feelings of injustice and victimization in regard to the persons he harassed and intimidated.
3. His actions since 2014 show a tendency towards impulsive conduct and criminal behaviour resulting in physical or psychological harm for members of the community.
4. It is also certain that the accused will not take medication and will engage in seriously harmful criminal behaviour, similar to the offences he committed in 2018.
5. The evidence shows that the accused suffers from a major mental illness. Hospitalization has not changed anything. The testimony of Dr. Delagrave and even that of Mr. Dubeau establish that the accused has continued to have delusional thoughts. He categorically refuses to admit that he suffers from a mental disorder and rejects all treatments considered to be risk management tools by the health care practitioners.
6. The accused’s belief that he is not ill increases the risk that he experiences an undetected mental deterioration if he is not under medical/legal supervision.
7. Although it goes back a long time, it is nevertheless significant that the record establishes that the accused committed criminal acts while subject to pending proceedings. Although his criminal record does not contain many entries for breach of court orders, other than a conviction in 2001 for two counts of failure to comply with a probation order, the accused was charged with breach of probation seven days after his conviction for criminal harassment, on June 18, 2001. The fact that he was under a probation order did not prevent the accused from breaking the rules.
8. It is also important to consider that the legal process did not necessarily achieve the objective of individual deterrence in the accused’s case. He was charged with counts of distribution of child pornography and identity fraud with intent to cause disadvantage to a person while he was still facing proceedings on charges of criminal harassment,[[158]](#footnote-158) use of a forged document, and possession of a forged document.
9. One of the elements that the Board considers in its analysis is the criminal record. The existence of a criminal record may help the Board determine the accused’s character.[[159]](#footnote-159)
10. An analysis of his criminal record informs us that the offence underlying the NCR verdict took place only three weeks after the accused was declared to be a quarrelsome litigant by the Court of Appeal of Quebec. The accused was given that designation on [...], 2018.
11. When the members of this panel examine the issue of the accused’s attitude with respect to the court judgments and his compliance with orders, they can only conclude that the accused constantly questions the accuracy or legitimacy of *res judicata*. While he cannot be described as non-compliant *per se*, he has a well-established history of failure to accept *res judicata*.[[160]](#footnote-160) Considering this constant and unwavering questioning of every decision and order, it is necessary for the members of a treatment team to supervise his conduct so as to manage the risk arising from the stress and frustration he might feel.
12. It is clear that the accused has been suffering from a severe mental disorder for almost 20 years. He has engaged in harassing behaviour over the years. Underlying his 2001 conviction is an acknowledgement that the victim’s safety concerns were reasonable. Offences involving psychological violence have consequences for the victims of such offences. The offence of criminal harassment does not involve conduct that is merely trivial or embarrassing. In the past, the accused’s acts constituted criminal behaviour for which he was convicted.
13. The evidence unequivocally establishes that the accused does not consider the possibility that he suffers from a mental illness. He has chronically resisted all forms of treatment or follow-up care for many years.
14. He is not able to identify the risk factors related to re-offending, that is, frustration and mood swings.
15. During his arguments, the accused insisted that *J.S. c. Centre universitaire de santé McGill, (CUSM)*,2016 QCCA 1085 (CanLII), supports his position. He referred to a passage concerning delusions focussed on legal proceedings:

[translation]

Indeed, beyond the disruptive behaviour the appellant might adopt, the evidence does not support the conclusion that such behaviour would be criminal in nature. **A delusion focussed on legal proceedings to recover millions of dollars** is not behaviour that is criminal in nature. Moreover, if he were to adopt criminal behaviour, the evidence is completely silent as to the serious threat, as per Winko, that the appellant could cause serious physical or psychological harm to a member of the public in accordance with section 672.5401 Cr. C.

[Emphasis added.]

