

Introduction

[1] On September 5, 2007, the Review Board conducted a disposition review in the matter of Fraser Begg. At the conclusion of the hearing the Board informed the parties of its unanimous decision to make a custodial disposition on similar terms to the order under review. These now are the reasons for that decision.

Index Offences

[2] The accused has a lengthy history of mental illness. He began to receive treatment from Dr. Michael Roburn, a psychiatrist, in January 1978. The accused met with Dr. Roburn frequently. It is estimated that he saw Dr. Roburn approximately 100 times over the next seven years. The accused ceased taking treatment from Dr. Roburn in January 1985. Dr. Roburn retired from practice in 1991.

[3] The accused developed paranoid delusions involving Dr. Roburn. Between September 21, 1994 and March 30, 1995 the accused engaged in a concerted series of attacks on Dr. Roburn and his property. The attacks were terrifying and escalated from mischief to arson to attempted murder. The accused tried to set Dr. Roburn's house on fire on several occasions and succeeded in causing significant damage. The accused's campaign against Dr. Roburn culminated on March 30, 1995 when he mounted a massive assault upon Dr. Roburn and his home starting at about 4:30 a.m..

[4] The accused began the attack by throwing several Molotov cocktails through windows into the home. Dr. Roburn had been awakened by intruder alarms that he had been forced to install over the preceding months. When he heard crashing noises he went downstairs and discovered fires burning in the dining room and den. He tried to put the fires out and then went outside in an attempt to drive the attacker away. The accused charged Dr. Roburn, stabbed him in the chest with a knife, and ran away. Although Dr. Roburn was able to retreat into his home the accused did not withdraw. Dr. Roburn later believed that the attacker had left and went outside a second time. The accused was still present and threw a lit Molotov cocktail at him. The accused continued to throw several more Molotov cocktails at the house before finally leaving.

[5] The stab wound came close to killing Dr. Roburn. The knife cut the pericardium surrounding the heart and inflicted a superficial cut in the heart's muscle wall. Dr. Roburn lost approximately one third of his blood. The house sustained about \$335,000 in fire damage.

[6] Dr. Roburn's intruder alarm system included surveillance video cameras. The accused was captured on video and portions of the attack were aired on television. On April 5, 1995, the accused was recognized. The police were notified and the accused was arrested.

[7] Mr. Begg was charged with four counts of attempting to murder Dr. Roburn and five counts of arson. He was found not criminally responsible by reason of mental disorder on these charges on December 22, 1995.

The Accused's Background

[8] Mr. Begg is now 58 years old.¹ He first began to develop symptoms of mental illness around 1971. He experienced an emotional breakdown in 1973. However, the accused was able to pursue education and he obtained a bachelor's degree in economics and commerce from Simon Fraser University in 1979. His mental illness worsened and by 1982 he was expressing irrational fears about being killed. The accused's relationship with his family deteriorated and ended in 1986 when he ceased all further contact with them. His mental health and function continued to decline. The accused was convicted in 1988 of setting a trap likely to cause death or bodily harm. The accused had rigged a booby-trap on the front door of his cabin in the Yukon. The presentence report² prepared at that time noted that the accused was experiencing a great deal of difficulty properly providing for himself in the context of his psychiatric disorder. Sadly the report's author opined that the accused would remain a real threat to the community unless he received proper medical treatment. At the time of the index offences the accused had been living under the Second Narrows Bridge for about three years.

¹ For complete details of the accused's background, see Exhibit 12, social history

² Exhibit 16

Forensic History

[9] The accused has been detained in hospital under custodial dispositions since the NCR verdict. This hearing was the 13th disposition review in these proceedings. The disposition information consists of 68 exhibits and has become so voluminous that the Board recently condensed the material to one binder in keeping with established Board administrative practice.³

[10] The accused's progress under forensic treatment has been thoroughly reviewed in prior reasons for disposition and need not again be revisited in any detail. In summary the accused's illness has proved highly resistant to treatment and there has been very little if any improvement since his arrest. He vigorously denies any mental illness or abnormality in his mental state. Not only has the accused continued to adhere to the delusions that led to the index offences, but he has also evolved new delusions that have incorporated other psychiatrists. He remains obsessed with multiple conspiracy theories. He adheres to racist ideology with prominent anti-Semitic themes.

