IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *R. v. Leclair,*
2021 BCSC 2202

Date: 20211206
Docket: 25783
Registry: Quesnel

Regina

v.

Kristopher Edward Leclair

Before: The Honourable Madam Justice Devlin

Oral Reasons for Judgment

Counsel for the Crown:	J.C Johnston and W.F. Wagner
Counsel for Accused:	T.E. La Liberte, Q.C. K.B. Wilkinson B. Walker, Articled Student
Place and Dates of Trial:	Quesnel, B.C. September 14-18; 21-24, 2020 September 28-October 2, 2020 October 5-9, 2020 Prince George, B.C. December 7-11, 2020 February 16-19; 22-26, 2021 May 10-14; 17-21, 2021 July 12-16, 2021 September 22, 23, 2021
Place and Date of Judgment:	Prince George, B.C. December 6, 2021

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THE COURT: This decision was delivered in the form of *Oral Reasons*. The *Reasons* have since been edited for publication.

Introduction

[1] The accused, Kristopher Edward Leclair, is charged with the second degree murder of Michael Potter, contrary to s. 235 of the *Criminal Code*, R.S.C., 1985, c. C-46 [*Code*]. He is also charged with the attempted murder of Sharon Tobin by assaulting her with a knife, contrary to s. 239(1)(b) of the *Code*, and the aggravated assault of Sharon Tobin, contrary to s. 268(2) of the *Code*. These charges arise out of an incident that occurred on July 21, 2018 at or near Quesnel, British Columbia.

[2] There is no dispute that Mr. Leclair committed these offences. A large body of evidence was tendered at trial, including the testimony of several Crown witnesses who described the events leading up to and immediately following these incidents. In addition, substantial admissions were filed together with photographs, videos, and other documentary evidence. The defence also called several witnesses, and Mr. Leclair himself, to testify.

[3] The primary issue in this trial is whether Mr. Leclair is criminally responsible for these acts. Mr. Leclair raises the defence that he is not criminally responsible by reason of a mental disorder pursuant to s. 16(1) of the *Code.* The defence says the evidence establishes that Mr. Leclair was suffering from a mental disorder—namely, schizophrenia—at the material time, which constitutes a disease of the mind. They say this disease of the mind made him incapable of knowing that his actions were morally wrong. The Crown submits that Mr. Leclair was not suffering from a mental disorder at the time of the offence. They say he has failed to establish that he had schizophrenia at the relevant time, and they advance a number of arguments to suggest that, during the offences, he was experiencing some form of drug-induced psychosis and/or that he was not experiencing psychosis on a level that would deprive him of the knowledge that his actions were wrong. They submit the evidence proves beyond a reasonable doubt that Mr. Leclair had the requisite intent.

[4] The defence and Crown each called a forensic psychiatrist to provide an opinion about Mr. Leclair's mental state at the time that he committed these acts. The defence called Dr. Morgan and the Crown called Dr. Lamba. The defence and Crown agreed that the psychiatrists' written reports could be admitted as evidence at trial.

[5] In cases where the defence of not criminally responsible by reason of mental disorder ("NCRMD") is raised, the court is first to consider whether the Crown has proven the *actus reus* of the offences beyond a reasonable doubt. If the Crown has proven the *actus reus*, the court must next examine whether the party claiming NCRMD has established the defence on a balance of probabilities. If the court determines NCRMD does not apply, it asks whether the Crown has proven the *mens rea* beyond a reasonable doubt.

[6] In this case, the *actus reus* for each offence is admitted. Having reviewed the admissions of fact, I am satisfied the Crown has proven the *actus reus* of each offence beyond a reasonable doubt. Accordingly, I can proceed directly to consider the NCRMD defence.

[7] I will begin these *Reasons* by setting out the applicable legal principles pertaining to an NCRMD defence because they guide my analysis throughout. I will then summarize the evidence pertaining to Mr. Leclair's background and the events leading up to the incident. Next, I will review the evidence of the two forensic psychiatrists. I will comment on issues that arise in the evidence as I proceed. Unless otherwise stated, I find the witnesses' evidence both credible and reliable. Finally, I will apply the relevant law to my analysis.

<u>The Governing Legal Principles</u>

[8] Section 16 of the *Code* describes mental disorder as a basis for an exemption from criminal liability:

> **Defence of mental disorder**
>
> **16 (1)** No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the

> person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.
>
> **Presumption**
>
> **(2)** Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.
>
> **Burden of proof**
>
> **(3)** The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.

[9] To meet the requirements for a defence under s. 16 of the *Code*, the accused must establish, on a balance of probabilities, either:

> a) that he was suffering from a mental disorder that rendered him incapable of appreciating the nature and quality of his act (or omission); or
>
> b) that he was suffering from a mental disorder that rendered him incapable of knowing that the act (or omission) was wrong.

[10] Before beginning my analysis, I note Molloy J.'s comments at para. 30 of *R. v. Minassian*, 2021 ONSC 1258 [*Minassian*] about the terminology used in NCRMD cases:

> Before turning to [the] analysis, I wish to first address the terminology. The language used in the Criminal Code referring to "mental disorder" and "disease of the mind" and to people "suffering" from such a disability is rooted in case law going back decades or more. I will use that language, not because it is consistent with modern perceptions of disability, but because these are legal terms that have particular meaning in this context, as developed over many years of jurisprudence.

[11] The analysis required under s. 16 of the *Code* proceeds in two stages: *R. v. Bouchard-Lebrun*, 2011 SCC 58 [*Bouchard-Lebrun*] at para. 56. First, I must *characterize* Mr. Leclair's mental state to decide whether he was suffering from a mental disorder, in the legal sense, at the time of the offence. If I find he was suffering from a mental disorder within the meaning of s. 16 at the relevant time, I must then turn to the second stage of the statutory test, which concerns the *effects* of the mental disorder. At this stage, I must determine whether, owing to his mental

condition, Mr. Leclair was incapable of knowing that his actions were wrong: *Bouchard-Lebrun* at para. 56.

[12] The determination of whether the accused had a mental disorder is a question of law for the judge – "the key issue to be decided at trial… is whether the accused was suffering from a mental disorder *in the legal sense* at the time of the alleged events" (*Bouchard-Lebrun* at para. 56, emphasis added). While the medical evidence will describe "the accused's mental condition and how it is considered from the medical point of view", the trial judge must answer the ultimate legal question of whether that condition is, in law, a mental disorder: *R. v. Cooper*, [1980] 1 S.C.R. 1149, 1979 CanLII 63 (SCC), [*Cooper*] at 1158 (citing to *R. v. Simpson*, 16 O.R. (2d) 129, 1977 CanLII 1142 (ONCA), at 349-350). The Court in *Cooper* explained that although medical evidence is directly linked to the legal conclusion, medical evidence is not dispositive and the test is ultimately a legal one (at 1153):

> Although the term expresses a legal concept and a finding is made according to a legal test, psychiatric knowledge is directly linked to the legal conclusion, for medical testimony forms part of the evidence on which the trier of fact must reach its decision. But medical and legal perspectives differ.

[13] The Court in *Bouchard-Lebrun* explained that if "the legal characterization exercise under s. 16 [of the *Code*] depend[ed] exclusively on a medical diagnosis" then "psychiatric experts would thus be responsible for determining the scope of the defence", shifting the responsibility for deciding the accused's guilt from the judge or jury to the expert (at para. 65).

Stage 1: Did the accused have a "mental disorder" at the time of the offence?

[14] A mental disorder means a "disease of the mind": *Code,* s. 2. In *Cooper*, a majority of the Supreme Court of Canada held that the term "disease of the mind" has a broad definition that embraces (at 1159):

> … any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion.

[15] The exclusion of “self-induced states caused by alcohol or drugs” from this definition gave rise to what is often called the *Cooper* exclusion.

Holistic Approach

[16] In *Bouchard-Lebrun*, the Supreme Court of Canada considered whether toxic psychosis flowing from the voluntary ingestion of drugs was a “mental disorder” within the meaning of s. 16 of the *Code*, or whether the *Cooper* exclusion applied to such a case. The Court noted that “[w]hen confronted with a difficult fact situation involving a state of toxic psychosis that emerged while the accused was intoxicated, a court should start from the general principle that temporary psychosis is covered by the exclusion from *Cooper*” (at para. 69). However, it urged that a holistic and contextual approach should be applied to determine whether an accused has discharged the burden of proof in this respect. It emphasized that the court has a responsibility to balance “the need to protect the public from persons whose mental state is inherently dangerous” against “the desire to impose criminal liability solely on persons who are responsible for the state they were in at the time of the offence” (at para. 68). Justice Lebel writing for the Court, explained that a fact-based inquiry was necessary because of the diversity of factors that could cause psychosis in any particular case (at para. 67):

> Many factors might contribute to a state of substance-induced psychosis, including the fact that symptoms of a paranoid personality disorder are active at the time drugs are taken (*Mailloux*), the combined effect of exposure to toxic vapours and a period of intense stress (*Oakley*), dependence on certain drugs, such as cocaine (*Moroz* and *Snelgrove*), heavy drug use during the days and hours leading up to the commission of the crime (*Lauv* and *Paul*), and withdrawal following a period of excessive drinking (*R. v. Malcolm* (1989), 1989 CanLII 214 (MB CA), 50 C.C.C. (3d) 172 (Man. C.A.)). It seems that this diversity of circumstances can be attributed to variations in psychological makeup and psychological histories from one accused to another, as well as … the nature of the drug use that contributed to their psychoses. The quantity and toxicity of the drugs taken also seem to have a significant effect in this regard. As a result, in each new situation, the case turns on its own facts and cannot always be fitted easily into the existing case law.

[17] The Court in *Bouchard-Lebrun* noted that “mental disorder” is a concept that continues to evolve, “which means that it can be adapted continually to advances in

medical science" (at para. 60). As a result, "it will undoubtedly never be possible to define and draw up an exhaustive list of the mental conditions that constitute 'disease[s] of the mind' within the meaning of s. 2 [of the *Code*]" (at para. 60). The Court further explained, at para. 60:

> As Martin J.A., writing for the Ontario Court of Appeal, stated in *R. v. Rabey* (1977), 1977 CanLII 48 (ON CA), 17 O.R. (2d) 1, this concept "is not capable of precise definition" (p. 12). It is thus flexible enough to apply to any mental condition that, according to medical science in its current or future state, is indicative of a disorder that impairs the human mind or its functioning, and the recognition of which is compatible with the policy considerations that underlie the defence provided for in s. 16 *Cr. C.*

[18] To distinguish between mental conditions within the scope of s. 16 of the *Code* and those covered by the *Cooper* exclusion, a trial judge should take a holistic approach: *Bouchard-Lebrun* at para. 70. This approach is informed by two analytical tools (the "internal cause factor" and the "continuing danger factor"), but a court may also consider other policy concerns: *R. v. Stone*, [1999] 2 S.C.R. 290, 1999 CanLII 688 (SCC) at para. 203, *Bouchard-Lebrun* at paras. 70-75. At para. 77 of *Bouchard-Lebrun*, the Court provides some guidance on how to apply the legal analysis to a particular case:

> Although the courts can seek assistance from the existing case law, it would be preferable for them to engage in an individualized analysis that takes account of the specific circumstances of each case. This means that the courts should determine on a case-by-case basis, applying the "more holistic approach" from *Stone*, whether the mental condition of each accused is included in or excluded from the definition of "disease of the mind" proposed by Dickson J. in *Cooper*. This approach is consistent with the line of authority based on *Rabey*, in which this Court endorsed Martin J.A.'s opinion that "[p]articular transient mental disturbances may not . . . be capable of being properly categorized in relation to whether they constitute 'disease of the mind' on the basis of a generalized statement and must be decided on a case-by-case basis" (pp. 519-20).