1. The Board is of the view that the accused’s situation must be distinguished from that of the person concerned in the judgment cited above.
2. In the case of J.S., he was properly complying with the Superior Court’s treatment order, and his behaviour confirmed it.
3. In this case, the evidence supports the conclusion that the behaviour that the accused could adopt would be criminal in nature. The problem in this case is not only delusions focussed on legal proceedings. The accused feels persecuted by the justice system. As the Court of Appeal stated in 2017, he also sometimes feels authorized to take justice into his own hands by committing wrongful acts. There is a serious and real risk that he will cause psychological harm to a member of the public by resorting to threats, harassment, and intimidation.
4. Above all, we cannot overlook the fact that in the recent past, the accused engaged in threatening and troubling behaviour.
5. The evidence leads us to believe that he will likely adopt behaviour similar to the offence underlying the NCR verdict.
6. It is also important to remember that when the accused committed the offence, he made reference to the use of a weapon, a non-negligible fact related to violence.
7. As for evidence of the significant risk that the accused will cause physical or psychological harm to a member of the public, in addition to the index offences underlying the verdict of not criminally responsible, the accused’s history includes not only an offence of psychological violence, but also a conviction for identity fraud with intent to cause disadvantage to a person.
8. During the hearing, in cross-examination, the accused asked Dr. Bouchard to detail the risk.
9. She answered that the accused poses a moderate risk for violence in the institution. She confirmed that it is [translation] “psychological”. She referred to harassment and threats and said that these acts could be criminal in nature.
10. It is also relevant that in the multidisciplinary assessment, the health care practitioners indicate that, during the interview, the accused even stated that although he does not condone violence, it may sometimes be appropriate to commit a criminal act against sometime who has committed a criminal act.[[161]](#footnote-161) The Board nevertheless acknowledges that he subsequently retracted his statement.
11. It must be kept in mind that the accused often considers himself to be the [translation] “victim of offences”. According to the information in the record, the accused alleges to have been the victim of sexual harassment (2014), mischief on his vehicle by a firearm (2015), harassment (2016), vandalism, slashed tires, damage to his front door, and breaking and entering (April 2018).[[162]](#footnote-162)
12. In addition, according to the understanding of criminologist Mr. Sepulveda, it is important to remember that the accused seems to believe that the lawyer concerned by his threats and intimidation may have been responsible for the breaking and entering of his home.[[163]](#footnote-163) The occupational therapist suggests that the accused thought that a police officer opened the door to put something inside his home.
13. During the criminologist’s testimony, the Board heard that the paranoid thoughts about the persons concerned were still present. According to him, the lack of treatment explains the fact that the accused committed the offence.
14. From this evidence, the Board infers that if the Board’s mandate is not maintained, the accused will likely resort to threats, harassment, and intimidation.
15. From the statements made by the accused during the hearing, the Board notes that he seems to still feel justified in reacting on his delusional beliefs, which he considers true. A few questions concerned the possibility that he is a victim or is mistreated.
16. In the disposition information concerning the offence of uttering threats, it is alleged that when he called the DCPP’s office, the accused stated that if the lawyer concerned by the complaint came to his house, he would arrest him, and that he made a vague reference to the death of that lawyer at the time of that arrest.
17. A year and a half later, the accused seemed to still have the same idea.
18. It is important to note that the accused returned to the idea that he was a crime victim during his assessment in May 2020.
19. It is not totally clear that the cognitive therapy with Mr. Dubeau had the effect for the accused of negating the idea that persons in positions of authority are responsible for “crimes” against him.
20. In view of this belief, it is likely that he will resort to violence in response to a perceived threat. The evidence shows that the delusions persist. The accused referred to them during Dr. Bouchard’s cross-examination.
21. It is also necessary to consider that according to the Court of Appeal for Ontario’s judgment in *Saikaley (Re)*, cited above, the test in section 672.54 of the *Criminal Code* does not require the Board to determine whether the victims of the index offences underlying the verdict suffered serious psychological harm, but to conclude that it is likely that an accused will behave in a manner likely to cause serious harm to a member of the public.
22. The evidence indicates that the accused’s mental illness has led him to harass a person with whom he had contact in the past, and to intimidate persons in 2018. The review of the accused’s background history establishes that one of the foreseeable results of his acts is serious psychological harm to his victim or victims.
23. The accused himself seems to acknowledge that intimidation may be prejudicial to others and associated with violence.[[164]](#footnote-164)
24. The Board is of the view that there will likely be other manifestations due to the accused’s disorder. The evidence as a whole establishes that, without treatment or supervision, the accused will engage in acts of criminal harassment or utter threats and cause serious psychological harm to members of the public. The Board opines that, without follow-up care, the threat he poses to the safety of the public will increase. This risk is foreseeable and real.
25. The risk of psychological harm arises from the accused’s mental condition and the circumstances. There has been very little change in the 22 months of hospitalization. He has no insight. His mental disorder is present. His feelings towards the victims and the members of his medical team have not changed. He categorically refuses psychiatric treatment.
26. He has continued to have delusional thoughts during his hospitalization. He does not want to discuss his symptoms.
27. The physician assigned to his case is of the view that if the accused is faced with the stress of an order to authorize care, he will likely become psychotic within a short period of time.
28. The panel’s concern is solely to protect the safety of the public and to fully reintegrate the accused into society.
29. The panel members cannot ignore the intensity and nature of the accused’s disorder. The accused has never accepted his illness, as illustrated by his insistence on the retraction of his former physician’s diagnosis.
30. For the Board, in view of the accused’s history, progress, and fixed position, it is clear that in the absence of change or follow-up care, the future risk to the safety of the public will be at least equal to if not greater than the risk on the day of the hearing.
31. The review of the record and the evidence presented at the hearing leads the Board to conclude that, in view of the obstacles and his lack of insight, the accused will act on his delusional impulses. The experts Bouchard and Sepulveda allude to a transfer towards more physical and direct acts against other persons. While not everyone agrees with this position, it is clear that the accused has little control and is at risk of re-offending.
32. In addition, it is highly likely that a major change in the accused’s situation will give rise to new stressors. The accused is sensitive to his environment. The evidence establishes that the accused has difficulty tolerating stress. His fragility places him at risk of confrontation and of committing acts that are dangerous to others.
33. A review of his criminal record over the past five years shows that the accused responds to frustration primarily with verbal aggression, by trying to damage the reputation of those he believes are persecuting him, and sometimes by committing psychologically violent criminal offences.
34. It is clear that if he were fully discharged, he might feel encouraged in his plans to clear his name and entitled to react by resorting to psychological violence, as he has done in the past. The fact that he requires leave from the courts before filing proceedings will inevitably lead to other feelings of anxiety.
35. The evidence is not conclusive as to whether the accused has been able to develop better strategies to manage situations that he finds unpleasant.
36. The Board believes that with the legal measures in place to manage the accused’s quarrelsomeness, an accumulation of emotions is the direct and likely consequence. The accused is at risk of repeating his conduct in similar situations.
37. With respect to the witness Dubeau, taking into account the accused’s propensity, the panel does not agree that the accused will be content with the mere possibility of trying to file legal applications to channel his emotions, even if they are dismissed later.
38. Contrary to that witness’s submissions, the accused’s general attitude during the hearing show that he still prone to feeling attacked, wronged, or unjustly treated by different people, especially those who suggest that his behaviour is inappropriate or due to his mental illness.
39. In addition, the Board does not agree that there is a sort of weariness starting to set in.
40. The Board notes that despite the judgment of the Supreme Court of Canada, the accused does not accept the NCR verdict. During the hearing, the accused returned to the 2018 offences a few times. In his view, he is not ill, and the judge of the court of justice erred in finding him guilty.
41. In addition to the fact that the accused has committed a few prior offences involving psychological violence, he continues to minimize his actions involved in the offence underlying the NCR verdict and attributes full responsibility to at least one of the victims.
42. During the hearing, the accused indicated that the Board should not take into account the offences he was convicted of.
43. The fact that he does not want to discuss the criminal offences he was convicted of prevents the clinicians from determining if he has learned anything from the experience or from correctly assessing whether he is likely to re-offend.
44. On the issue of the use of criminal charges that did not result in a conviction, the Board accepts the teachings of the Court of Appeal for Ontario.[[165]](#footnote-165) In *Runnalls*, the Court noted that such charges are inadmissible at Board hearings, except to the extent that they are part of an actuarial tool used for risk assessment.

[translation]

In the multidisciplinary assessment filed in the record, the assessors stated, [translation] “We note charges of criminal harassment for facts committed in 1998 (convicted) **and in 2004** (**judgment ordering a stay of proceedings**, mental examination, and the imposition of conditions). …[[166]](#footnote-166)

[Emphasis added.]

1. The Board therefore finds that, although the accused was granted a stay of proceedings on the charge of harassment in 2004 – as an example of prior conduct – the professionals of [Institute B] were entitled to consider it in their assessment of the significant risk to the safety of the public, even if the Board considers that it can be ascribed only limited probative value.
2. The clinicians who assessed the accused are of the view that his delusional thoughts remain present.
3. As for his persecutory thoughts, he is rigid and obsessed with the idea that M.L. and G.L. caused him harm and were looking for him.
4. The Board considers this to be a factor to conclude that there is a real risk that the accused will become more intensely disorganized and that, based on past experience, he could again choose to act against the subjects of his beliefs in a violent manner.
5. The Board acknowledges that the accused has no intention of taking medication. In the circumstances, it agrees with Dr. Bouchard and Dr. Delagrave that psychiatric supervision and monitoring are necessary to be able to act in the event of a likely and inevitable decompensation.
6. In the analysis of the management of the significant threat posed by the accused, it is also necessary to consider that this is the Review Board’s second mandate.
7. The health care practitioners at Institute B and Dr. Delagrave have opined on the risk of dangerousness considering the accused’s refusal to accept treatment voluntarily.
8. The Court of Appeal for Ontario[[167]](#footnote-167) recently analyzed the issue of the potential for physical or psychological violence. It stated:

evidence of the potential for physical or psychological violence, such as a lack of insight into the index offence and mental illness, rule breaking and concerns over discontinuing medication and substance abuse, which could result in decompensation, psychosis and problematic conduct, like in the present case, may support such a finding.