[11] One unusual feature of the accused's presentation is his refusal to speak with the treatment team about his mental state. The accused appreciates that his thinking is construed as evidence of mental illness. As a result, and with minor exception, he has declined to participate in his treatment or reveal his thinking since shortly after his admission to FPH.

[12] Dr. Riley was assigned as the accused's treating psychiatrist following the NCR verdicts. He was familiar with the accused as he had prepared reports for court on the issue of the accused's criminal responsibility. As early as 1996, he assessed the accused's risk as:

"... a grave and immediate threat to the safety of the public if not detained in a secure place. The risk he poses will only likely change if there is a substantial and convincing improvement in his mental condition and without his cooperation it is very difficult to see how this can be achieved. ... Mr. Begg ... remains bereft of any insight into the nature of his mental condition."⁴ (Emphasis added)

³ Review Board letter to parties, August 30, 2007

⁴ Exhibit 23, report of Dr. Riley, October 10, 1996, p. 3

[13] The accused's illness and unchanging presentation led Dr. Riley to refer the accused to Dr. McKibbin for second opinion in 2004. The accused agreed to speak with Dr. McKibbin and met with him in February and March of 2004. Dr. Riley's next report stated as follows:

"Dr. McKibbin met with Mr. Begg on two occasions, and from Mr. Begg's other interactions with staff over the past year, it is clear that his mental condition has not changed to any significant extent. He continues to hold a complex belief system concerning both events on an international scale and Mr. Begg's more immediate circumstances. He continues to believe that he has had a pivotal role in influencing political events, and believes that he still has an important role to play in the future. The victim of Mr. Begg's index offence, Dr. Roburn, continues to be identified by Mr. Begg as a person who has persecuted him in the past, and Mr. Begg also told Dr. McKibbin that another previous treating psychiatrist, Dr. Semrau, may have been involved in a Jewish conspiracy in 1989. ... his interpretation of what others have said to him in the past suggests at least delusional misinterpretation, and possibly delusions of reference." ⁵

[14] The accused saw Dr. McKibbin a third time later that year. Dr. Riley summarized Dr. McKibbin's assessment as follows:

"Mr. Begg was reassessed by my colleague Dr. McKibbin in November of last year. At that time Mr. Begg agreed that some of his conjectures may prove to be false. Dr. McKibbin suggested that this may represent over-valued ideas rather than delusional beliefs. Dr. McKibbin did not offer an alternate diagnosis to the existing diagnosis of Schizophrenia. ... Regardless of which specific diagnostic label is chosen, Mr. Begg's abnormal beliefs are directly related to his risk for violent offending, and as long as these beliefs persist, or are at risk of recurring, Mr. Begg will continue to be a significant threat to public safety." ⁶ (Emphasis added)

[15] In an attempt to break the impasse created by the accused's silence, the accused's psychiatric care was transferred to Dr. Russell in September 2005. The accused initially refused to speak with Dr. Russell. However, he relented on January 5, 2006 and spoke with him for about 45 minutes, before resuming his silence. Dr. Russell reported that the accused insisted that he was not mentally ill, was a victim of a Jewish conspiracy, and that Dr. Roburn was part of that conspiracy. Dr. Russell noted that the accused had no remorse for stabbing Dr. Roburn and that he was prepared to resort to physical violence in the future if legal channels were

⁵ Exhibit 51, report of Dr. Riley, May 31, 2004, p. 2

⁶ Exhibit 55, report of Dr. Riley, May 24, 2005, p. 3

unsuccessful in his struggle against those who conspire against him. Dr. Russell concluded that:

"Mr. Begg continues to hold delusional beliefs similar in nature to those that motivated him at the time of the index offence, and would pose a high risk of violent reoffending if released from a secure facility."⁷

New Evidence

[16] Dr. Russell left FPH after the last disposition review. Dr. Wanis was assigned as the accused's treating psychiatrist in August of 2006. He provided the Board with two reports. Ms. Armstrong, the accused's case manager, also provided a report. The accused filed a letter dated September 24, 2006. The Board heard oral evidence from Dr. Wanis, Ms. Armstrong and Mr. Begg.