Internal Cause Factor

[19] The first analytical tool, the "internal cause factor", asks whether the accused's mental state has an internal cause or an external cause. The court in *Bouchard-Lebrun* explains this factor at paras. 71-72:

> The *internal cause factor*, the first of the analytical tools described in *Stone*, involves comparing the accused with a normal person. In that case, Bastarache J. noted that “the trial judge must consider the nature of the trigger and determine whether a normal person in the same circumstances might have reacted to it by entering an automatistic state as the accused claims to have done” (para. 206). The comparison between the circumstances of the accused and those of a normal person will be objective and may be based on the psychiatric evidence. The more the psychiatric evidence suggests that a normal person, that is, a person suffering from no disease of the mind, is susceptible to such a state, the more justified the courts will be in finding that the trigger is external. Such a finding would exclude the condition of the accused from the scope of s. 16 *Cr. C.* The reverse also holds true.
>
> Although the trigger associated with the internal cause factor often involves a “psychological blow”, there is no reason why it cannot consist of alcohol or drug use contemporaneous with the offence. What must therefore be determined is what state a normal person might have entered after consuming the same substances in the same quantities as the accused. Since certain factors such as fatigue and the pace of consumption may influence the effects of drugs, this comparison must take account of all the circumstances in which the accused consumed the drugs that triggered the psychotic condition. If a normal person might also have reacted to similar drug use by developing toxic psychosis, it will be easier for the court to find that the mental disorder of the accused was purely external in origin (*Rabey* (S.C.C.), at pp. 519 and 533; see also *Moroz*, at para. 46) and was not a disease of the mind within the meaning of the *Criminal Code*.

[20] Therefore, when applying the internal cause factor to alcohol or drug use contemporaneous with the offence, the court must ask “what state a normal person might have entered after consuming the same substances in the same quantities as the accused” (*Bouchard Lebrun* at para. 72). If a normal person would have entered a psychotic state, this suggests the cause was “external” and that there was no disease of the mind. The inverse is also true. This comparison is an objective one and requires the trial judge to consider the circumstances of the case.

[21] In addition to the decisions referred to by counsel, I also found *R. v. Alexander*, 2015 BCCA 484 (leave to SCC ref’d: 2016 CanLII 23173 (SCC)) [*Alexander*] to be of assistance. While this case dealt with automatism, it contains a helpful discussion of how the *Bouchard-Lebrun* framework is applied. In *Alexander,* the court stated that the internal cause approach “may not be helpful in all situations” and, in particular, it “may not be helpful when the line between internal and external causes is blurred and it is impossible to classify the trigger as internal or external” (at

para. 43). The internal cause factor is therefore “a factor for trial judges to consider in cases in which they deem it useful”: *Stone* at para. 206.

Continuing Danger Factor

[22] The second analytical tool, the “continuing danger” factor, is directly related to the need to ensure public safety, as the Court in *Bouchard-Lebrun* explained at para. 73:

> The purpose of this factor is to assess the likelihood of recurring danger to others. Where a condition is likely to present a recurring danger, there is a greater chance that it will be regarded as a disease of the mind.

[23] Two issues are particularly relevant when considering the continuing danger factor – the accused’s psychiatric history and the likelihood that the trigger alleged to have caused the episode will recur: *Stone* at para. 214. This factor only accounts for inherent dangers that arise independently of the accused’s voluntary behaviour and persist despite the accused’s will – it does not include dangers voluntarily created by the accused’s future consumption of drugs: *Alexander* at para. 44, *Bouchard-Lebrun* at para. 74. Although the Court in *Bouchard-Lebrun* did not decide this issue, it observed at para. 83 that an accused might present a continuing danger if he “had a dependency on drugs that affected his ability to stop using them voluntarily” as “[t]he likelihood of recurring danger might then be greater”.

[24] The continuing danger posed by the accused is a factor to be considered in the disease of the mind inquiry; however, “a finding of no continuing danger does not preclude a finding of a disease of the mind”: *Stone* at para. 212.

Other Policy Considerations

[25] The third branch of the holistic approach allows trial judges to consider the policy concerns that underlie the disease of the mind inquiry: *Stone* at para. 218. This branch is helpful where the internal cause and continuing danger factors do not yield a conclusive response: *Stone* at para. 218. The main consideration is the protection of society, so “if the circumstances of a case suggest that a pre-existing condition of the accused does not require any particular treatment and is not a threat

to others, the court should more easily hold that the accused was not suffering from a disease of the mind at the time of the alleged events”: *Bouchard-Lebrun* at para. 75. The list of policy considerations is not closed, however, and a trial judge may consider any valid policy concern: *Stone* at para. 218.

Applying the Bouchard-Lebrun/Stone Factors

[26] In *Bouchard-Lebrun*, the accused had assaulted two people while in a psychotic condition caused by a “*poire bleue*” ecstasy pill that he had ingested a few hours earlier. The psychotic symptoms appeared rapidly and coincided with the duration of his intoxication, disappearing after the drugs had worn off. The evidence established that toxic psychosis with this type of drug was common and that the likely “reaction of a normal person to such a pill would indeed be to develop toxic psychosis” (at para. 80). Accordingly, the Court found the psychosis had an external cause. The accused did not present an inherent danger, as he was capable of abstaining from drugs voluntarily; however, the Court was careful to qualify this conclusion, noting that they “might have concluded otherwise” if he were dependent on drugs (para. 83). There were no other policy considerations militating in favour of an NCRMD finding, as the accused’s mental condition could be “attributed exclusively to a state of temporary self-induced intoxication” and he posed no continuing danger to others (at para. 84). In concluding that the accused was not suffering from a “mental disorder” for the purpose of s. 16 of the *Code*, the Court found that he “failed to rebut the presumption that his toxic psychosis was a ‘self-induced stat[e] caused by alcohol or drugs’ in accordance with the definition in *Cooper*”: *Bouchard-Lebrun* at para. 85. The Court explained that a “malfunctioning of the mind that results *exclusively* from self-induced intoxication cannot be considered a disease of the mind in the legal sense, since it is not a product of the individual’s inherent psychological makeup” (para. 85, emphasis in original).

[27] As discussed, the contextual approach in *Stone* demands an individualized analysis of each accused’s state of mind based on the circumstances of each case. *Bouchard-Lebrun* addressed “just one type of toxic psychosis, namely one that resulted *exclusively* from a single episode of self-induced intoxication” (at para. 76,

emphasis in original). As the court of appeal remarked in *R. c. Turcotte*, 2013 QCCA 1916 (leave to SCC ref'd: 2014 CanLII 12484) [*Turcotte*] "self-induced intoxication does not, in and of itself, rule out the defence of mental disorder, except when, as in *Bouchard-Lebrun*, it is the single cause of the psychosis" (at para. 118). Where both mental disorder and intoxication are contributing factors, a nuanced analysis is required to determine what caused the accused's mental condition at the time of the offence.

[28] Further, excessive focus on the words of the *Cooper* exclusion, without considering the holistic approach outlined in *Bouchard-Lebrun*, is a legal error: *Alexander* at para. 64. In *Alexander,* Stromberg-Stein J.A., writing for the court, found that the trial judge had failed to engage in the holistic analysis or weigh the factors from *Stone/Bouchard-Lebrun*. Instead, the trial judge had concluded that the accused could not avail herself of the mental disorder automatism defence because the evidence described her state as "transient" and "[t]he legal definition of 'disease of the mind' explicitly excludes transitory mental states": *R. v. Alexander*, 2014 BCSC 554 at para. 19. On appeal, Justice Stromberg-Stein observed that "the mere fact that a mental state is transitory does not automatically mean it cannot be characterized as mental disorder automatism": *Alexander* at para. 64. She emphasized that a court must apply the holistic approach to determine this question, noting that "[i]t is still necessary to apply the internal cause and continuing danger factors and consider the policy concerns to properly classify the condition" (at para. 64). In my view, this analysis is of particular assistance when considering the Crown's argument that the *Cooper* exclusion should be extended in this case. Their argument seems to ignore the contextual factors mandated by *Stone* and *Bouchard-Lebrun* in favour of focusing entirely on whether Mr. Leclair's disease of the mind is "unrelated to the intoxication-related symptoms", within the language of para. 69 of *Bouchard-Lebrun*. This is not the test.

Stage 2: Did the accused's mental disorder render him incapable of knowing that his actions were wrong?

[29] If I find that Mr. Leclair was suffering from a mental disorder within the meaning of s. 16 at the time of the offence, then I must consider the effects of the mental disorder, and in particular, whether his mental condition made him incapable of knowing that his actions were wrong: *Bouchard-Lebrun* at para. 56.

[30] The Supreme Court of Canada affirmed in *R. v. Chaulk*, 1990] 3 S.C.R. 1303, 1990 CanLII 34, (SCC), that the focus at this stage of the inquiry must be on the accused's capacity to know that the *specific act committed* was wrong, and not merely on their general capacity to distinguish right from wrong. At 1354, Lamer J., writing for the majority, stated as follows:

> … The principal issue in this regard is the capacity of the accused person to know that a particular act or omission is wrong. As such, to ask simply what is the meaning of the word "wrong", for the purposes of section 16(2) is to frame the question too narrowly. To paraphrase the words of the House of Lords in *M'Naghten's Case*, the courts must determine in any particular case whether an accused was rendered incapable, by the fact of his mental disorder, of knowing that the act committed was one that he ought not have done.
>
> [Emphasis in original.]

[31] In *R. v. Oommen*, [1994] 2 S.C.R. 507, 1994 CanLII 101 (SCC), the Supreme Court of Canada reconsidered "what is meant by the phrase 'knowing that [the act] was wrong' in 16(1)". Justice McLachlin (as she then was) explained that "the crux of the inquiry is whether the accused lacks the capacity to rationally decide whether the act is right or wrong and hence to make a rational choice about whether to do it or not" (at 518). She found that "the inability to make a rational choice may result from a variety of mental dysfunctions", including "delusions which make the accused perceive an act which is wrong as right or justifiable" or a "disordered condition of the mind which deprives the accused of the ability to rationally evaluate what he is doing" (at 518). She explained that the standard of what was right or wrong turned on society's views, rather than an accused's own moral code (at 521):

> Finally, it should be noted that we are not here concerned with the psychopath or the person who follows a personal and deviant code of right and wrong. The accused in the case at bar accepted society's views on right and wrong. The suggestion is that, accepting those views, he was unable because of his delusion to perceive that his act of killing was wrong in the particular circumstances of the case. On the contrary, as the psychiatrists testified, he viewed it as right. This is different from the psychopath or person following a deviant moral code. Such a person is capable of knowing that his or her acts are wrong in the eyes of society, and despite such knowledge, chooses to commit them.

[32] *In Oommen,* the appellant believed that his life was in imminent danger, so he shot and killed a young woman who was sleeping in his apartment. The appellant had a mental illness causing paranoid delusional thoughts that the victim was part of the conspiracy that was out to kill him. The trial judge had rejected the defence of NCRMD on the basis that although the accused had a mental disorder, he was generally capable of distinguishing right from wrong. The trial judge found that he "was capable of knowing that what he was doing was wrong according to moral standards of society… [H]e was capable of knowing that society in general would regard it as wrong" (at 514), although the trial judge found that he could not apply this general ability to distinguish right from wrong to prevent himself from committing the offence. He "believed he had no choice to do anything but what he did" (at 514). A majority of the Alberta Court of Appeal found the trial judge had erred in finding NCRMD was not available and ordered a new trial. Affirming the majority's decision, the Supreme Court of Canada found that the evidence, and the trial judge's own conclusions, supported a finding that the accused was deprived of the capacity to know his act was wrong (at 522-523):

> First, there was evidence that the accused honestly felt that he was under imminent danger of being killed by Ms. Beaton if he did not kill her first, and that for this reason, believed that the act of killing her was justified. This delusion would have deprived the accused of the ability to know that his act was wrong; in his eyes, it was right. Second (and this may be to say the same thing), there was evidence capable of supporting the conclusion that the accused's mental state was so disordered that he was unable to rationally consider whether his act was right or wrong in the way a normal person would.
>
> The trial judge found that while the accused was generally capable of knowing that the act of killing was wrong, he could not apply that capacity for distinguishing right from wrong at the time of the killing because of his mental disorder. He further found that because of that disorder, Mr. Oommen was

> deluded into believing that he had no choice but to kill. These findings are consistent with the conclusion that Mr. Oommen's mental disorder deprived him of the capacity to know his act was wrong by the standards of the ordinary person. As the cases make clear s. 16(1) of the *Criminal Code* embraces not only the intellectual ability to know right from wrong, but the capacity to apply that knowledge to the situation at hand.