1. With respect to “rule breaking”, in this case, although the accused’s refusal to accept court decisions does not necessarily involve violating rules, his criminal record includes an entry for failing to comply with the conditions of a probation order.
2. The Review Board has broad power to examine [translation] “disposition information” that may not comply with the strict rules of evidence in all respects.
3. Keeping in mind that the accused was acquitted of the offence of breach of probation on October 26, 2018, it must be noted that at the time he committed the offence underlying the NCR verdict, the accused had been subject to a probation order since December 12, 2015.[[168]](#footnote-168)
4. In addition, since 2015, he has developed a fixation on certain justice system participants. His thoughts recently gave rise to problematic behaviour. Despite the evidence that one of the victims said she did not fear for her safety after bring informed of the accused’s remarks on April 23, 2018,[[169]](#footnote-169) the same victim also wanted to make a complaint[[170]](#footnote-170) against the accused a week later, after she was informed of other statements made on April 30, 2018.[[171]](#footnote-171) The obsession with this person has been going on now for over four years.
5. He seems to continue to perceive insults and threats by persons in positions of authority. He is consumed by the idea of obtaining a remedy for the wrongs he is convinced of having suffered.
6. In addition, the Board notes that, according to the uncontested evidence, despite the fact that he has been hospitalized since December 2018, the accused is unable to establish a therapeutic alliance with a physician. He consistently refuses to give the psychiatrists access to his thoughts.
7. The physicians are of the view that the accused has shown no real change since the offence. He does not recognize any risk of relapsing or re-offending. He denies practically all criminal conduct in his life. He denies the existence of fluctuations in his mental condition. During the entire hospitalization, the accused has continued to show a lack of transparency and has disclosed nothing.
8. The Board is convinced that the accused’s mental condition may deteriorate in the absence of a change in perception and given his therapeutic resistance.
9. What is more troubling is that he will not be able to recognize the signs of deterioration in the future. That is explained by the fact that he has not developed the necessary introspection to take the appropriate precautions. In addition, the accused considers the constant supervision by the treatment team to be intrusive and unnecessary. He expresses the wish to be free from all supervision.
10. Nor can the health care professionals count on the cooperation of the accused’s few relatives to inform them about his condition. According to the evidence, some of his family members are distrustful of the medical and legal systems.[[172]](#footnote-172)
11. Together, the chronic nature of the accused’s untreated illness, the gravity of the offence underlying the NCR verdict, the accused’s lack of insight, and his impulsivity meet the threshold of “significant threat”.
12. The Board is of the view that the accused needs a solid community plan designed to decrease the risk to the public before he can be granted an absolute discharge.
13. Although the accused was within his rights when he decided not to answer the questions of the panel members, he prevented them from informing themselves about the mitigating factors, his perception of his current mental condition, and his plans and projects. For reasons the panel members still do not know but that seem akin to extreme distrust, the panel was deprived of hearing the accused’s position as to whether he poses a danger or not.
14. The Board notes that the accused’s conduct at the hearing revealed the extent of his delusions.
15. To summarize, the accused continues to suffer from a major mental illness, an untreated active persecutory delusional disorder. He has been psychologically violent in the past. The offence underlying the verdict is objectively serious. The evidence includes several incidents where the accused engaged in verbal aggression.
16. He also has a history of non-compliance with treatment and follow-up care. He is closed to any discussion of the existence of an illness or the usefulness of medication. His has a limited social circle. He has no known support from his peers, apart from his immediate family. He has no professional support.
17. In addition, the same thoughts that he had and that appear to have motivated the offence underlying the NCR verdict persist. The offence underlying the verdict consisted of threatening to use violence against a justice system participant.
18. The psychiatrists have noted that the accused’s behaviour is somewhat agitated and that, without treatment, which he continues to refuse, there is a significant risk that he will resort to psychological violence.
19. Dr. Bouchard based her opinion in part on the result of a moderate risk of psychological violence that the accused obtained further to the assessment based on the HCR-20. It is also probative that even during an assessment that could have helped him to establish his current risk level, the accused persisted in his refusal to engage with the professionals.
20. With respect to the assessment conducted on May 15, 2020, it is important to remember that, despite a note indicating that the accused said that, because of a sedative he had taken the night before for a physical examination, he was not quite himself, the Board gives no probative value to this assertion given the lack of evidence in that regard and/or on the effects of a sedative, on the accused’s capacity to be interviewed, or on his consent.
21. The delusions and the suspicion towards the medical members of his treatment team may also have been hindered them in their assessment of the risk that he poses and in their suggestion of the treatment required.
22. The evidence establishes that the distrust he shows for the psychiatrists and the mental health system is not limited to one person or hospital in particular.
23. Other than his interaction with the social members, he is not open to educational interventions, thereby sabotaging his own reintegration and rehabilitation.
24. The Board is of the view that, as things now stand, if the accused were to be absolutely discharged, it is very likely that he would re-offend. The accused’s feelings about the two victims are still very strong. Mr. Dubeau very clearly stated that the accused has not abandoned the idea of clearing his name. He continues to contest the acts that led to the NCR verdict.
25. It is more than reasonable to think that, without a major change and in the face of the legal challenges resulting from his designation as a quarrelsome litigant, the accused will persist in his delusional beliefs and his refusal to accept treatment, which will lead him to repeat his reprehensible acts.
26. There is direct positive evidence that the accused’s mental illness led him in the past to harass others with whom he had or thought he had a dispute and to cause them to fear for their safety. The conviction for harassment in 2001 is evidence of criminal behaviour causing serious psychological harm to his victim.
27. Before examining the issue of the accused’s criminal responsibility, Morand J. decided that proof of the elements of the offence of intimidation of a justice system participant had been made out beyond a reasonable doubt.
28. The Board is entitled to rely on the testimony of experts and the attending physician, according to which, in the absence of treatment and legal restrictions, the accused will again engage in criminal behaviour and pose a significant risk of causing serious psychological harm to members of the public.
29. The attending physician testified that, at this time, the accused’s actions are more focussed on legal aspects. He is of the view that the accused could become more impulsive and pose a greater risk of committing an offence if the intensity of his stress, his urges, and his suffering increases. The Board is of the view that this scenario is highly probable, in view of his habits and his tendency to act on his delusional impulses.
30. The accused has been without medication since at least 2014. Not only did he commit a criminal act, but an increase in delusions and wrongful acts was also noted.
31. It is important to consider that the accused reacted swiftly after the Court of Appeal rendered its judgment declaring him to be quarrelsome. An act of the justice system triggered frustration for the accused and a quick reaction.
32. The accused has been detained since May 1, 2018. While Mr. Dubeau and Dr. Delagrave acknowledge that he channels his energy into his legal proceedings, the context must be taken into account.
33. The legal proceedings instituted after May 2018 were filed while the accused was in detention. His freedom to act was greatly restricted, and he was supervised closely.
34. The Board cannot overlook the fact that, although the accused was active in the legal sphere, that did not prevent him from committing criminal offences in 2014 and 2015. The Board is of the view that some frustrations may have sidestepped the legal channel.
35. It is true that the accused relies on the judgment of the Court of Appeal rendered in October 2019 finding that the [translation] “RBMD could not reasonably conclude, in light of the evidence, that the legal harassment alleged against the appellant resulted in a serious risk of harm for the victims or the public in general”.
36. With respect, the Board submits that there is a distinction to be made between the evidence filed before the June 2019 panel and the 2020 panel.
37. The evidence filed at this hearing establishes that it is likely that the accused will commit the offence of either uttering threats, harassment, or intimidation. The fear is not limited to the mere concern that someone could be subject to legal proceedings, with the inconveniences resulting therefrom. The Board considers the analysis conducted by Dr. Bouchard and Mr. Sepulveda to be reasonable.
38. The evidence as a whole establishes that the accused poses a foreseeable and significant risk of causing psychological harm that is more than trivial or bothersome to members of the public.
39. The potential victims of harassment, threats, or intimidation will suffer significant psychological harm.
40. In addition, the analysis of the psychological harm likely to be caused to members of the public is not based solely on the opinion of a physician or psychiatrist.
41. According to the case law, for the purposes of section 264.1 of the *Criminal Code*, which codifies the offence of uttering threats, the expression “serious bodily harm” means any hurt or injury, whether physical or psychological, that interferes in a substantial way with the integrity, health or well‑being of a victim.[[173]](#footnote-173)
42. Under section 264 of the *Code*, the offence of harassment requires that the accused’s conduct cause the victim to “reasonably … fear for their safety”, which is not limited to physical safety, but may include serious psychological harm or emotional distress.[[174]](#footnote-174)
43. One of the essential elements of the offence of criminal harassment is that the complainant must fear for their safety. The effect of the acts on the victim corresponds to the characterization of the psychological injury, which may be serious.
44. Last, the intent to harm a justice system participant is the intent to provoke a state of fear or to intimidate and thus influence the courts of justice. Again, reference is made to strong emotions that a victim may experience. The Board understands that the result is serious psychological harm.
45. It is important to recall the applicable test, as established by the Court of Appeal for Ontario in *Saikaley*, cited above:

The test under s. 672.54 of the *Criminal Code* is not whether the victims of the index offences had suffered serious psychological harm, but whether the appellant’s conduct and future conduct is likely to pose a real risk of such harm to a member of the public.

1. The notion of likely refers to the requirement that the evidence establish a pattern of repetitive behaviour by the offender that shows probability.
2. The evidence presented to the Board is an admissible and reliable demonstration of the probability that the accused will again commit offences such as harassment, threats, and intimidation.
3. It is important to remember that other courts had declared the accused to be quarrelsome before April 2018. The Court of Québec declared him to be quarrelsome in 2007. That did not prevent him from being active in the legal sphere. That is not where the significant threat lies.
4. It is important to note that recourse to the court system was not enough for the accused. Although he could have tried some other legal manoeuvres, that option did not stop him from venting his frustrations by committing other objectively serious offences.
5. Moreover, given the nature of the accused’s illness and his categorical refusal to cooperate, the Board is of the view that there is a risk of serious harm tor the public, taking the risk factors into account.
6. The members of this panel are of the view that treatment and follow-up care are the best options for the accused’s reintegration into the community.
7. According to Dr. Delagrave’s testimony and to Dr. Laforme’s note, the delusions are active and complex.
8. As for the intensity and frequency, it is difficult to obtain a complete picture because the accused does not give access to his thoughts.
9. The accused suffers from an untreated mental illness. The explanation for the recent improvement in the accused’s behaviour is the hospital’s laissez-faire approach, in a protected environment, under supervision. Given the nature of the disorder, it seems inevitable to us that if the accused were to be in contact with others who do not agree with his perspective, he would revert to his previous behaviour. The lessons resulting from the approach have not yet been integrated.
10. In response to the accused’s question as to whether he is able to manage complications, his own witness did not support his suggestion.
11. In *Winko*, the Supreme Court stated the following with respect to the possibility of treatment:

Part XX.1 protects society. If society is to be protected on a long-term basis, it must address the cause of the offending behaviour -- the mental illness. It cannot content itself with locking the ill offender up for a term of imprisonment and then releasing him or her into society, without having provided any opportunities for psychiatric or other treatment. Public safety will only be ensured by stabilizing the mental condition of dangerous NCR accused*.*

Part XX.1 also protects the NCR offender. The assessment-treatment model introduced by Part XX.1 of the *Criminal Code* is fairer to the NCR offender than the traditional common law model. The NCR offender is not criminally responsible, but ill. Providing opportunities to receive treatment, not imposing punishment, is the just and appropriate response.

1. The RBMD cannot justify continuing its mandate to ensure that the accused complies with a treatment plan, but for the purposes of protecting the safety of the public, treatment could be an effect or an incident,[[175]](#footnote-175) and it is a factor to consider.
2. Counsel for the person in charge of the designated hospital indicated that the entire hearing was at the very heart of the accused’s delusion. The *amicus curiae*, for his part, seemed to suggest that the accused is now able to put things into perspective, as he called only one witness.
3. While the Board does not agree with Mtre Angers in this respect, it nevertheless notes that even if the entire debate may have had the unwanted effect of feeding the accused’s delusion, the panel was alert to the situation of the accused, who was also representing himself.
4. However, the Board acknowledges that the arguments concerning the physicians’ collusion against him and the request to order [translation] “psychiatric assessments of the various persons involved in the prosecution, who are likely to still show signs of a psychological injury subsequent to a persecutory delusional disorder” falls within the definition of delusion provided by the accused.
5. In this case, the accused denies the existence of his metal illness, refuses all treatment, suffers from persecutory delusions, and continues to believe that his reactions are justified. The Board finds that the role the illness played in the index offences underlying the NCR verdict is an additional risk factor.
6. The tenacity of his convictions is troubling given his history of impulsive behaviour based on false beliefs.
7. The background variables suggest that the accused runs a high risk of committing other prejudicial acts (mainly psychological). The problematic clinical variables include delusional thoughts and a limited understanding of them.
8. The accused shows no intuition or empathy. The evidence as a whole confirms the emotional connection of his delusions, which remain intact.
9. Considering that the accused still has symptoms of his illness, the Board is of the view that the lack of cooperation with the treatment team in a risk factor. In the current circumstances, the team is unable to identify other destabilizing factors and reinforce the management of risk.
10. The Board believes that in the event of an absolute discharge, the accused’s delusional beliefs, to which he continues to be attached, will eventually increase. He will become increasingly symptomatic and disorganized, and based on past experience, will choose to act against the subjects of his beliefs in a violent manner. The evidence shows a real likelihood that he will exercise poor judgment in his decision-making and quickly become unstable. There is certainly an increased risk of violence driven by the delusion.
11. An absolute discharge is not an appropriate disposition at this time because the evidence shows that the accused would not ask for help if he needed it. In the absence of supervision and monitoring services, it is very likely that the accused will continue to deteriorate and present egregious behaviour, as he has done in the past.
12. During the hearing, the members of this panel explained to the accused that he had no burden of proof.
13. The accused decided to refuse to answer all questions.
14. From the evidence gathered, the board members note that there is nothing to support a conclusion that precautions have been put in place to avoid the trajectory that Dr. Bouchard and Dr. Delagrave foresee, that is, a refusal of treatment followed by decompensation and behaviour that is as egregious as the behaviour he displayed when he committed the index offences underlying the NCR verdict, if not more so.
15. This trajectory is supported by the psychiatric evidence, the circumstances surrounding the index offences and the accused’s prior offences between 1998 and 2009 (when he was receiving irregular treatment and follow-up and was under the Board’s jurisdiction), and those between 2014 and May 2018. During that last period, without treatment or follow-up care, an escalation of wrongful acts is noted.
16. To a great extent, the elements presented by the accused serve only as an attempt to contest the accuracy of the index offences underlying the NCR verdict and the validity of the judgment rendered by the Court of Québec on March 12, 2019. In addition, the accused suggested that he was misdiagnosed and mistreated, and that the authorities failed him by not investigating his allegations.
17. In regard to the central issue of dangerousness, the accused did no more than state that he was not dangerous, relying solely on a very short, although contemporary, period of his life, between the start of his hospitalization and the date of the hearing.
18. His theory is essentially limited to the argument that he is not dangerous because he did not commit any offences during his detention, even though he did not receive treatment.[[176]](#footnote-176)
19. The Board is of the view that the evidence as a whole establishes a pattern of behaviour indicating that the accused is likely to re-offend.
20. There are also concerns of an increased risk that was not present until now: the hearing on the application to authorize care and the eventual end of the proceedings.
21. The accused has shown a tendency to stalk the victims of his wrongful acts. It was established on a balance of probabilities that he can be bad-tempered, with low tolerance for the rules imposed on him, and prone to confrontation. The evidence gathered by the Board has not alleviated these concerns.
22. In addition, the accused shows that he is vehemently opposed to psychiatry and psychiatrists. He has no confidence in the medical staff of the designated hospital, including his current physician, Dr. Delagrave, with whom he has no therapeutic alliance.
23. Even if there has been some progress made in this regard as a result of Mr. Dubeau’s work and patience, the extent of the accused’s inflexibility remains a significant source of concern. This type of reflection leaves the accused subject to cognitive distortions. It leaves him unable to assess the nuances of the threat he poses.
24. Intransigence leads the accused to develop responses that are inappropriate to his situation. It creates an obstacle to his better understanding of his situation. In addition, it has a negative impact on his quality of life.
25. The accused’s inflexibility will cause him to run a real risk of developing significant stress in the future when faced with unexpected or unwanted events, which will in turn affect his mental stability.
26. If he is fully discharged, the accused will not take any medication and will continue to pose a significant threat to the public due to his difficulties controlling his impulses and his need for revenge.
27. A re-offence would very likely involve members of the public in positions of authority. The evidence shows that the accused acts aggressively and unpredictably, without concern for the impact on others.
28. In addition, considering his criminal behaviour since 2014, there is a high probability that the risk will materialize, causing serious harm.
29. In *Collins*,[[177]](#footnote-177) the Court of Appeal for Ontario acknowledged that a lack of insight and a refusal to continue pharmacological treatment could be considered evidence that an NCR accused poses a significant threat to the safety of the public.
30. Last, this case is similar to one heard by the Court of Appeal for Ontario in 2018.[[178]](#footnote-178)
31. In *Duquette*, the appellant was found NCR on two counts of having uttered threats to cause death or bodily harm in 2010.
32. Following his annual review hearing on May 1, 2017, the Ontario Review Board found that he continued to pose a significant threat to the safety of the public.
33. The index offences were the result of a series of 153 emails containing threats, some of which were explicit and concerning. The emails were handed over to the police, and two of them led to charges.
34. The Court of Appeal dismissed Mr. Duquette’s appeal. Its reasoning was as follows:

Dr. Prakash recognized that the appellant had not been physically violent. However, he stated that the appellant’s conduct, while not criminal, was threatening. This conduct involved intimidation using threats to sue and issue complaints to professional organizations. … He described the risk the appellant posed as being psychological in nature and stated the re-offence scenario would be similar to the index offences.

It was reasonable for the Board to rely on this evidence to find that the appellant posed a significant threat to the safety of the public. To accept the appellant’s submission that his current situation did not pose a risk of significant psychological harm would be to conclude that his threatening conduct at the time of the index offences did not pose a risk of such harm (which, given the nature of the emails that were sent, we do not accept).

1. While lack of insight is one factor among others for the Review Board to consider, it is not in itself a ground for maintaining detention.[[179]](#footnote-179) The issue of whether an NCR accused has insight about his or her mental illness and the extent of that insight is part of the analysis to determine whether there is a significant threat to the safety of the public.[[180]](#footnote-180) In this case, the accused in no way recognizes his potential for violence.
2. The arguments he presented only confirm that he is focussed on justification and retribution.
3. In making this disposition, the Board maintains that it is not refusing to grant the accused an absolute discharge on the sole basis of his lack of insight.
4. In view of his diagnosis, history, non-compliance, prior offences, and lack of insight concerning the connection between his illness and his propensity for violence against others, it is likely that without supervision, the threat that the accused poses to the security of the public will increase.
5. Considering his long illness, his impulsiveness, his difficulty controlling his frustration, his threatening behaviour, and the strong probability that he will deteriorate without treatment or follow-up care, the safety of the public justifies the conclusion that he poses a significant threat.
6. In the absence of supervision and/or treatment, this panel is convinced that the accused will probably engage in criminal behaviour resulting in psychological harm. It is also clear to the panel that the resulting harm could be serious.
7. The accused needs supervision and structure to prevent the deterioration of his condition, which would put the safety of others in danger, and to control the threat that he poses to the safety of the public due to his mental condition.
8. The Board is of the view that the accused cannot on his own ensure that the measures required to help him avoid relapsing and committing further criminal acts that would put the physical and psychological safety of others in danger. Without a legal and therapeutic framework, the accused’s condition will deteriorate, causing him to once again become a significant threat to others.
9. There are still several factors indicating a risk of dangerousness. The Board must ensure the safety of the public and encourage the accused’s reintegration into society. Only a legal and therapeutic framework will control the significant threat that the accused poses to the safety of the public due to his mental condition.
10. In view of the evidence, the Board is justified in not accepting the recommendations of Dr. Bouchard and Dr. Delagrave, for appropriate reasons.[[181]](#footnote-181)
11. The Board reiterates that its mandate is not extended because of the refusal of treatment. It is quite aware that the authorization of care and the Board’s mandate have different objectives. The first is not intended to protect the safety of the public.
12. The Board cannot detain the accused simply because it believes that hospitalization is in his best interest or more favourable to his health care or his [translation] “risk management plan”.[[182]](#footnote-182)
13. The Board is of the view that the accused’s recent behaviour and his new openness to the non-medical members of the team and others justify the conclusion that the threat is manageable if the accused reintegrates into the community, subject to his compliance with several conditions.
14. To make this disposition, the Board took into account the need to consider the accused’s reintegration into society and his other needs.
15. In addition, it is required to make the order that is the least restrictive to the accused.
16. The accused’s recent tolerance brings hope that he has started on his path to dealing with his own vulnerability.
17. Of course, detention has had an impact on the accused’s emotional state. The evidence shows that since the end of last year, with only a few exceptions, the accused has generally remained calm and sometimes displayed pro-social values.
18. To his benefit, for the purposes of making the appropriate disposition, the members of the panel consider it relevant that the accused was able to build at least a utilitarian relationship with the social case workers of the team and that he has started to show interest in people other than himself and a few family members.
19. The Board takes into account his increased interaction with the occupational therapist and his commitment to leisure activities in the global analysis of risk reduction.
20. The Board supports the position of Dr. Delagrave, Dr. Bouchard, and Mr. Dubeau that if the accused is authorized to spend his time otherwise, he will be less likely to engage in persecutory thoughts and react to his frustrations.
21. The Board reiterates that, until the date of the hearing, the accused was not receiving any treatment. The only assistance he received was psychosocial, provided essentially by the occupational therapist.
22. The members of this panel note that this change in attitude is nevertheless recent. It is necessary to take a step back to determine whether this progress will continue, especially in a new context.
23. While the Board acknowledges the accused’s efforts and progress and the fact that his advancement is good considering his context, there remains work to be done by the medical team and the accused.
24. Indeed, letting him live outside the hospital will allow the Board to assess the extent to which the accused’s recent progress is due to his hospitalization.
25. Meanwhile, the accused’s mental condition requires structure to monitor the manifestations of his illness and quickly access psychiatric services if needed. After almost one year in strict detention, his mental condition could fluctuate in the event of a return to his environment and the new challenges that await him.