[17] Dr. Wanis began his testimony by reporting that the accused continues to refuse to meet with his treatment team. He said that the accused is prepared to speak with Dr. McKibbin, and has requested transfer to his care. Dr. Wanis opposed the accused's request, explaining that the accused has already had the benefit of several other psychiatrists. He added that there would be administrative chaos if patients were allowed to choose their psychiatrists. He noted that the accused is prepared to speak with staff in order to address his physical health and other needs.

[18] Dr. Wanis said that Dr. McKibbin's assessment of the accused did not significantly differ from his opinion. He said that any differences were minor and related to the distinction between overvalued ideas and delusions. Dr. Wanis adopted the risk assessments contained in his reports and recommended against any loosening of the accused restrictions until he could learn more about the accused's thinking.

[19] Ms. Armstrong said that she has been the accused's case manager since March of 2006. She said that the treatment team had tried to engage the accused in monthly treatment planning conferences but that he had refused all participation. She said that the accused only speaks to staff about superficial matters or to make his physical health needs known. He said that the accused had requested escorted access to the community to go to Small Claims Court. Although this was approved, the accused has yet to go on that outing. She said the accused has had

approximately 10 outings to attend to various medical and dental needs. She said that the accused has refused all other privileges.

[20] Although Mr. Begg refuses to speak with his treatment team, he has always been willing if not eager to provide evidence before the Board. The accused said that he wanted an absolute or conditional discharge. He said that he had saved \$71,000 which he would use to pay for accommodation for several days while he contacted his parents. He described his current circumstances as his third unlawful incarceration. He insisted that Dr. McKibbin had said that he did not have a mental illness. He said he trusted Dr. McKibbin because of his ethnic background. He said that he would not take medication if absolutely discharged, but would do so on a conditional discharge. If discharged, he intended to build a cabin near Prince George. This would allow him to conduct a re-enactment of the events that led to his 1988 conviction for setting a trap and prove that his conviction was wrong. He said that he would not be a risk "as long as the law worked for me". An example of the law working for him was his success in "firing the last Chair". He said that Board Chair Walter had acted "non-judicially" and should be fired. He said he refused to speak to his psychiatrist because it led to him being called delusional which created more problems for him. He insisted that he was being incarcerated to silence him about his knowledge about the Kennedy assassination. He said that he had been friends with Charles Fortin, a former patient at FPH, and shared his views⁸. He said that Mr. Fortin received an absolute discharge three weeks after he was transferred to Québec, and the same thing would happen to him if he was transferred. He confirmed that he had retained Dr. Zoffman to provide a risk assessment, but chose not to use it because it was not to his liking.

Positions of the Parties

[21] The Director, represented by Ms. Westmacott, submitted that the severity of the index offences combined with the accused's absence of insight and remorse continued to establish that he remained at high risk. She noted the accused has had the benefit of several psychiatrists. She submitted that the Board should accept Dr.

⁷ Exhibit 60, report of Dr. Russell, May 11, 2006, p. 3

⁸ Charles Fortin was an advocate of Nazi ideology. See: In the Matter of the Disposition Hearing of Charles Fortin, unreported, December 19, 2001

Wanis' risk assessment, leaving the Board with no alternative to a custodial order on the same terms as the order under review.