[33] In *R. v. Szostak*, 2012 ONCA 503, the accused was charged with threatening and harassing his former common law wife. A psychiatrist testified that the accused was suffering from alcohol-related dementia and that, as a result of the dementia, he was under the delusion that his son was in danger from his ex-wife's boyfriend. The trial judge found that the requirements of s. 16 were met because the accused believed he was entitled to engage in the threatening and harassing conduct in order to protect his son. This was "not simply the result of a transitory state of intoxication but a fixed delusional belief that was a consequence of his mental disorder" (at para. 32). Therefore, the trial judge was satisfied that as a result of his delusional beliefs he was "deprived of the ability to rationally evaluate his conduct and to know that his death threats and criminal harassment of the complainant were morally wrong" (para. 32). On appeal, the court found that the trial judge had properly applied the law, as while the accused had "a general understanding of the difference between right and wrong and even appreciated that his actions were illegal", he felt compelled to act in the way he did to protect his child (at para. 57). Rosenberg J.A., writing for the court, emphasized McLachlin J.'s comments in *Oommen* (at 520):

> There is no suggestion in the authorities that the accused must establish that his delusion permits him to raise a specific defence, such as self-defence. The issue is whether the accused possessed the capacity present in the ordinary person to know that the act in question was wrong having regard to the everyday standards of the ordinary person. . . . Thus the question is not whether, assuming the delusions to be true, a reasonable person would have seen a threat to life and a need for death-threatening force. Rather, the real question is whether the accused should be exempted from criminal responsibility because a mental disorder at the time of the act deprived him of the capacity for rational perception and hence rational choice about the rightness or wrongness of the act.
>
> [Emphasis added.]

[34] At this stage of the test, I have also considered Molloy J.'s analysis in *Minassian* at paras. 45-86, which helpfully outlines what it means to know that one's actions were wrong.

[35] The issues raised are questions of fact and law, which are to be decided based on the evidence adduced at trial. Therefore, with the legal principles that govern my analysis in mind, I will turn to a consideration of the evidence adduced at trial and my findings of fact.

Summary of the Evidence

[36] I will begin the summary of the evidence with a brief description of Mr. Leclair's background and then proceed to consider his activity in the two-year period before the incident. In addition to the detail provided in the admissions filed at trial, I base this summary on witness testimony, video footage, and documentary evidence tendered at trial.

Mr. Leclair's Background

[37] Mr. Leclair was born in Chetwynd, B.C. and was raised primarily by his mother Georgina Tobin. Mr. Leclair had a difficult upbringing involving physical abuse, alcohol and drug abuse, and domestic violence. Due to various performance issues and learning difficulties, Mr. Leclair did not do well in school and eventually dropped out in grade 10. By the age of 16, he began using cocaine and continued to use various illicit substances throughout his adult life.

[38] Despite his difficult upbringing, Mr. Leclair has a close relationship with his mother who has provided him with emotional and financial support throughout his life. His mother was the one person he trusted and confided in. Mr. Leclair has two children from a relationship with a woman he met in high school. For various reasons, this continues to be a stressful relationship, although he did have access to his children.

[39] Mr. Leclair has experienced depression and anxiety throughout his life and at one point, he attempted suicide. He has also had some involvement with the justice

system, including serving a penitentiary term for a stabbing when he was 19 years old.

[40] In addition to a history of alcohol and drug abuse, Mr. Leclair's family has a history of schizophrenia. His aunt, Sharon Tobin, and several other relatives have been diagnosed with schizophrenia. Mr. Leclair testified that he began hearing voices in his head when he was 17 although, as I will discuss later in these *Reasons*, it is unclear from the evidence at trial when exactly he began to hear voices.

Mr. Leclair's time at Aspen Heights

[41] In the fall of 2016, Mr. Leclair moved into the Aspen Heights apartments in Quesnel, B.C. He remained there until early spring 2017, when his mother took him to Prince George and he was admitted into St. Patrick's Treatment Centre.

[42] While at Aspen Heights, Mr. Leclair continued to consume drugs including cocaine and methamphetamine, sometimes alone and sometimes together with other residents of the building. However, he also managed to upgrade his high school education during this period. In addition to his testimony, he recorded details of what occurred while he was residing at Aspen Heights in a journal. The journal was tendered at trial. While Mr. Leclair was unable to say when exactly he wrote the entries in his journal, it was certainly prior to the offence. Mr. Leclair explained that he wrote the journal because he wanted a record in case he was killed. One page of the journal read: "This book is the truth and could get me killed, But the way I see it is im dead already. They call me a RAT!"

[43] The first entry in the journal is "it all started when I was in Mackenzie" and described how his cellphone, Facebook, and internet were all infiltrated by people he identified as "they". Every time he obtained a new cell phone "they" would break into it. In his journal, he notes that he told his mother about what was happening to his phones. His mother confirmed this.

[44] According to Mr. Leclair's journal, "things didn't really start to get weird untill" he moved into Aspen Heights. The journal entries reveal that Mr. Leclair believed he was being harassed and threatened by people who could hack into his accounts and send him messages through Google. He wrote that people he thought were his friends told him "they were [poisoning] me and that it would kill me slowly". Mr. Leclair's testimony aligned with his journal entries.

Mr. Leclair attends St. Patrick's Treatment Centre

[45] In the spring of 2017, Mr. Leclair left Aspen Heights and spent a week at a detox centre in Prince George before entering residential treatment at St. Patrick's Treatment Centre, also in Prince George. He remained at the treatment centre for approximately three months, during which time he reports he maintained his sobriety; however, he continued to hear a voice and experience what he believed to be threats. The portion of the journal where Mr. Leclair wrote "now here at St Pats" is referring to when he was residing at the treatment centre, although it is unclear when he made the journal entry. Mr. Leclair's belief that he was being threatened by a group of individuals whom he referred to as "they" continued: he indicated in his journal, "[n]ow im in P.G. and their still harassing me and threatning my life. I'm scared and dont know what to do or who to tell". In this section of the journal, Mr. Leclair provided a list of names of people he believed were after him, including Jessica Penner and Amanda. Even after leaving Aspen Heights, Mr. Leclair continued to believe that people were stalking him. In cross-examination, he explained that he was afraid of the "Illuminati", who he said was a group of people that hacked into systems, part of the new world order, and like a gang. He testified that he believed the names listed in the journal were members of the Illuminati.

[46] After leaving St. Patrick's Treatment Centre, Mr. Leclair went to reside with his mother and her partner on Beach Crescent in Prince George for three or four months. In his journal entry dated June 4, 2018, he wrote that he went to live with his mother in the summer of 2017 and "everything seemed fine, they seemed like they had left me alone". "They" means the people he believed were after him.

Mr. Leclair attends New Caledonia College

[47] In the fall of 2017, Mr. Leclair enrolled in a welding program at New Caledonia College in Prince George and moved into residence. Mr. Leclair graduated from the program on March 30, 2018. He struggled in school, which impacted his mental health. He was also stressed because he learned that his former partner was in a relationship with his father. Although sober when he arrived at school, he soon began to use drugs. In his journal, he wrote that “they” took over his phone and told him they were going to poison his kids. He wrote that various threatening images were sent to his phone, which he perceived as a specific threat to kidnap him, hide him in a container, and ship him away.

[48] In April 2018, after he graduated from his welding program, he rented a room from Paige Bohn in Prince George. Mr. Leclair testified that at first things were going well but then he noticed things were happening, such as the people hacking into his phone, Facebook and email, which led him to believe Ms. Bohn was part of the group of people trying to kill him. He said he confronted her about it but she denied doing anything to him. He pointed an air gun at Ms. Bohn, which resulted in him being arrested and charged. His mother assisted him in getting bail.

Mr. Leclair moves in with Sharon Tobin and Michael Potter

[49] After he was released on bail, Mr. Leclair went to live with his aunt Sharon Tobin and her husband Michael Potter at their trailer home in Quesnel, B.C. where he remained until the incident in July 2018.

[50] When he first moved into the trailer, Mr. Leclair was working as a welder at Babcon Industries; however, after a few weeks, he lost his job. Mr. Leclair testified that he was having mental health issues at the time, believing that people were out to get him. He was drinking and doing drugs at night, which caused him to miss work and eventually get fired.

[51] Mr. Leclair and Michael Potter would smoke crack cocaine each evening. Mr. Leclair testified that he stopped using methamphetamine and started using crack

cocaine, which Mr. Potter would share with him. He said that he and Mr. Potter would usually share $100 worth of cocaine, purchased by Mr. Potter. Sharon Tobin did not use crack cocaine and usually went to bed early, leaving the two of them to smoke their crack in the kitchen.

[52] Mr. Leclair had a good relationship with both Sharon Tobin and Mr. Potter. However, in his journal entry after June 4, 2018, he wrote:

> I have recently found out that it's much, much, much worse then I thought and I fear that the only person in my life right now that I can trust is my mother. It seems that Mike Potter, Sharon Tobin, And Clayton Bye are all Dirty and working for the bad guys. Unfortunately, I don't have all of the answers...

[53] Mr. Leclair testified that he was concerned about Mr. Potter—he thought Mr. Potter was one of the people trying to get him and set him up to be killed. He held this belief because Mr. Potter was always on his computer, and he would not tell Mr. Leclair what he was doing. He testified that he believed his aunt, Sharon Tobin, was also “in on it”: He believed that she would poison the food she cooked for him, and when he ate the food, his “legs went numb” and he “could feel electricity running through [his] body”. He said that during this time, he continued to hear the voices. He said he was scared for his own safety.

[54] In this section of the journal there are also some drawings including an eye inside a triangle. Mr. Leclair wrote “ILLUMINATIVE” on the same page, which he explained was in reference to the Illuminati, whom he believed was the group after him.

Mr. Leclair attends G.R. Baker Memorial Hospital Emergency Room (June 4-July 17, 2018)

[55] In the weeks preceding the incident, Mr. Leclair attended the emergency department (the “Emergency Room”) at G.R. Baker Memorial Hospital (“GR Baker”) on several occasions.

[56] On June 4, 2018, the clinical records show Mr. Leclair attended the Emergency Room complaining of a burning sensation on his skin for the past three

weeks. He reported that he believed someone might have poisoned him. The record notes that Mr. Leclair was under a lot of stress. He was diagnosed with "paresthesia", which is an abnormal sensation on the skin.

[57] On June 15, 2018, he attended the Emergency Room again. He asked to be admitted for depression. The records note that his affect was flat and he appeared depressed. He was diagnosed with major depressive disorder. Mr. Leclair was admitted to the inpatient psychiatric unit, but he discharged himself within a few hours. The discharge summary notes that Mr. Leclair reported being harassed over the preceding two years and threatened by gang members. This is consistent with his testimony, entries in his journal and, as I will discuss, the evidence of both Georgina Tobin and Jessica Penner. The clinical records describe Mr. Leclair as having a paranoid thought process but no homicidal ideation.

[58] On July 12, 2018, Mr. Leclair attended the Quesnel R.C.M.P. detachment where he dealt with Constable Balaux. Mr. Leclair told Cst. Balaux that there was a secret society following him and threatening him. This is consistent with other evidence of Mr. Leclair's beliefs at the time. He told Cst. Balaux that someone had given him a watch and the back of the watch was engraved: It said that people were going to kill him. Mr. Leclair was not able to produce the watch. He also said he made a list of licence plates of cars that had been following him, but he was unable to provide the list to the R.C.M.P. On July 12, 2018, Mr. Leclair asked to be placed in the witness protection program. Cst. Balaux found Mr. Leclair to be evasive and illogical. She decided to apprehend Mr. Leclair under the *Mental Health Act*, R.S.B.C. 1996, c. 288 [*Mental Health Act*], and she took Mr. Leclair to the hospital where he was admitted.

[59] Mr. Leclair reported the same incident regarding the watch to nurse Myers at the Emergency Room. Nurse Myers noted that Mr. Leclair was guarded, suspicious, and he did not answer questions. She noted he appeared to be calm but clenched his fists. She reported that he was unpredictable, delusional, and prone to anger. Nurse Myers recommended an assessment under the *Mental Health Act*, after

which, Mr. Leclair was diagnosed with paranoid psychosis and admitted to the inpatient psychiatric unit. The doctor who examined Mr. Leclair noted that he was suffering from severe paranoia and his rational thinking had been lost. Mr. Leclair reported feeling unsafe, but he could not provide specifics. The clinical records describe him as having a flat affect and speaking little. A urine drug screen tested positive for methamphetamine, cocaine, cannabis, methadone, and amphetamine. The next morning, Dr. Obanye saw Mr. Leclair and diagnosed him with drug-induced psychosis and anti-social personality disorder. Mr. Leclair was discharged with a recommendation to follow up with outpatient mental health.