**FOR THESE REASONS, THE BOARD:**

**ORDERS** the accused’s discharge subject to the following conditions. He must:

* live at a location known by the person in charge of the hospital;
* comply with the recommendations of the treatment team;
* keep the peace;
* not acquire or possess any bladed weapons or firearms;
* not communicate, directly or indirectly, with Mtre M.L. or Judge G.L.;
* not be in a courthouse, unless required for the ends of justice or with the permission of the Chief Justice of the Court of Québec, the Superior Court, or the Court of Appeal of Quebec, and register his presence with a special constable if he is released.

**DELEGATES** to the person in charge of the CIUSSS A (Centre A), in accordance with section 672.56 of the *Criminal Code* and subject to the conditions determined in this disposition, the authority to increase restrictions on the liberty of the accused, including the authority to have him once again detained at such institution, if his mental condition deteriorates or if there are behavioural changes that increase the threat that he continues to represent to the safety of the public to such a degree that this safety could no longer be ensured were he to remain free.

**ORDERS** the person in charge who decides, in accordance with this delegation of authority, to significantly increase the restrictions on the liberty of the accused, to record this decision in the accused’s file and give him notice thereof. If this increase in the restrictions on liberty remains in effect for more than seven days, **ORDERS** the person in charge to give notice to the Board (s. 672.56(2) of the *Criminal Code*). A new hearing will then take place as soon as practicable (s. 672.81(2.1) of the *Criminal Code*).

**DELEGATES** the power to decrease restrictions on the liberty of the accused to the person in charge who, pursuant to this delegation, has previously increased such restrictions. This decrease may go so far as to release the accused, subject to the conditions determined herein, if the clinical condition and behaviour of the accused are deemed by the person in charge to be so improved that they justify such a decrease, even after he or she has given notice to the Board in accordance with the second paragraph above.

The person in charge will inform the Board if he or she releases the accused in accordance with the previous paragraph. In that case, the hearing under s. 672.81(2.1) of the *Criminal Code* will not be held.

**INSTRUCTS** the person in charge of the hospital to act accordingly.

**INFORMS** the accused that the Board will hold a new hearing to review his file within twelve months of this disposition.

This disposition, rendered unanimously, was communicated to the parties from the bench during the hearing held on October 14, 2020, the day that it took effect.

|  |  |
| --- | --- |
|  | PAULO GOUVEIA, a.j.t.a.q.Alternate Chairperson |

Lambert Therrien s.e.n.c.

Mtre Dominic Tourigny

Counsel for the person in charge of the hospital

Director of Criminal and Penal Prosecutions

Mtre Gabriel Bervin

Counsel representing the DCPP

Stéphane Angers, avocat Inc.

Mtre Stéphane Angers

*Amicus Curiae*

1. R.S.C. 1985, c. C-46. [↑](#footnote-ref-1)
2. Administrative record at 141–142. [↑](#footnote-ref-2)
3. October 18, 2019. [↑](#footnote-ref-3)
4. Administrative record at 829 to 831. [↑](#footnote-ref-4)
5. Administrative record at 1776 to 1873. [↑](#footnote-ref-5)
6. Administrative record at 1034 and 1778. [↑](#footnote-ref-6)
7. Administrative record at 1905, line 15. [↑](#footnote-ref-7)
8. Administrative record at 1903 to 1931. [↑](#footnote-ref-8)
9. Administrative record at 1604. [↑](#footnote-ref-9)
10. [...]. [↑](#footnote-ref-10)
11. Administrative record at 1720–1721. [↑](#footnote-ref-11)
12. Administrative record at 42 to 51. [↑](#footnote-ref-12)
13. Administrative record at 40, 41, 1605, and 1606. [↑](#footnote-ref-13)
14. Administrative record at 1591 to 1602, file [...]. [↑](#footnote-ref-14)
15. Administrative record at 193 to 203. [↑](#footnote-ref-15)
16. Administrative record at 16 to 23. [↑](#footnote-ref-16)
17. Administrative record at 15. [↑](#footnote-ref-17)
18. Administrative record at 14. [↑](#footnote-ref-18)
19. Administrative record at 1436. [↑](#footnote-ref-19)
20. Administrative record at 1424, 1443, and 1444. [↑](#footnote-ref-20)
21. Administrative record at 1423. [↑](#footnote-ref-21)
22. Administrative record at 12–13. [↑](#footnote-ref-22)
23. Administrative record at 163 to 191. [↑](#footnote-ref-23)
24. Administrative record at 85 to 106. [↑](#footnote-ref-24)
25. *Criminal Code*, s. 672.5401. [↑](#footnote-ref-25)
26. July 28, August 25, 27, September 25, and October 2, 2020. [↑](#footnote-ref-26)
27. Administrative record at 76 to 84. [↑](#footnote-ref-27)
28. Documents sent on October 1, 2020. [↑](#footnote-ref-28)
29. Dr. Delagrave’s report at 76. [↑](#footnote-ref-29)
30. Administrative record at 1765. [↑](#footnote-ref-30)
31. Administrative record at 1987, line 12. [↑](#footnote-ref-31)
32. *Milette c. R*., 2018 QCCA 736. [↑](#footnote-ref-32)
33. Administrative record at 1413–1414. [↑](#footnote-ref-33)
34. Administrative record at 3013–3014. [↑](#footnote-ref-34)
35. Administrative record at 3016, para. 9. [↑](#footnote-ref-35)
36. Administrative record at 194. [↑](#footnote-ref-36)
37. *R. v. Swain*, [1991] 1 S.C.R. 933. [↑](#footnote-ref-37)
38. *Romanowicz*, 1998 CanLII 14957 (ON SC). [↑](#footnote-ref-38)
39. *Criminal Code*, s. 672.5(7). [↑](#footnote-ref-39)
40. *R. v. Starson*, [2004] O.J. No. 941 (ONCA). [↑](#footnote-ref-40)
41. 2006 Can LII 37775 (ONCA).