[22] The Crown, represented by Mr. Hillaby, supported the Director's submission. He added that the evidence showed that the accused was tenacious in sticking to his delusional beliefs and list of grievances, citing the example of the accused's desire to build a cabin so that he could prove that he was wrongfully convicted in 1988.

[23] The accused, represented by his advocate Mr. Reyes, seeks an absolute discharge or conditional discharge. He submitted that the accused's behaviour was stable and he did not exhibit any aggression. In the alternative, the accused seeks a six-month custodial disposition with conditions requiring that Dr. McKibbin be assigned as his psychiatrist, or at least be required to provide a comprehensive risk assessment. Mr. Reyes further submitted that the Board could employ sections 672.12 and 672.13 of the *Criminal Code* to order Dr. McKibbin to provide a risk assessment.

Discussion

[24] The uncontested evidence establishes that there have been no material changes in the accused's illness or his presentation since the last disposition review, or for that matter, since the NCR verdict. Nevertheless the Board is required to assess the accused's risk at every disposition review in accordance with the provisions of s. 672.54 of the *Code*.

[25] Dr. Wanis is now the accused's third treating psychiatrist since the NCR verdict. His assessment of the accused's risk agrees with the opinions of Dr. Riley and Dr. Russell. He wrote that the accused has:

"... no retrospective insight or regret feelings towards his index offence, and if he had to, he would do it again. Although he has not spoken to me, I am confident to say that given that no changes have taken place in his mental state, cooperation or his insight since last year, Mr. Begg will continue to present as high risk to reoffend violently."⁹

[26] The thrust of the accused's challenge to the Director's risk assessments is

⁹ Exhibit 62, report of Dr. Wanis, April 30, 2007, page 1

that they are outdated or inaccurate because they are not based on interviews with him. This argument is fundamentally misconceived and fails to take into account that the Director has in fact had significant access to the accused's thinking over the years. Mr. Begg has given and indeed continues to provide extensive oral evidence at his disposition reviews. He has also submitted numerous letters to the Review Board.

[27] For example when the accused last appeared for an annual disposition review on July 5, 2007, he argued that numerous errors made by Chair Walter in his previous reasons¹⁰ established bias. He requested that Chair Walter recuse himself from the hearing. The accused sought to admit a letter written by him, dated September 24, 2006¹¹ that listed his complaints. The panel declined to admit the letter, holding that it amounted to an argument with the previous Chair. The panel found that the proper venue for expressing such views was by appeal to the Court of Appeal. However, out of an abundance of caution, Chair Walter agreed to step aside based upon the accused's subjective perception of bias. As a result the last hearing did not proceed as scheduled and a new panel was formed to conduct this disposition review.

[28] The accused renewed his application to admit his letter of September 24, 2006. We had little hesitation in agreeing with the last panel that the letter amounted to an argument that challenged the correctness of the reasons of June 5, 2006. The letter contained no evidence relevant to any issue to be decided by the Board, with one notable exception. It did provide evidence of the accused's thinking and to that extent had the potential to be valuable given the accused's refusal to speak with his treatment team. In fairness to the accused, the Board warned the accused of the only possible use of his letter. The Board then adjourned briefly in order to give the accused an opportunity to reconsider his position and discuss the matter with his advocate. When the hearing resumed, the accused did not resile, and renewed his request to file the letter. The Board then admitted the letter into evidence.

[29] The Board found that the letter was helpful in documenting the accused's thinking. The letter establishes that the accused remains obsessed by his beliefs of injustices that have been visited upon him. This letter, when read in conjunction with previous letters submitted by the accused (exhibits 29, 39, 42, 53, 56), demonstrates

¹⁰ Exhibit 61, Reasons for Disposition, June 5, 2006

the accused's unceasing preoccupation with elaborate conspiracy theories. The letters are convincing evidence of a seriously disturbed mind.

[30] The accused's oral evidence laid to rest any potential doubt about the extent of his illness. His testimony established that he is utterly without insight into his illness or the index offences. Perhaps the most disturbing portion of the accused's evidence was his assertion that he would only obey the law as long as it worked for him.