[60] On July 13, 2018, after being discharged, Mr. Leclair returned to the Quesnel R.C.M.P. detachment parking lot. A front desk clerk advised Cst. McGregor that a vehicle had been parked there for a couple of hours with one person inside. Cst. McGregor approached the vehicle and observed Mr. Leclair sitting in the front passenger seat, hands on the steering wheel, staring straight ahead. When Cst. McGregor asked him if he required assistance, Mr. Leclair said he wanted to admit a crime: He had assaulted his aunt. Mr. Leclair agreed to go into the detachment with Cst. McGregor. As they walked toward the detachment, Cst. McGregor noticed Mr. Leclair looking around the parking lot at cars as they drove by.

[61] Cst. McGregor determined that Mr. Leclair had already reported assaulting his aunt and decided not to charge Mr. Leclair. When Cst. McGregor told Mr. Leclair he was not being charged, Mr. Leclair said he forgot about the prior report. He pled with Cst. McGregor to let him go to jail. He told Cst. McGregor he would admit to any crime as he wanted to go to jail and be locked up for a long time. Mr. Leclair said that people were after him and he was concerned for his safety. When Cst. McGregor asked Mr. Leclair who was after him, he said the Illuminati and the new world order. He said they had been watching him using cameras and they were around every corner, messaging him on YouTube. I note that this report to Cst. McGregor is consistent with what Mr. Leclair had told medical staff at GR Baker and with the entries in his journal. Mr. Leclair said he put his phone in tinfoil to prevent it from being tracked. When Cst. McGregor told Mr. Leclair he could not be arrested

without a reason, Mr. Leclair asked “what do I have to do to go to jail, do I have to steal a chocolate bar, or do I have to kill someone?”

[62] Cst. McGregor apprehended Mr. Leclair under the *Mental Health Act* and transported him to the hospital. Cst. McGregor said Mr. Leclair appeared to be a drug user but did not appear to be under the influence at the time. Mr. Leclair told him he had used speed, coke, heroin, and crack. Mr. Leclair told Cst. McGregor that he had just been released from the hospital and that he drove directly to the R.C.M.P. after being discharged. He said he knew what to say and that he had lied to the doctors so he could get out.

[63] At the hospital, Cst. McGregor advised the nurse and Dr. Obanye about his encounter with Mr. Leclair. Mr. Leclair was certified under the *Mental Health Act* and, according to the clinical records, he remained in the hospital until July 17, 2018. Mr. Leclair was diagnosed with drug-induced psychosis with paranoid delusions. He was prescribed 10mg of olanzapine twice daily and placed in a seclusion room. According to the records, on July 14, 2018, Mr. Leclair told Dr. Obanye he did not feel ready to return home. The records note that Mr. Leclair did not make eye contact with the doctor during this session. On July 16, 2018, the records show that Mr. Leclair had improved and there were no overt signs of psychosis, although Mr. Leclair requested to remain in the hospital. On July 17, 2018, he was prescribed olanzapine and discharged.

Mr. Leclair attacks Mr. Potter and Sharon Tobin (July 21, 2018)

[64] Following his discharge from the hospital on July 17, 2018, Mr. Leclair returned to live with Sharon Tobin and Mr. Potter. He said he did not have the funds to pay to have his olanzapine prescription filled. During the four-day period prior to the incident, there were no further reports of Mr. Leclair attending at the R.C.M.P. or the hospital. According to the evidence of both Mr. Leclair and Sharon Tobin, he and Mr. Potter continued to smoke crack cocaine each night. There is no evidence to suggest that Mr. Leclair had stopped being concerned for his safety during this period. Given that his mother was gone and he had nowhere else to go, I do not

consider his decision to live with his aunt and her husband – despite his concerns about each of them – as an indication that he was no longer concerned for his safety. As I will discuss in more detail, I find no basis to conclude that Mr. Leclair's psychosis had abated during this period.

[65] Sharon Tobin said there had been some minor disagreements with Mr. Leclair before the incident, but generally, she thought they all got along well. Sharon Tobin testified that in the months leading up to the offence, she noticed Mr. Leclair was behaving more strangely. She heard him tell his mother that he thought people were out to get him. She also testified that Mr. Leclair seemed to be concerned about what Mr. Potter was doing on his computer.

[66] On the evening of July 20, 2018, Sharon Tobin testified that she was at home with Mr. Leclair and Mr. Potter. She went to bed at around 7 p.m. and awoke in the early morning hours of July 21, 2018. When she walked into her kitchen, she saw Mr. Potter sitting in a chair near the kitchen table. Mr. Leclair had a knife to Mr. Potter's throat. She testified that she heard Mr. Potter say "No, no, no". Mr. Leclair then told Sharon Tobin not to move, but she stumbled backwards. That is when Mr. Leclair cut Mr. Potter's neck. Mr. Potter then ran out of the trailer and Mr. Leclair began attacking Sharon Tobin with a knife. She told him "no Kristopher, no Kristopher". She said Mr. Leclair seemed furious. She called out for Mr. Potter and as Mr. Potter ran back into the trailer, she ran out. She ran to her neighbours to get help. She saw Mr. Leclair get into his car and leave the area – he was driving a "little bit faster" than usual.

[67] Sharon Tobin suffered life threatening stab wounds. Mr. Potter was located in the hallway of the residence. He was deceased. His cause of death was blood loss due to a stab wound to the neck.

[68] Mr. Leclair was not able to provide many details as to what happened inside the trailer on July 21, 2018. He testified that he and Mr. Potter were using crack cocaine. He thought it might have been a couple of hundred dollars worth, although his evidence on this point was not clear. Mr. Leclair told both psychiatrists that he

had "blacked out" and that he could recall little from the incident. I pause to note that Mr. Leclair had some difficulty recalling events during his testimony and he had difficulty remaining alert throughout the trial. I did not find him to be evasive; rather, he appeared drowsy or sedated.

After the incident, Mr. Leclair drove to Mr. McMurray's residence

[69] Sometime around 5 a.m. on July 21, 2018, Mr. Leclair arrived at Kenneth McMurray's residence at 5022 Bartels Road, Quesnel. He had driven there. Mr. McMurray was Jessica Penner's father. Mr. McMurray recalled that he was awake, watching a fishing show, when Mr. Leclair arrived at his home unexpectedly.

[70] Mr. Leclair testified that he went to Mr. McMurray's house because he wanted to speak with Ms. Penner. In his evidence, he stated that he believed she "had something to do with it and I know it sounds bad, but I wanted to hurt her too."

[71] Mr. McMurray testified that Mr. Leclair was in an upset state: His body was shaking and he looked scared to death. Mr. Leclair said, "Uh, Ken, I'm in a lot of trouble. I -- I fucked up, now". Mr. Leclair recounted that he got into an argument and hurt his uncle and that he thought his uncle was dead. Mr. McMurray testified that Mr. Leclair did not tell him what had happened; only that his uncle wasn't alive. When he asked if his aunt was hurt, Mr. Leclair said he could not remember. Mr. McMurray recalled that Mr. Leclair wanted to call his mother, so he made the call for him. It was not a long phone call.

[72] When Mr. Leclair asked Mr. McMurray what he should do, Mr. McMurray told him to contact the "5-0", referring to the police. Mr. Leclair agreed. There was no evidence to suggest that Mr. Leclair was resistant to the idea of going to the police or that Mr. McMurray had to persuade him. Although Mr. Leclair asked Mr. McMurray for gas and clothes, I do not consider this to be an indication that he planned to flee to avoid arrest, as such an inference would be entirely speculative.

[73] In cross-examination, Mr. McMurray agreed that he had told the police that Mr. Leclair "had that dark look in his face. Like I could see right through his eyes.

They were black”. The Crown emphasized the importance of Mr. McMurray’s testimony; however, it was obvious during his testimony that Mr. McMurray was very fatigued and finding it difficult to recall the precise details of what Mr. Leclair had said to him that morning. His testimony was somewhat difficult to follow. It was hard to understand, based on his evidence, exactly what had occurred or what was said that morning.

Mr. Leclair’s arrest

[74] The video recording of Mr. Leclair arriving at the R.C.M.P. detachment parking lot and his arrest was an exhibit at trial. Several police officers who dealt with Mr. Leclair testified at trial.

[75] When he arrived at the detachment, Mr. Leclair got out of his car. He walked to the rear of the car, knelt down on the ground, and put his hands on his head. Police sirens are audible in the video, as various cars arrive back at the detachment. As the officers move towards Mr. Leclair, he maintains his position. When asked his name, Mr. Leclair faintly utters his name—although it is somewhat mumbled and difficult to hear. It is obvious, as the police interact with Mr. Leclair, that he is in a very distressed state. Officers help him to stand up and walk towards the detachment. He is bent over and moaning. Corporal Steve Pelletier, one of the officers who interacted directly with Mr. Leclair at this initial phase, testified that he was not able to establish eye contact with Mr. Leclair at first but he asked Mr. Leclair if he knew where he was. Mr. Leclair responded that he thought he was at the Calgary Zoo. For some inexplicable reason, in the midst of this very chaotic scene, Cpl. Pelletier began to address Mr. Leclair as “Vincent”. Unfortunately, when the paramedics arrived, police advised them that Mr. Leclair responded to the name Vincent. As a result, all who dealt with Mr. Leclair that day addressed him as Vincent. Given the distressed state he was in at this time, it no doubt added to his confusion to have everyone calling him Vincent.

[76] While at the detachment, Mr. Leclair began to hyperventilate. He is seen bent over, rocking back and forth, and moaning. He is heard repeating the name “Steve”,

which is Cpl. Pelletier's first name. Cpl. Pelletier acknowledged that Mr. Leclair seemed off—he was breathing heavily and he was not verbally responding. Although Cpl. Pelletier described Mr. Leclair as being fully compliant with his commands, it was evident from my review of the video that while Mr. Leclair did not resist commands, either the police or paramedics assisted him to comply. Mr. Archer, the attending paramedic, testified that Mr. Leclair appeared to be in a state of shock, as he was confused and staring straight ahead.

[77] Mr. Leclair was transported to the Emergency Room, where he arrived shortly after 6:30 a.m. According to the clinical records, he was disoriented as to person, time, and place. He presented as confused. He was hunched over and making moaning sounds. He was diagnosed with substance abuse and confusion. He was released back to the R.C.M.P.

Other evidence about Mr. Leclair's mental health

[78] Mr. Leclair's mother, Georgina Tobin, testified at trial. So did Jessica Penner, a long time friend. They both described noticing changes in Mr. Leclair's behaviour in the months leading up to the incident.

[79] Georgina Tobin testified that Mr. Leclair had told her about hearing a voice three or four years ago. She said he first told her that he was scared for his safety a couple of years before the incident. She said he only felt safe talking outside because he was concerned that "they" could listen if he spoke to her in the car or in the house. She also testified that Mr. Leclair had obtained a lot of phones because he was worried that they would send him messages through his phone or on YouTube. She said Mr. Leclair expressed his concern and fear both when he was sober and while using drugs. After she posted his bail in April 2018, he asked her to revoke his bail so he could go to jail because he was scared for his life. She testified that at one point, he showed her a book and said that people were trying to kill him and "I'm writing everything down, Mom… you need to read this", which I find is a reference to the journal discussed earlier in these *Reasons*. He also referred to a list

of names in the journal and stated that she was to look at the list of names if anything ever happened to him or if he went missing.

[80] Georgina Tobin confirmed that sometimes they would have this discussion in the presence of her sister, Sharon Tobin. The night before the incident, Georgina Tobin had phoned the trailer and spoke to Sharon Tobin, who said they were all getting along. Mr. Leclair told her he had his hair cut earlier that day. The next morning at 5 a.m. she received a call from Mr. McMurray. Mr. Leclair came on the phone and said “your son’s going away, he just killed Auntie and Mike”. Georgina Tobin testified that he sounded out of breath and devastated, much different from their conversation the night before. Georgina Tobin has talked to her son since the incident – she reports that he continues to think what he did was right. She said he continues to believe that people are going to kill him.

[81] Jessica Penner has known Mr. Leclair since they were young children. Like Mr. Leclair, Ms. Penner struggled with substance abuse. For a period of time, they both lived in Aspen Heights, although in different buildings. It was at Aspen Heights that Ms. Penner said she noticed a change in Mr. Leclair. She said he started to make “crazy” accusations about her hacking his Wi-Fi, social media, and working with others to harm him. She said he seemed convinced that she was betraying him. He also mentioned that she was working together with her friends Amanda and Samantha to betray him.