42. *Runnalls (Re),* 2011 ONCA 364. [↑](#footnote-ref-41)
42. *Ontario v. Criminal Lawyers’ Association Ontario*, 2013 SCC 43, [2013] 3 S.C.R. 3. [↑](#footnote-ref-42)
43. 2016 ONCA 918. [↑](#footnote-ref-43)
44. 2017 ONCA 731. [↑](#footnote-ref-44)
45. 2019 ONCA 252 (CanLII). [↑](#footnote-ref-45)
46. Joan Barrett & Riun Shandler, *Mental Disorder in Canadian Criminal Law*, looseleaf (updated to January 2020), (Toronto: Thomson Reuters Canada) at 7-22. [↑](#footnote-ref-46)
47. Administrative record at 1407 to 1410. [↑](#footnote-ref-47)
48. Although he did not mention it in his letter, he also requested that S.B. be summoned. [↑](#footnote-ref-48)
49. Administrative record at 1654. [↑](#footnote-ref-49)
50. Administrative record at 1642–1643. [↑](#footnote-ref-50)
51. Administrative record at 1458. [↑](#footnote-ref-51)
52. Administrative record at 1733. [↑](#footnote-ref-52)
53. At 894 and 1407 – letter from the accused dated July 13, 2020. [↑](#footnote-ref-53)
54. Disposition rendered on December 23, 2019, by the Review Board for mental disorder. [↑](#footnote-ref-54)
55. Page 118 of the administrative record. [↑](#footnote-ref-55)
56. Page 753 of the administrative record. [↑](#footnote-ref-56)
57. *Robertson (Re),* 2019 ONCA 88. [↑](#footnote-ref-57)
58. Dated August 27, 2018, Administrative record at 643–832. [↑](#footnote-ref-58)
59. Administrative record at 1419. [↑](#footnote-ref-59)
60. *Smethurst (Re)*, 2015 ONCA 649 (CanLII). [↑](#footnote-ref-60)
61. Administrative record at 3015. [↑](#footnote-ref-61)
62. See also paragraph 12 of the Court of Appeal’s judgment dated October 18, 2019. [↑](#footnote-ref-62)
63. 2019 BCCA 410. [↑](#footnote-ref-63)
64. *R. v. Owen*, [2003] 1 S.C.R. 779: The Board has a duty to consider all relevant information. [↑](#footnote-ref-64)
65. Administrative record at 892 and 1419 – letter from the accused, dated July 10, 2020. [↑](#footnote-ref-65)
66. Administrative record at 894 – letter of the accused dated July 13, 2020, Administrative record at 1390–1394 and 1399–1406. [↑](#footnote-ref-66)
67. Administrative record at 1398–1406. [↑](#footnote-ref-67)
68. 2017 QCCS 1321. [↑](#footnote-ref-68)
69. Administrative record at 2674. [↑](#footnote-ref-69)
70. Administrative record at 932 to 935 and 938. [↑](#footnote-ref-70)
71. *Starz (Re)*, 2015 ONCA 318. [↑](#footnote-ref-71)
72. R.S.C. (1985), c. I-11; *Criminal Code*, s. 672.43. [↑](#footnote-ref-72)
73. 1994 CanLII 694. [↑](#footnote-ref-73)
74. Judgment at para. 61; administrative record at 1157–1207. [↑](#footnote-ref-74)
75. *Criminal Code*, ss. 672.35 and 672.36. [↑](#footnote-ref-75)
76. *Winko* at para. 62(4)*.* [↑](#footnote-ref-76)
77. *Winko*, *supra* note 73 at para. 54. [↑](#footnote-ref-77)
78. *Velasquez (Re)*, [2001] B.C.R.B.D. No. 220. [↑](#footnote-ref-78)
79. Joan Barrett & Riun Shandler, *Mental Disorder in Canadian Criminal Law* (Toronto: Thomson Reuters Canada) (looseleaf updated June 2019 2020) at 7-16. [↑](#footnote-ref-79)
80. 672.85 of the *Criminal Code*. [↑](#footnote-ref-80)
81. 1999 CanLII 14744 (NB CA). [↑](#footnote-ref-81)
82. Judgment at 4. [↑](#footnote-ref-82)
83. *W. (C.) v. Manitoba (Mental Health Review Board)*, 1994 CanLII 16690 (MB CA) at para. 35. [↑](#footnote-ref-83)
84. Administrative record at 2973. [↑](#footnote-ref-84)
85. Administrative record at 86; Report at 1. [↑](#footnote-ref-85)
86. Administrative record at 89. [↑](#footnote-ref-86)
87. Actually, the facts occurred in April 2018. [↑](#footnote-ref-87)
88. Administrative record at 95 and 96; Report at 10–11. [↑](#footnote-ref-88)
89. Administrative record at 98; Report at 13. [↑](#footnote-ref-89)
90. Administrative record at 100; Report at 15. [↑](#footnote-ref-90)
91. Administrative record at 102; Report at 17. [↑](#footnote-ref-91)
92. Administrative record at 105; Report at 20. [↑](#footnote-ref-92)
93. Administrative record at 106; Report at 21. [↑](#footnote-ref-93)
94. Administrative record at 1745 to 1752. [↑](#footnote-ref-94)
95. *Nelson v. British-Columbia*, 2017 BCCA 40. [↑](#footnote-ref-95)
96. Administrative record at 1462–1467. [↑](#footnote-ref-96)
97. Administrative record at 96; Report at 11. [↑](#footnote-ref-97)
98. Medication taken as needed. [↑](#footnote-ref-98)
99. *Winko v. British Columbia (Forensic Psychiatric Institute)*,[1999] 2 S.C.R. 625 at para. 61. [↑](#footnote-ref-99)
100. Administrative record at 197. [↑](#footnote-ref-100)
101. D-2. [↑](#footnote-ref-101)
102. Mtre Annie-Pierre Ouimet-Comtois, *La non-responsabilité criminelle pour cause de troubles mentaux : le difficile mariage entre justice et santé* (master’s program in law and health policy, December 2014), Savoirs U de S at 26. [↑](#footnote-ref-102)
103. See e.g., *F.N. c. CSSS A*, 2012 QCTAQ 95035. [↑](#footnote-ref-103)
104. Administrative record at 113 to 116. [↑](#footnote-ref-104)
105. Administrative record at 41. [↑](#footnote-ref-105)
106. Administrative record at 109 to 112. [↑](#footnote-ref-106)
107. Administrative record at 655; Stenographic notes at 11. [↑](#footnote-ref-107)
108. Administrative record at 653; Stenographic notes at 9. [↑](#footnote-ref-108)
109. Administrative record at 661; Stenographic notes at 17. [↑](#footnote-ref-109)
110. Administrative record at 664; Stenographic notes at 20. [↑](#footnote-ref-110)
111. Administrative record at 671; Stenographic notes at 27. [↑](#footnote-ref-111)
112. Administrative record at 672; Stenographic notes at 28. [↑](#footnote-ref-112)
113. Administrative record at 673; Stenographic notes at 29. [↑](#footnote-ref-113)
114. Administrative record at 677; Stenographic notes at 33. [↑](#footnote-ref-114)
115. Administrative record at 677; Stenographic notes at 33. [↑](#footnote-ref-115)
116. Administrative record at 678; Stenographic notes at 34. [↑](#footnote-ref-116)
117. Administrative record at 686; Stenographic notes at 42. [↑](#footnote-ref-117)