[31] We conclude that the evidence of the accused's mental state obtained from his letters and oral evidence before the Board is more than sufficient to obtain an accurate picture of the accused's thinking. This evidence conclusively establishes that the accused's beliefs, which led him to commit the index offences, remain intact. This is exactly as assumed by Dr. Wanis, Dr. Russell, and Dr. Riley. These experts agree that the accused remains acutely ill and that his risk to the public remains high.

[32] The last reasons for disposition considered the argument that the treatment impasse created by the accused's silence was a symptom of his illness for which he should not be held responsible. The Board rejected that argument, concluding that any treatment impasse was "created entirely by his volitional and considered refusal to communicate with his treatment team."¹² We agree that the accused's decision represents a deliberate and indeed careful strategy on his part. He understands that his thinking is considered paranoid, delusional, and evidence of mental illness. The accused refuses to speak with his treatment team because he does not want to provide any additional evidence of his illness. We agree with the last panel that there is no treatment impasse of the type that might require the Review Board to intervene in some fashion.

[33] The accused argued that the Board should order Dr. McKibbin be assigned as his treating psychiatrist, or in the alternative, be required to provide a comprehensive risk assessment. These arguments are based on the premise that Dr. McKibbin's assessment of the accused's illness differs from the other psychiatrists who have treated the accused. Dr. McKibbin's clinical notes are at Exhibit 57. The notes show that Dr. McKibbin found that some of the accused's thinking was not technically delusional, but more in the nature of overvalued ideas. This was because the accused

¹¹ Exhibit 68

¹² *supra*, footnote 10, at paragraph 13

was willing to consider alternate explanations, even though none had been presented to him. Dr. Wanis, and Dr. Riley, found that nothing of any consequence turned on this distinction. Significantly there is absolutely nothing in these notes to support the accused's contention that Dr. McKibbin's assessment of the accused illness, and more importantly the accused's risk, differs to any meaningful extent from any of the other expert assessments. In any event there was nothing to prevent the accused from calling Dr. McKibbin as a witness to give evidence. However, the accused has made no effort to do so.

[34] We conclude that the accused wants Dr. McKibbin as his psychiatrist because of his misunderstanding that Dr. McKibbin does not believe that he has a mental illness and perhaps because of his racist views. The last panel suggested that the Director consider assigning Dr. McKibbin solely because the accused indicated he was prepared to engage with him. The Director has chosen to not act on that suggestion. We have no doubt the accused's cooperation would immediately cease once he appreciated that Dr. McKibbin considered him to be mentally ill, which is an assumption that we are prepared to make. We conclude that the accused's arguments with respect to Dr. McKibbin are entirely devoid of merit.

[35] Lastly it should not be overlooked that the accused had the means to obtain his own expert risk assessment. He retained Dr. Zoffman, an experienced forensic psychiatrist. The accused said that Dr. Zoffman had provided a report, but that was not to his liking and was all errors. He is now planning to sue Dr. Zoffman and was granted permission to visit Small Claims Court so that he could learn something about the legal process to assist his claim against Dr. Zoffman. The accused is not obliged to share Dr. Zoffman's report, since he is entitled to claim privilege. However, his decision to keep the report confidential simply reinforces the Board's view that the previous risk assessments continue to fairly reflect the accused's circumstances.

Conclusion

[36] The evidence overwhelmingly establishes that the accused remains acutely ill. The accused's thinking and beliefs that caused him to commit the index offences have not diminished in the slightest. The expert risk assessments have consistently concluded that the accused's risk remains high, justifying detention in hospital under

strict conditions. The accused therefore remains a significant threat to public safety. We therefore conclude that the least onerous and least restrictive disposition compatible with his circumstances continues to be a strict custodial disposition.

Reserved reasons prepared by Barry Long,
Dr. H. Parfitt, F. Jeffries concurring
October 24, 2007