[82] On one occasion, she saw him in the Aspen Heights parking lot and he looked really stressed out. His demeanour led her to believe that he was still suspicious of her. She said this was a change in his personality. On other occasions, he would not seem so strange. She pressed him for information about what was troubling him. She said, “he would just look at me like I already knew” or would tell her “I can’t say that, I just can’t say that”. It seemed to her that Mr. Leclair thought she had been hired to kill him.

[83] For period of time, Ms. Penner moved away from Quesnel and was not in contact with Mr. Leclair. When she returned they got together one day for a drive to

Tim Horton's. She said he was fine at first, but then he started to tell her about people out to get him. She thought he was acting unusually. When he suggested to her that the settlement she got for her car accident was actually payment from someone for her to kill him, she knew something was definitely wrong.

[84] Ms. Penner also described an encounter with Mr. Leclair about a month before the incident. She said she saw Mr. Leclair at Walmart and was nervous to speak to him. She said he was first looking very angrily, directly at her, but then he started begging her to help him. The last encounter she had with Mr. Leclair was at a pawn shop, two weeks before the incident. She said he appeared to be terrified. She followed him to his car and asked him what was wrong. He told her again that someone was trying to kill him. She pressed him for more details but he would not give any names except Amanda and Samantha. Ms. Penner felt there was no way to convince him that she was not against him. She told her father about her fear that Mr. Leclair might be out to get her.

The Expert Psychiatric Evidence

[85] Two forensic psychiatrists – Dr. Morgan, called by the defence, and Dr. Lamba, called by the Crown in rebuttal – were qualified as experts in forensic psychiatry to provide expert opinion evidence as to Mr. Leclair's mental condition at the time of the offence. Both reviewed a large body of records, including voluminous clinical records detailing Mr. Leclair's medical history.

[86] Both experts agree that where an individual such as Mr. Leclair has a history of chronic stimulant use and develops severe psychotic symptoms, it can be very difficult to disentangle the precise cause of the psychosis. Specifically, it can be difficult to distinguish between a psychotic "process illness" (such as schizophrenia) that arises independent of drug use and a substance-induced psychosis (such as chronic or persistent methamphetamine-induced psychosis).

[87] Dr. Morgan stated that persistent stimulant induced psychosis is difficult to differentiate from schizophrenia. However, as discussed below he was satisfied that the evidence supported a diagnosis of schizophrenia.

[88] Dr. Lamba agreed that the two are difficult to differentiate. He noted that in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-V"), which is used to diagnose mental disorders, chronic methamphetamine induced psychosis is categorized as "Other Specified Schizophrenia" disorder. Dr. Lamba disagreed with the diagnosis of schizophrenia. He opined that Mr. Leclair likely had a pre-existing vulnerability to persistent stimulant induced psychosis due to his heavy use of stimulants, particularly cocaine and methamphetamine. Dr. Lamba opined that Mr. Leclair's psychosis had remitted before the incident, although a vulnerability to psychosis remained that could be triggered with further drug use. His opinion was that *if* Mr. Leclair had psychosis at the time of the offence, then it was likely triggered by his drug use on that evening. He opined that Mr. Leclair developed a chronic psychosis of an internal nature—persistent stimulant induced psychosis—sometime after the offence, which accounts for Mr. Leclair's ongoing symptoms in custody and in the absence of drug consumption.

Evidence of Dr. Morgan

[89] As stated earlier, Dr. Morgan testified at trial on behalf of the defence. His expert report was marked as Exhibit 24. In addition to reviewing the large body of documentary material, including substantial clinical records, Dr. Morgan also conducted two interviews with Mr. Leclair. The first interview was a 3-hour, in-person interview at the Prince George Regional Correctional Centre on March 22, 2019. The second interview was a 90-minute interview conducted by videoconference on September 11, 2020. Dr. Morgan explained that Mr. Leclair behaved differently across the two interviews. He explained that while he assumed Mr. Leclair participated in the interviews to the best of his ability, he did not rely only on those interviews to form his opinion. Rather, cognizant of the discrepancies between the two interviews, Dr. Morgan considered the interviews together with the collateral information and testimony at trial to inform his opinion.

[90] Dr. Morgan acknowledged that chronic methamphetamine psychosis is indistinguishable—both genetically and phenomenologically—from schizophrenia.

[91] Based on his comprehensive review of the information available to him together with his interviews of Mr. Leclair and his observation of Mr. Leclair's testimony at trial, Dr. Morgan formed the opinion that Mr. Leclair qualifies for a diagnosis of schizophrenia. Considering Mr. Leclair's family history of schizophrenia, the nature of the symptoms he experienced, and the fact that the symptoms continued for more than one month after his remand into custody, Dr. Morgan opined that he met the DSM-V criteria for a diagnosis of schizophrenia. He opined that Mr. Leclair has numerous other medical conditions including attention deficit hyperactivity disorder, learning disorders, depression, anxiety, severe alcohol use disorder, and severe stimulant use disorder. Dr. Morgan acknowledged that Mr. Leclair's substance use would make his mental state much worse.

[92] Dr. Morgan applied a longitudinal methodology to assess Mr. Leclair – in other words, he considered things that happened over time to form an evolving and holistic picture of Mr. Leclair's condition. In his words:

> … if you look at any one piece of evidence on its own, you could pick holes in it. But if you look at it in totality, a picture emerges.

[93] The things Dr. Morgan considered to form this holistic picture included Mr. Leclair's developmental history, his upbringing, and his family history of schizophrenia. He also considered Mr. Leclair's historical presentation to services, as this provided Dr. Morgan with a picture of how Mr. Leclair presented to different people throughout his life. Similarly, he considered the reported changes in Mr. Leclair's mental state leading up to the incident, his mental state at the time of the offences, and his presentation following the offences, including during his post-arrest detention. Dr. Morgan explained that this process gives him insight into the evolution of Mr. Leclair's clinical presentation. In addition to Mr. Leclair's self-reported symptoms, he also considered collateral information, such as Mr. Leclair's journal, which he noted provided a "picture from his own mind of what was happening in the lead-up to this offence". Based on all of this information, Dr. Morgan formed the opinion that Mr. Leclair's schizophrenia likely became more severe by April 2018.

[94] Important to Dr. Morgan's assessment is the fact that while Mr. Leclair has a long history of substance abuse, he has not been consistently psychotic. Dr. Morgan explained that based on his review of the collateral information, including clinical records, Correction Service of Canada records, and a pre-sentence report, there was no suggestion that Mr. Leclair was psychotic prior to 2016, even though he was using substances in this period. From Dr. Morgan's review of the documentary records prior to 2016, which I note is consistent with Dr. Lamba's evidence, there was no notation of any symptoms – either positive or negative – of psychosis. Dr. Morgan explained that the DSM-V identifies "positive symptoms" of psychosis as symptoms that are *superimposed* on normal mental functioning – such as hallucinations, delusions, and disorganized thought processes. Negative symptoms, on the other hand, are a "defect state" where a person *lacks* normal function – for example, poverty of thought, poverty of speech, and poverty of emotion. Dr. Morgan explained that negative symptoms are "a progressive and inexorable deterioration" (or a loss of) that person's normal mental functioning.

[95] Dr. Morgan opined that Mr. Leclair was suffering from psychotic symptoms in the months, and possibly years, leading to the offence. He said these symptoms developed against a long-term pattern of paranoid thinking. Dr. Morgan also noted that there was a significant change in Mr. Leclair's behaviour at least by 2018. He considered the entries in Mr. Leclair's journal regarding his time at Aspen Heights as an example of this behavioural change. For example, Dr. Morgan found the entries describing people messaging Mr. Leclair through Google, hacking into his accounts, and threatening him demonstrated that Mr. Leclair was scared and believed his life was in danger. Dr. Morgan opined that this was a pronounced deterioration in Mr. Leclair's mental state; it was evidence that Mr. Leclair's delusions had become systematized – or highly developed and organized.

[96] Dr. Morgan explained that Mr. Leclair's system of delusions was constantly evolving, with more people from his social circle becoming drawn in over time. For example, in a journal entry, Mr. Leclair notes that things are getting worse with reference to his belief that "Mike" and "Sharon" were plotting against him.

Dr. Morgan also noted the journal reference to the Illuminati and that when Mr. Leclair was asked about that entry at trial, he said "I don't want to get into trouble. I don't want to talk about that". In Dr. Morgan's opinion, the fact that Mr. Leclair's concern about the Illuminati prevailed—even when he was on trial for murder—demonstrates that he was not thinking rationally, and that he was ill.

[97] Dr. Morgan considered Mr. Leclair's attendance at the Emergency Room on June 15, 2018 and his repeated attendance at both the R.C.M.P. and Emergency Room in July 2018 as further evidence that he was experiencing persecutory delusions throughout this period. He noted that although Mr. Leclair was diagnosed with drug-induced psychosis, he was prescribed olanzapine, an anti-psychotic drug. Dr. Morgan explained that if Mr. Leclair's psychosis was the result of drug use, then the psychosis would be expected to resolve once the drug wears off without the need for ongoing anti-psychotic medication. Dr. Morgan inferred that anti-psychotic medication was prescribed because there was a concern the psychosis would continue.

[98] Further, although the clinical records noted that no overt signs of psychosis were observed as of July 16, 2018, Dr. Morgan explained that this does not mean Mr. Leclair was not psychotic at that time. He noted that the nursing staff had minimal interaction with Mr. Leclair around this time, as he was in seclusion. This made a conclusion about psychosis difficult because, in Dr. Morgan's words, "usually you realize people are psychotic and unwell by talking to them". Similarly, while Mr. Leclair presented as calm but evasive with the police during these encounters, there was clearly "something going on underneath the surface": Mr. Leclair had repeatedly sought help from the police due to his acute fear that his life was in danger. Dr. Morgan opined that "what's going on in his head may not be apparent on the outside". He noted that Mr. Leclair was "a very closed book, and it will probably take a long time to talk to him to understand exactly what is going on" because he "doesn't speak freely" and often refuses to answer questions, stating "I can't talk about that".

[99] Dr. Morgan also reviewed and considered the video of Mr. Leclair's presentation at the R.C.M.P. detachment when he was arrested. Dr. Morgan described Mr. Leclair as "confused, disoriented, hyperventilating and making very, very strange noises". He said Mr. Leclair's repetition of the name "Steve" was abnormal. He believed this was a "perseveration", which he explained is when "a person gets stuck" and repeats the same word over and over again. He noted that Mr. Leclair's presentation was very unusual and he could not explain it – it was "almost consistent with delirium".

[100] Dr. Morgan opined that Mr. Leclair developed persecutory delusional beliefs as a direct result of his hallucinations. He explained that delusions are a "fixed, false belief which is held with unshakeable conviction". It is Dr. Morgan's opinion that Mr. Leclair developed persecutory delusional beliefs after experiencing auditory hallucinations that spoke to him in an extremely threatening manner, as described in his journal entries. Dr. Morgan opined that these psychotic symptoms were due to an illness and not just because of Mr. Leclair's drug use. Considering that Mr. Leclair's symptoms continued for months after the offence while he was in a controlled environment, without access to intoxicants, Dr. Morgan concluded in his report:

> In my clinical opinion, in Mr. Leclair's case the psychotic symptoms which developed were more severe, and of longer duration, than one would ordinarily expect to have occurred purely as a result of substance use, particularly given the short half-life of stimulants in the body…

[101] While Dr. Morgan acknowledged that there is a very close relationship between the psychosis and substance use prior to the offence, he concluded that Mr. Leclair had a schizophrenic illness. In reaching this conclusion, he considered Mr. Leclair's family history of schizophrenia, the nature of the symptoms he experienced, and the fact that these symptoms continued for more than one month after his remand into custody, when drug tests confirmed that Mr. Leclair was not using stimulants or cannabis, which he said pointed "strongly towards an illness". The family history of schizophrenia included the fact that his aunt, a second degree family member, has schizophrenia. Mr. Leclair's symptoms included both delusions

and hallucinations, which are both psychotic symptoms indicative of a schizophrenic illness.