118. Administrative record at 687; Stenographic notes at 43. [↑](#footnote-ref-118)
119. Administrative record at 716; Stenographic notes at 72. [↑](#footnote-ref-119)
120. Administrative record at 716; Stenographic notes at 72. [↑](#footnote-ref-120)
121. Administrative record at 718; Stenographic notes at 74. [↑](#footnote-ref-121)
122. Administrative record at 730; Stenographic notes at 86. [↑](#footnote-ref-122)
123. Stenographic notes at 44. [↑](#footnote-ref-123)
124. Stenographic notes at 45–46. [↑](#footnote-ref-124)
125. Stenographic notes at 55. [↑](#footnote-ref-125)
126. Stenographic notes at 58. [↑](#footnote-ref-126)
127. Administrative record at 69 and 70. [↑](#footnote-ref-127)
128. Administrative record at 71; page 8 of 10 of the report. [↑](#footnote-ref-128)
129. Administrative record at 202; Judgment at 10. [translation] “[T]he declaration of quarrelsomeness entails that the appellant obtain leave before instituting new proceedings. The judgment of this Court prohibits the appellant from filing, directly or indirectly, any proceeding before the Court of Appeal; the same applies for the Superior Court, the Court of Québec, and any court or administrative body subject to the to the superintending power of the Superior Court, which greatly limits the possibility of instituting new proceedings*.* [↑](#footnote-ref-129)
130. Administrative record at 71; Report at 8. [↑](#footnote-ref-130)
131. Administrative record at 1033, 1459 – letter dated July 2, 2009. [↑](#footnote-ref-131)
132. 2018 ONCA 373. [↑](#footnote-ref-132)
133. 2018 QCCA 665. [↑](#footnote-ref-133)
134. 2018 ONCA 833. [↑](#footnote-ref-134)
135. 1999 CanLII 694 (SCC) at para. 49. [↑](#footnote-ref-135)
136. *Y.M. c. Directeur du centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal,* 2016 QCCA 1576 (CanLII). [↑](#footnote-ref-136)
137. *Ibid*. at paras. 49, 52. [↑](#footnote-ref-137)
138. At para. 61. [↑](#footnote-ref-138)
139. *Ibid*. at para. 57; see also *R. v. Ferguson*, 2010 ONCA 810, 271 O.A.C. 104. [↑](#footnote-ref-139)
140. *Owen*, 2003 SCC 33 (CanLII), [2003] 1 S.C.R. 779. [↑](#footnote-ref-140)
141. *Centre de santé et de services sociaux Pierre-Boucher c. A.G*., 2009 QCCA 2395. [↑](#footnote-ref-141)
142. *S.P. c. DPCP*, 2018 QCCA 665. [↑](#footnote-ref-142)
143. *J.F.B. c. Hôpital Jean-Talon*, 2005 QCCA 909 (CanLII). [↑](#footnote-ref-143)
144. *R. v. Conway*, *supra* note 43 at paras. 93, 97, 100; *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7 (CanLII), [2006] 1 S.C.R. 326 at paras. 31–35; *Directeur des poursuites criminelles et pénales c. A.P*., 2013 QCCA 491 at para. 24. [↑](#footnote-ref-144)
145. Merck Manual, “Delusional Disorder” by Carol Tamminga, Administrative record at 930. [↑](#footnote-ref-145)
146. *Re Woods*, 2019 ONCA 87 at para. 16; *Carrick (Re)*, 2018 ONCA 752. [↑](#footnote-ref-146)
147. *Moore (Re)*, 2019 ONCA 1003. [↑](#footnote-ref-147)
148. *Ranieri (Re)*, [2015] 336 O.A.C. 88 (C.A.). [↑](#footnote-ref-148)
149. *Conway (Re),* 2016 ONCA 918 (CanLII). [↑](#footnote-ref-149)
150. 2006 CanLII 21587 (ON CA). [↑](#footnote-ref-150)
151. Administrative record at 70. [↑](#footnote-ref-151)
152. *R. v. Ferguson*, 2010 ONCA 810 at paras. 1-3; *Wall (Re)*, 2017 ONCA 713 at paras. 25 and 29. [↑](#footnote-ref-152)
153. 2011 ONCA 136. [↑](#footnote-ref-153)
154. Administrative record at 111. [↑](#footnote-ref-154)
155. Administrative record at 69; Report at 6 of 10. [↑](#footnote-ref-155)
156. *Ibid*. at note 137. [↑](#footnote-ref-156)
157. See also *Gibson (Re),* 2020 ONCA 619. [↑](#footnote-ref-157)
158. The accused was acquitted of this offence on August 19, 2015. [↑](#footnote-ref-158)
159. *R. v. Wright*, (2010) 261 CCC (3d) 333 (Man. C.A.). [↑](#footnote-ref-159)
160. The Court of Appeal’s judgment dated [...] 2018 sets out an index of the files in which the appellant appeared as a plaintiff, appellant, or accused; Administrative record at 2676 to 2680; Judgment at 4 to 8. [↑](#footnote-ref-160)
161. Administrative record at 97. [↑](#footnote-ref-161)
162. Administrative record at 1913-1914. [↑](#footnote-ref-162)
163. Administrative record at 97; Report at 12. [↑](#footnote-ref-163)
164. Administrative record at 95. [↑](#footnote-ref-164)
165. *R. v. Runnalls*, 2009 ONCA 504. [↑](#footnote-ref-165)
166. Administrative record at 90. [↑](#footnote-ref-166)
167. *Mott (Re)*, 2019 ONCA 560 (CanLII). [↑](#footnote-ref-167)
168. *Palmer (Re)*, 2013 ONCA 475, 2013 CarswellOnt 9322 [↑](#footnote-ref-168)
169. Administrative record at 1791. [↑](#footnote-ref-169)
170. Administrative record at 1782. [↑](#footnote-ref-170)
171. Administrative record at 1788. [↑](#footnote-ref-171)
172. The Court of Appeal for Ontario considered the lack of insight of a key family member with respect to the appellant’s mental health problems and his family’s inability to provide the structure and supervision required in *Abdikarim (Re)*, 2017 ONCA 793 (CanLII). [↑](#footnote-ref-172)
173. For this offence, he was granted a conditional stay of proceedings in view of the rule against multiple convictions. [↑](#footnote-ref-173)
174. *R. v. Szostak*, 2012 ONCA 503. [↑](#footnote-ref-174)
175. *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7 (CanLII), [2006] 1 S.C.R. 326. [↑](#footnote-ref-175)
176. *Normore,* 2004 NLCA 76 (CanLII). [↑](#footnote-ref-176)
177. 2018 ONCA 563 (CanLII). [↑](#footnote-ref-177)
178. *Duquette (Re)*, 2018 ONCA 357 (CanLII). [↑](#footnote-ref-178)
179. *Carrick (Re)* 2015 ONCA 866; *Wall (Re),* 2017 ONCA 713. [↑](#footnote-ref-179)
180. *Woods* [2019] ONCA 87*; Kalra* [2018] ONCA 833; *Sim* [2019] ONCA 719; *Abeje* [2019] ONCA 734. [↑](#footnote-ref-180)
181. See *Laberakis (Re)*, 2012 ONCA 70, 99 W.C.B. (2d) 832 at para. 3. [↑](#footnote-ref-181)
182. *R. v. WCR*, 2019 ABCA 170 (CanLII). [↑](#footnote-ref-182)