[102] Dr. Morgan also opined that Mr. Leclair would have been capable of appreciating the nature and quality of his actions at the time of the incident and that they were *legally* wrong – he noted in his report that Mr. Leclair “was able to foresee the physical consequences of his actions and knew what he was doing”. However, Dr. Morgan’s opinion was that the intense fear that arose from Mr. Leclair’s psychotic symptoms overwhelmed his ability to understand that his actions were *morally* wrong. Dr. Morgan testified:

> He believed that his life was [threatened]; that he was going to be killed; that the people closest, the nearest, and dearest two people were involved and that was the factor that ultimately drove his behaviour.

[103] The Crown expert, Dr. Lamba, opined that Mr. Leclair could be experiencing “pseudohallucinations” from his substance abuse. The difference between these two phenomena is that while a person experiencing a true hallucination believes it to be “absolutely real”, a person experiencing a “pseudohallucination” has greater awareness and greater insight. Dr. Morgan explained that to determine whether something is a “pseudohallucination” or a real hallucination, the most important thing is the behavioural response that arises *from* the hallucination. He explained that in Mr. Leclair’s case, what arose from the hallucinations were persecutory beliefs and fear: “from the auditory hallucinations he was experiencing, he developed persecutory delusional beliefs. And from those persecutory delusional beliefs came overwhelming fear, and that in turn drove his actions”.

[104] Dr. Morgan also explained that the presence of voices is one symptom that would support a diagnosis of schizophrenia. He explained that it is most often more than one voice – in his words, “they are voices, plural, usually in the third person, which argue, discuss, or provide a running commentary on the person’s actions”. He explained that hearing voices is a “Schneiderian first-rank symptom”, which I understand is a diagnostic tool other than the DSM-V.

[105] The foundation supporting Dr. Morgan's opinion was not undermined despite extensive cross-examination. For example, Dr. Morgan was challenged on the basis that he relied on Mr. Leclair's self-report of hearing a voice to conclude Mr. Leclair experienced hallucinations or thought insertion. However, Dr. Morgan was clear throughout his testimony that his opinion was not grounded only on Mr. Leclair's self-reports, and rather, his opinion was "predominantly grounded in the collateral information". He emphasized that his opinion with respect to thought insertion and hallucinations, for example, was supported by the assessment of Dr. Udumaga, an independent psychiatrist who was not involved in the legal process, who diagnosed Mr. Leclair with schizophrenia two weeks after the offence based on these same symptoms. He noted that Mr. Leclair reported the same thing in his interview with Dr. Udumaga on August 4, 2018 as he had reported to Dr. Morgan in his interview: he said he heard a voice called "Vincent" who put thoughts into his head. What was important to Dr. Morgan was not the name of the voice, but that Mr. Leclair had described on both occasions that the voice "[put a] thought into his head that was not the product of his own mind, and that's thought insertion". As I have already discussed, the name Vincent first arose at the time of Mr. Leclair's arrest when Cpl. Pelletier addressed him as Vincent. Dr. Morgan was careful not to rely on information that had no support in the collateral record – for example, he stated that although Mr. Leclair told him that Vincent would take over Mr. Leclair's body, Dr. Morgan attached no significance to this report because it was not supported in the collateral record.

[106] Dr. Morgan also addressed an inconsistency in Mr. Leclair's evidence – namely, Mr. Leclair had told Dr. Lamba he began hearing voices when he was 17 or 18 years old, and testified to this effect at trial, but this was inconsistent with what he told Dr. Morgan. Dr. Morgan said he could not reconcile the two accounts without speaking further to Mr. Leclair. However, he noted that the reports of hearing a voice at 17 or 18 did not appear to be related to substance use and could be stress related.

[107] Dr. Morgan had a number of compelling reasons for concluding that the psychosis resulted from Mr. Leclair's schizophrenia rather than his drug use, which I accept. For example, he emphasized that his review of the materials showed no significant evidence of psychosis until some years prior to the incident, despite chronic drug use in this same period.

[108] Additionally, Dr. Morgan explained that there are two factors that help to differentiate clinically between schizophrenia and methamphetamine-induced psychosis: the presence of "negative symptoms" and "genetic loading" for schizophrenia. Dr. Morgan testified that according to the literature, negative symptoms, such as blunt affect, are particularly associated with schizophrenia or a psychotic disorder, but "[n]ot so much with a meth-associated psychosis". Likewise, he explained that schizophrenia has a strong genetic—or inherited—component, which makes the disease more prevalent amongst biological relatives: While the risk of developing schizophrenia for a member of the general population is approximately 1%, the risk rises to 2.4% for a person like Mr. Leclair whose second-degree relative has schizophrenia. In other words, a person in Mr. Leclair's situation is more than two times more likely to develop schizophrenia when compared to the general population, although Dr. Morgan explained that the genetics of schizophrenia are nuanced.

[109] Dr. Morgan also explained that the cause of schizophrenia is unknown; therefore, schizophrenia is not understood in terms of causation. He explained:

> Let me give an example … it would be akin to jaundice. The causes of jaundice are legion, you cannot find one specific cause, it could be a neoplasm, it could be an obstructing stone, it could be an infected process. Schizophrenia similarly is not understood in terms of causation. We have factors which are associated with an increased risk at the population level, but ... it is not a well-understood disorder.

[110] He agreed that consuming methamphetamine over a long period of time could cause a person to develop schizophrenia. However, he stressed that his review of the totality of the evidence – including the presence of negative symptoms

and the genetic predisposition in Mr. Leclair's case – led him to the opinion that "this is a primary psychotic disorder and not a substance induced disorder".

[111] With respect to the observations recorded in the various clinical records, Dr. Morgan explained that psychotic symptoms are not constant at all points in time. Rather, the presentation of psychosis "waxes and wanes in intensity"; therefore, sometimes the symptoms will be reflected in the records, and sometimes they won't. He observed that while he extracted negative symptoms from the records, Dr. Lamba did not appear to do so.

[112] Dr. Morgan was not prepared to conclude that Mr. Leclair was malingering because he could not provide any details of the incident: Rather, he said that if Mr. Leclair was malingering, he was "doing a very, very convincing job" and that Dr. Morgan had "never seen a job that convincing". Dr. Morgan described Mr. Leclair as a complex individual, and observed that it was "clear throughout the record that he has problems relaying information". From his review of the circumstances of the incident, Dr. Morgan concluded that it was a frenzied attack driven by emotion. He explained that Mr. Leclair's behaviour was not driven by his delusional beliefs; rather, the driving force was the emotion that resulted from these beliefs. In Mr. Leclair's case, the intensity of his fear overwhelmed his ability to understand that his actions were morally wrong. His behaviour was driven by fear for his life.

Evidence of Dr. Lamba

[113] The Crown called Dr. Lamba as a rebuttal witness. His expert report, dated February 6, 2021, was marked as Exhibit 26. His preliminary report, dated September 28, 2020, was marked for identification. Dr. Lamba reviewed a large body of documentary material including the clinical records reviewed by Dr. Morgan. Dr. Lamba interviewed Mr. Leclair on July 17, 2020. The three-hour interview was conducted by video while Mr. Leclair was being held at the Quesnel R.C.M.P. detachment.

[114] In Dr. Lamba's expert report, he identified several possible diagnoses. He recognized that this was a complicated case due to Mr. Leclair's long history of

stimulant use disorder, noting in his report that "it is well known that stimulants such as cocaine and amphetamines cause psychosis, as symptoms of acute intoxication, as drug induced psychosis and as more persistent psychosis". He also explained that stimulant-induced psychosis was dose dependent, meaning that "those who use higher quantities for longer durations are more likely to experience psychosis". Dr. Lamba acknowledged that it can be difficult for a clinician to disentangle the precise cause of psychosis—psychosis could be caused by an underlying primary psychotic illness, or it could be acute stimulant intoxication (with psychosis lasting days), or stimulant-induced psychosis (with psychosis lasting weeks). He noted that it was also possible for chronic use of stimulants to lead to persistent psychosis, which Dr. Lamba would diagnose as "Other Specified Schizophrenia Spectrum" and "Other Psychotic Disorders" by the DSM-V.

[115] In his report, Dr. Lamba considered whether Mr. Leclair's chronic and heavy use of illicit stimulants had induced a persisting psychotic disorder, particularly after he started using crystal methamphetamine. He concluded that if Mr. Leclair felt paranoid and heard voices even during periods of abstinence, then this resulted from his repeated bouts of acute intoxication or drug-induced psychosis, either alone or in combination. In his report, he concluded that Mr. Leclair likely had drug-induced persistent psychotic disorder at the time of the offence but that it went undiagnosed because of his repeated bouts of heavy drug use resulting in psychotic symptoms. He concluded that prior to the offence, "he did not have persistent methamphetamine induced psychosis" because he was in remission after the episode that resulted in his hospitalization from July 12-17, 2018.

[116] In testimony, Dr. Lamba explained that his opinion had evolved since he wrote his report and that he now believed Mr. Leclair likely had a vulnerability to persistent methamphetamine induced psychosis at the time of the offence, which resulted from sensitization. Dr. Lamba clarified his opinion, further explaining that at the time of the offence "persistent but temporary psychosis had not yet manifested, but likely the propensity to it, the vulnerability to it, had likely been created at that point already". It was his opinion that Mr. Leclair's drug use had sensitized him—or

made him more vulnerable—to this kind of psychosis. He explained as follows in his testimony:

> [T]he changes in the brain being created by chronic drug use… lead to sensitization and a drug-induced vulnerability. The drug induces its own vulnerability to psychosis.
>
> …
>
> [S]o future use would be more likely to… cause psychosis, to induce a psychotic episode. And again, the question is how much use. A small amount, or a large amount? I think that even a small amount would, and certainly a large amount would… but even a small amount could.

[117] Because Mr. Leclair's psychotic symptoms persisted for months after the offence and after his cessation of drug use, Dr. Lamba would diagnose Mr. Leclair with chronic crystal methamphetamine psychosis. He explained that under the DSM-V, chronic crystal methamphetamine psychosis was classified as "other specified schizophrenia spectrum" and "other psychotic disorders with attenuated psychosis".

[118] Dr. Lamba explained that the process of sensitization is an internal biological process that happens within the brain, and that it is "believed to be caused by neurotoxicity and impact on receptors, impact on transmitters". In other words, external drug use triggers an internal cause for the psychosis. He also explained that as a biological process, it impacts the regulation of receptors in the brain resulting in psychosis with even a small dose of a drug (cocaine or methamphetamine). In his report, he explained that because Mr. Leclair had experienced one bout of acute psychosis precipitated by crystal methamphetamine, "he is now more prone to develop psychosis… as a response to stress in the absence of drugs or to the use of even small amounts of drug". In other words, "chronic drug use could [be] said to have induced a 'disease of the mind' or 'mental disorder'". He noted that it takes, on average, about 1.7 years after the onset of regular use to develop persistent psychosis. He explained that after a number of years of abstinence from the drug, the neurotoxicity in the brain can heal, but that the vulnerability to develop psychosis remains—psychosis could be caused by re-exposure to stimulants or by "plain stress" in the absence of drugs.

[119] One factor that informed Dr. Lamba's opinion regarding the development of sensitization was his consideration of the clinical reports from July 12, 2018 until the time of the incident—this period included Mr. Leclair's visit to the Emergency Room, his discharge, and the four days leading up to the offence. Given that there were no reports of Mr. Leclair experiencing psychotic symptoms in the four days prior to the incident, Dr. Lamba assumed Mr. Leclair's psychosis was in remission. This assumption was vigorously challenged on cross-examination and although Dr. Lamba did not resile from his opinion, I agree with defence counsel that there is a fundamental flaw in this reasoning. Dr. Lamba's assumption is based on there being no record of Mr. Leclair experiencing psychosis in this time frame. I agree with defence counsel that the absence of a record does not establish that Mr. Leclair was not psychotic at the time: Dr. Lamba equates the absence of evidence with evidence of absence. In my view, this flawed assumption detracts from the weight of his opinion.

[120] Dr. Lamba agreed with Dr. Morgan that there is evidence to suggest Mr. Leclair held persecutory ideas that people wanted to kill him; however, he dismisses these as being the acute effects of substance use. Dr. Lamba considered Mr. Leclair's journal entries and his presentation at the R.C.M.P. and Emergency Room on June 15, July 12, and July 13, 2018. While he acknowledged that these ideas could have been delusionary, he concluded that they occurred during periods of daily use of crack cocaine. Therefore, Dr. Lamba was unable to determine the strength of Mr. Leclair's belief and whether it was indeed a delusion—a false, fixed belief.

[121] Another factor that influenced Dr. Lamba's opinion was the fact that Mr. Leclair chose to live with Mr. Potter and Sharon Tobin after he was discharged from hospital, despite his expressed belief that they were against him. Dr. Lamba opined that if Mr. Leclair had delusional beliefs, he would not voluntarily return to the residence of the people he thought were a threat. In my view, Dr. Lamba failed to consider the fact that Mr. Leclair had no other viable option. His mother was out of town and he was concerned that many of his friends, including Jessica Penner,

posed a threat. In addition, Mr. Leclair has a chronic drug addiction and Mr. Potter presented an easy source for crack cocaine. Dr. Lamba acknowledged the evidence that Mr. Leclair experienced paranoid thoughts about people wanting to hurt him, including Michael Potter and Sharon Tobin; however, he could not conclude that these were delusions because he was unable to determine either the intensity or duration of the thoughts. As I noted earlier, given Mr. Leclair's circumstances at the time, I do not find Mr. Leclair's decision to return to live with Mr. Potter and his aunt was evidence that he did not have concerns for his safety.

[122] While Dr. Lamba's revised opinion was that Mr. Leclair had developed a vulnerability to drug-induced psychosis, he was unable to provide an opinion as to Mr. Leclair's mental state at the time of the offences. In particular, he could not opine as to whether Mr. Leclair had signs of psychosis at the time of the offences—whether drug-induced or schizophrenia-based—as he found there was insufficient information to form a conclusion about this period of time.

[123] Dr. Lamba's opinion was also informed by the evidence of Mr. Leclair's behaviour during the time of the offence, as reported by Sharon Tobin. While Dr. Lamba acknowledged that Mr. Leclair's actions might be consistent with his paranoia that Michael Potter and Sharon Tobin were a threat, he concluded that fear did not account for his actions.

[124] Dr. Lamba also considered Mr. Leclair's behaviour immediately after the incident. He opined that Mr. Leclair's words and actions when speaking to Mr. McMurray and then to his mother on the phone indicate that he understood what he had done and was aware of both the legal and moral wrongfulness. He notes in his report:

> Immediately after the incident, Mr. Leclair left the house and drove himself to Mr. McMurray's house, and said to Mr. McMurray that he was in trouble, and reported that he had killed his uncle, and attacked his aunt as well, but that she had run away. He was asking for a change of clothes and for gas. Mr. McMurray asked him to call his mother and Mr. Leclair did call his mother, telling her what he had done. He was quite aware of what had happened and that he was in trouble. He was persuaded by Mr. McMurray to give him self up to the police. Mr. Leclair drove himself to the RCMP detachment station in

> Quesnel and surrendered himself. There is good indication that he was aware of the wrongfulness of his actions, both morally and legally, immediately after the incident, which was minutes after the very time of the offence.

[125] He viewed the fact that Mr. Leclair was unable to describe what took place as inconsistent with someone who had experienced a profound event. Dr. Lamba opined that if Mr. Leclair experienced a delusion at the time of the offence that led him to act the way he did, the delusion would have been profound and subjectively important to him at the time, and one would expect him to be able to describe it. Based on all of these considerations, Dr. Lamba concluded there was no indication that Mr. Leclair could not appreciate the wrongfulness of his actions at the time of the offence.

[126] Dr. Lamba was cross-examined extensively over several days regarding the foundation for his opinion, and the cross-examination raised significant difficulties with this foundation. While I do not propose to review all of the evidence from Dr. Lamba's cross-examination, I will discuss the areas that impact the underpinnings for his opinion. I have already discussed the flaw in Dr. Lamba's assumption that Mr. Leclair was in remission in the days prior to the incident, and I agree with defence counsel that Dr. Lamba's conclusion to this effect was purely speculative. What I find most troubling about Dr. Lamba is that his opinion hinges on this problematic assumption, which I find is unsupported in the evidentiary record. I do not find that Mr. Leclair's psychotic symptoms abated during this period, but even if they had, I consider that, rather than indicating remission, this would be more consistent with Dr. Morgan's evidence that the presentation of psychotic symptoms "waxes and wanes"; the symptoms are not constant over time. Considering all of these factors, I find no support for Dr. Lamba's finding that Mr. Leclair was in remission.

[127] I also found Dr. Lamba's evidence internally inconsistent and difficult to reconcile. For example, his assumption that Mr. Leclair's psychotic symptoms had abated in the nights leading up to the offence, even if I had accepted this to be true, would seem to contradict his own theory of sensitization. Dr. Lamba acknowledged

that Mr. Leclair used drugs on a nightly basis immediately before the offence. Yet, he advanced a theory of sensitization and, when asked about future consumption of drugs after the alleged remission on July 17, 2018, opined that even a small amount of drugs could, “and certainly a large amount would”, trigger psychosis. Yet, he opined that Mr. Leclair—a person who he accepted used drugs on a nightly basis between July 17 and July 21, 2018—experienced no psychosis in that same period, as he was in remission. Although, as noted, I do not accept that the symptoms abated in this period, I observe that Dr. Lamba’s opinion in this regard contradicts itself.

[128] I had numerous and significant difficulties with the factual foundation of Dr. Lamba’s report, as I found that on multiple occasions, he disbelieved or dismissed evidence of Mr. Leclair’s symptoms without providing an adequate explanation for doing so. This prevents me from relying on his report in these areas. For example, Dr. Lamba was challenged during cross-examination about why he did not believe Mr. Leclair had experienced hallucinations. Dr. Lamba had dismissed Mr. Leclair’s reports to both the R.C.M.P. officer and nurse Myers that he observed threatening writing on the back of a watch. He was pressed on this issue in cross-examination and maintained that since there was no “objective evidence” of a hallucination at the time nurse Myers prepared the report, Mr. Leclair was likely experiencing a pseudohallucination. In his words:

> The objective evidence of a hallucination is … how they are distracted, how their gaze moves back and forth, how this individual respond[s] to something in their outer space. Those are your objective indicia that speak to perception disturbances.

[129] However, as noted above, the nurse’s notes at that time describe Mr. Leclair as making fleeting eye contact, having clenched fists, appearing guarded and suspicious, answering questions somewhat evasively, and having paranoid thoughts. Dr. Lamba says that because the nurse’s notes do not show Mr. Leclair actively reacting to a hallucination while he is being evaluated, there is no objective evidence of a hallucination. This is despite the fact that the report about seeing

writing on a watch pertained to the night before – Mr. Leclair did not say that it was presently affecting him when he arrived at the hospital. Dr. Lamba says:

> So I would like to make, again, the distinction between his subjective report sometime before he came to the hospital, he experienced this. That is his subjective report. ... Now he is in the hospital where he's being objectively assessed. There is no evidence of perceptual disturbance, the kind of indicia I described. Sandra Meyers did not see those.

[130] When pressed further on this point, Dr. Lamba conceded that *if* Mr. Leclair saw something, it would have been a visual hallucination; however, he maintained that it could also be a delusional misinterpretation (meaning that he may have seen something on his watch and misinterpreted it to be the threatening words in question). Dr. Lamba noted that a person can form beliefs or delusions based on their hallucinations, and that there was evidence from nurse Myers' report that Mr. Leclair had "very strong delusions or beliefs". However, Dr. Lamba observed that *at the time* he was assessed, Mr. Leclair was not actively experiencing a hallucination or perceptual disturbance. I accept, based on all of the evidence, that Mr. Leclair experienced a hallucination the night before he arrived at the hospital. I do not draw any inference from the fact that there were no objective indicia of this hallucination when he arrived at the hospital the following day to report having experienced a hallucination the night before.

[131] Likewise, when Mr. Leclair reports that he is being followed, Dr. Lamba's response is, similarly, that there is no objective indicia of this at the time he is assessed:

> The only way I know is because Nurse Meyers concluded that there is no evidence of perceptual disturbances noted or voiced. So she is not observing him respond physically to being followed in the room … by a person or a vehicle. He is not looking behind his shoulder. Those are examples of the areas that could possibly inform an -- an observer, an assessor like Nurse Meyers. So in the context of that assessment she has concluded, in spite of this reported history in the present tense, he is being followed, she has concluded that there are no constructural anomalies noted or voiced, and that is what I base my observations on.

[132] However, as Mr. Leclair's report was not that he was being followed *by someone who was in the room with the nurse at the time of his assessment*, I do not give any weight to the lack of objective indicia of the hallucination at the time he was assessed. Rather, I find that Mr. Leclair reported having hallucinations, and he presented at the hospital with strong beliefs or delusions that were related to these hallucinations. As Dr. Lamba noted, "if a hallucination and delusion coincide with a subject, they reinforce each other and they have more impact on the behaviour of a person". As the evidence was clear that a person with schizophrenia does not experience hallucinations 100% of the time, I do not consider it important that Mr. Leclair was not experiencing hallucinations at the precise time he arrived at the hospital. I accept from the totality of the evidence that he did experience hallucinations.

[133] Dr. Lamba was also challenged about his reluctance to acknowledge negative symptoms and other features associated with schizophrenia in the clinical records pertaining to Mr. Leclair's July 2018 attendance at the Emergency Room. Dr. Lamba reluctantly agreed with defence counsel that some observations could be viewed as negative symptoms or associated features, but did not agree with a diagnosis of schizophrenia.

[134] Dr. Lamba was also challenged about his opinion of Mr. Leclair's presentation during their interview on September 17, 2020. He explained that during the interview, Mr. Leclair responded to his questions by stating "I can't say". Dr. Lamba then asked Mr. Leclair a "random" leading question regarding why people were trying to kill him:

> … what I did was see how he reacts to a leading question or suggestion. And I said to him, around the reason why Sharon and Mike and others wanted to kill him, if that had something to do with some special knowledge or special thing he had. And he agreed -- readily endorsed it, and said "I thought I knew stuff they didn't want me to know."
>
> And so this is, you know, somewhat suspect, in terms of as soon as I give him a suggestion, he endorsed it. "Yes, I knew stuff that they didn't want me to know." The suggestion I had given him was of course quite random and just speculative.

[135] As I understand Dr. Lamba's evidence, the fact that Mr. Leclair agreed with Dr. Lamba's suggestion as to why he was afraid detracts from the veracity of that fear. I find Dr. Lamba's interpretation of this exchange puzzling. From my review of that portion of the interview, Mr. Leclair was simply confirming the basis for his fear that people were out to kill him. Although Dr. Lamba testified that he would ask "a leading question of a random suggestion, a suggestion that I don't know is true", I agree with the defence's submission that the suggestion used was not random, and rather, was consistent with what Mr. Leclair had expressed in his journal and to other people. I also agree with defence counsel that Mr. Leclair's reluctance to discuss the reason for his fear of being killed is consistent with what he told his mother, Ms. Penner, the police officers, and hospital staff he dealt with in July 2018. It was also consistent with what he wrote in his journal in the months leading up to the offence. The fact that Mr. Leclair did not mention the Illuminati during his interview does not detract from the body of evidence that establishes Mr. Leclair had a persisting belief that various people, including a group of people he believed to be the Illuminati, were threatening him. In this regard, I note that in Mr. Leclair's testimony, he explained that he did not want to tell the doctors about his fear of the Illuminati because he thought they could be part of the Illuminati.

[136] I also have concerns regarding Dr. Lamba's assessment of the importance of Mr. Leclair's journal. While Dr. Lamba agreed the journal entries indicate paranoia and an expanding suspicion, he was not prepared to agree with Dr. Morgan's findings that the journal provides evidence of the scope and intensity of Mr. Leclair's delusions. Dr. Lamba testified that the journal does not establish a link between the list of names Mr. Leclair records and his references to the Illuminati. The concern I have with Dr. Lamba's findings is that he does not consider the journal as a whole, nor does he seem to consider it together with other evidence regarding Mr. Leclair's ongoing persecutory delusional belief that he was in danger.

[137] In summary, Dr. Morgan and Dr. Lamba agree that chronic methamphetamine induced psychosis is difficult to differentiate from schizophrenia. Both agree that the DSM-V recognizes both diagnoses as a mental illness and that

either illness can cause psychosis. Both have identified an internal cause mental disorder—either schizophrenia or a sensitization to chronic methamphetamine induced psychosis caused by changes to the brain. Dr. Lamba's own testimony shows this difficulty clearly:

> I would be remiss if I didn't say that there is a section of the literature… that says that chronic crystal methamphetamine psychosis *is* schizophrenia, really; it's not separate.
>
> [Emphasis added.]

[138] Given how difficult it is to distinguish between these two conditions, it is not surprising that Dr. Morgan's diagnosis differs from that of Dr. Lamba. However, I find as a fact that a number of the aspects underpinning Dr. Lamba's opinion were not established in the evidence, as explained above. Accordingly, I attach limited weight to his opinion. I do not have similar concerns with Dr. Morgan's opinion.

[139] As discussed earlier in these reasons, the function of the psychiatrist is to describe the accused's mental condition and how it is considered from a medical perspective. My task is to determine whether the condition Mr. Leclair was experiencing at the time of the offence – whether it be schizophrenia or chronic methamphetamine induced psychosis – is a mental disorder as defined in the *Code.*

<u>Analysis</u>

Stage 1: Was Mr. Leclair suffering from a mental disorder at the time of the offence?

[140] As discussed in *Stone* and *Bouchard-Lebrun*, in order to determine whether a condition amounts to a disease of the mind, a trial judge must take a holistic approach informed by the internal cause factor, the continuing danger factor, and other policy considerations. In doing so, they must take into account the specific circumstances of each case.

Internal Cause Factor

[141] The defence submits that Mr. Leclair suffers from schizophrenia, a mental disorder recognized in the DSM-V, with an internal cause. They say that at the time

of the offence, Mr. Leclair was experiencing psychosis due to his mental disorder. They rely on the opinion of Dr. Morgan, which they submit is supported by the large body of evidence tendered a trial. They say this opinion demonstrates that Mr. Leclair was experiencing psychotic symptoms, including persecutory delusional beliefs, during the relevant timeframe. The defence submits that Dr. Morgan considered Mr. Leclair's chronic substance use in reaching his conclusion. As I have discussed, a comprehensive cross-examination of Dr. Morgan did not detract from the foundation for his opinion. Indeed, Dr. Morgan acknowledged that it is difficult to distinguish between schizophrenia and substance induced psychosis but explained that he reached a diagnosis of schizophrenia because of the presence of negative symptoms and a family history of schizophrenia. Contrary to the Crown's submission, in my view, there is nothing imprecise in Dr. Morgan's opinion.

[142] The Crown submits that Mr. Leclair suffered from persistent stimulant induced psychosis, which they say has an external cause—namely, Mr. Leclair's continued substance use. They say that Mr. Leclair caused neurotoxic damage to his neurotransmitters, which in turn "sensitized" him to experience toxic psychosis with further drug use. They say that "nearly every person who abuses enough stimulants will go on to develop a persisting psychosis", and therefore, the cause of Mr. Leclair's psychosis is external. The Crown submits that it is impossible for early-stage persistent stimulant induced psychosis to be classified as a disease of the mind because "it is impossible for the accused to establish that the psychosis was, 'unrelated to the intoxication-related symptoms' [citing to *Bouchard-Lebrun* at para. 69]". As noted above, I have difficulties with this submission as it seems to ask the court to focus on the internal cause factor in isolation, without approaching the issue holistically as mandated by *Bouchard-Lebrun* – but this is not the test I must apply. The Crown asks me to find that Mr. Leclair's psychosis was caused by his drug use and that it is therefore not a disease of the mind, or that Mr. Leclair was not experiencing psychosis at the time of the offence.

[143] While I respect Dr. Lamba's expertise, I attribute little weight to his opinion in my determination of whether Mr. Leclair was suffering from a mental disorder

because of the flaws I have identified in the underpinnings of his opinion. While I accept that Mr. Leclair had consumed a significant amount of crack cocaine on the evening in question and had a history of chronic substance abuse that could cause substance-induced psychosis, I do not accept that Mr. Leclair's psychosis on the evening in question was due to self-induced intoxication by crack cocaine.

[144] As stated in *Turcotte*, where both mental disorder and intoxication are contributing factors, a nuanced analysis is required to determine what caused the accused's mental condition at the time of the offence (at para. 118). I find the analysis in *R. v. Cramer*, 2014 BCSC 1166 [*Cramer*] and *R. v. Coogan,* 2021 BCSC 217 [*Coogan*] to be of some assistance in my analysis, as both take a nuanced approach to this issue. I recognize, of course, that these cases are not determinative of the issue, given the fact-specific nature of the inquiry.

[145] In *Cramer*, Justice Schultes concluded that the accused's comorbid schizophrenia and chronic crystal methamphetamine use was a disease of the mind; this was not toxic psychosis brought on only by external drug use. The accused was a regular drug user for several years, but on the night of the offence, his crystal meth use was not particularly high. Schultes J. concluded that the accused had underlying schizophrenia or schizoaffective disorder, and that within the context of these underlying illnesses, his meth use "played only a releasing or a contributing role" (at para. 120). In other words, the drug acted as a catalyst, causing him to act out on schizophrenia-related delusions that were already present prior to the offence. Two of the three experts opined that the chronic crystal meth use had caused structural changes to the accused's brain, although one did not arrive at a diagnosis. There was no evidentiary foundation for Schultes J. to conclude that the crystal meth use on the night of the offence was sufficient in magnitude to trigger psychosis even in a person without a mental disorder. Therefore, he found the mental state had an internal cause, and that it was not caused by the crystal meth use alone. He was also satisfied that the accused's severe symptoms and inherent vulnerability to future violence in similar circumstances made him a recurring danger. Accordingly,

the accused had a disease of the mind: This was “not a transitory toxic psychosis brought about only by the external crystal meth use” (at para. 124).

[146] *Coogan* is also instructive, although counsel were in agreement that NCRMD applied in this case. In *Coogan,* the accused was a chronic poly-drug user with a substance abuse problem. He had diagnoses of schizophrenia, ketamine use disorder, and cannabis use disorder. He attacked his brother with a knife during an episode of psychosis, but he was also intoxicated on ketamine at the time. The uncontradicted expert evidence found the source of his incapacity to be primarily the mental disorder; the ketamine intoxication played only a “minor role” (at para. 54). Accordingly, the accused had a disease of the mind within the meaning of s. 16.

[147] I am satisfied that Mr. Leclair had schizophrenia. Although I accept that his substance use could have exacerbated his psychotic symptoms, as Dr. Morgan opines, I do not accept that his drug use *caused* his psychosis. In other words, his drug use may have played “a releasing or a contributing role” or acted as a catalyst, as was the case in *Cramer*, by causing Mr. Leclair to act on delusions already present as a result of his schizophrenia: *Cramer* at para. 120. I find that a person in the same circumstances as Mr. Leclair, who used the same drugs in the same quantities but who did not have underlying schizophrenia, would not have reacted as he did. Indeed, although it is by no means determinative on this point, I accept the defence’s submission that, on various occasions, “Mr. Potter [wa]s a ‘normal person’ using the same amount of cocaine as Mr. Leclair, and there is no evidence he ever entered a psychotic state.” Based upon all of the evidence, I am satisfied that Mr. Leclair’s psychosis had an internal cause.

[148] Given that I accept Dr. Morgan’s evidence that Mr. Leclair had schizophrenia and reject Dr. Lamba’s diagnosis of chronic methamphetamine induced psychosis, it is not necessary for me to consider the legal question of whether chronic methamphetamine induced psychosis has an “internal cause” or constitutes a “disease of the mind” within the meaning of s. 16. However, even if I were required to decide this issue, I note that *Alexander* emphasized the limited utility of the

internal cause approach where the "line between internal and external causes is blurred and it is impossible to classify [a] trigger as internal or external", as it seems would be the case for chronic methamphetamine induced psychosis (at para. 43).

Continuing Danger Factor

[149] With respect to the continuing danger factor set out in *Stone*, I am satisfied that Mr. Leclair's psychiatric history combined with his chronic substance abuse creates a strong likelihood of recurring violence, particularly as I have identified that his substance use may compound the pre-existing psychosis resulting from his schizophrenia. In particular, the fact that Mr. Leclair's psychosis remains active (although somewhat attenuated) more than two years after the offence supports my finding that he presents as a continuing danger. I note that during their submissions, Crown conceded that this factor was established.

Policy Considerations

[150] The relevant policy considerations favour a finding of NCRMD: I have found that Mr. Leclair's psychosis resulted from his psychological make-up and that he presents a continuing danger, and I consider that he may benefit from treatment.

Stage 1 Conclusion

[151] I am satisfied that Mr. Leclair's psychosis was caused by schizophrenia, which I find is a mental disorder within the meaning of s. 16 of the *Code.* I make this legal finding on the basis that Mr. Leclair's disease of the mind had an internal cause, that he presents a continuing danger, and that the relevant policy considerations favour a finding of NCRMD.

[152] Having found that Mr. Leclair's mental condition was a "mental disorder" within the meaning of s. 16 of the *Code*, I turn to a consideration of whether the defence has established on a balance of probabilities that the mental disorder was operative at the time he committed the offence. I find this is proven for the following reasons.

[153] The evidence has established that Mr. Leclair was experiencing psychotic symptoms in the months prior to the offence. These symptoms had escalated in their intensity, particularly in the two weeks prior to the incident. This is clear from Mr. Leclair's repeated attendance at the R.C.M.P., where he sought protection. Similarly, Mr. Leclair had pleaded with Ms. Penner to help him when she spoke to him about a week before the incident. As I have already discussed, the fact that there were no reported psychotic episodes during the four days prior to the incident does not mean his psychosis was in remission. I have considered the unprovoked nature of the attack on Mr. Potter and Sharon Tobin, with whom Mr. Leclair otherwise reportedly had a good relationship.

[154] While Mr. Leclair was not able to provide many details regarding what took place, Sharon Tobin described him as appearing furious. Mr. Leclair's journal indicated that he believed both Mr. Potter and Sharon Tobin were part of the conspiracy to harm him. Mr. Leclair testified that he went to Mr. McMurray's house immediately after the offence because he wanted to speak to Ms. Penner and ask her if she had anything to do with things that were going on. As noted above, when asked what he was thinking about, Mr. Leclair stated:

> I thought -- I thought that she might'a -- I thought she had something to do with it and I know it sounds bad, but I wanted to hurt her too.

[155] Mr. Leclair's concern that Ms. Penner was involved in the conspiracy to harm him was consistent with how Ms. Penner described his behaviour when she encountered him. It was also consistent with the entries in his journal.

[156] I have also considered Mr. Leclair's presentation at the R.C.M.P. detachment when he was arrested and his interaction with the police officers and paramedics. He was in an extremely distressed state, moaning and hyperventilating. He was disoriented as to time and place.

[157] Considering Mr. Leclair's presentation before, during, and immediately after the incident, I am satisfied that Mr. Leclair was suffering from a mental disorder, schizophrenia, at the time these tragic events occurred. I am satisfied that the

evidence has established that Mr. Leclair was actively psychotic at the time of these offences.

Stage 2: Did Mr. Leclair's mental disorder render him incapable of knowing his actions were morally wrong?

[158] Defence counsel conceded that Mr. Leclair knew the nature and quality of his acts, but they submit that Mr. Leclair lacked the capacity to know that his acts were morally wrong due to his mental disorder. The Crown submits Mr. Leclair knew that his acts were both legally and morally wrong.

[159] In determining whether an accused was incapable of knowing the act was wrong, Justice McLachlin (as she then was) emphasized that "[t]he crux of the inquiry is whether the accused lacks the capacity to rationally decide whether the act is right or wrong and hence to make a rational choice about whether to do it or not": *Oommen* at 518.

[160] The Crown submits that Mr. Leclair's admission to Mr. McMurray—his statement that "I'm in trouble. Like I fucked up bad this time"—demonstrates that Mr. Leclair not only knew what he did, but that he knew it was both legally and morally wrong. They submit there is no other interpretation of "I fucked up": It is an admission of moral culpability. They say his admission to his mother further supports their position. I cannot agree.

[161] In my view, the present case is similar to the circumstances in *Oommen.* In *Oommen*, the accused believed that his life was in imminent danger when he shot and killed a young woman who was sleeping in his apartment. The Court found that "this delusion would have deprived the accused of the ability to know that his act was wrong; in his eyes, it was right" (at 522-523). Similarly, in *Szostak*, the court accepted that the accused's mental disorder caused a fixed delusional belief that deprived him of the ability to rationally evaluate his conduct and know that his acts were morally wrong. He "did have a general understanding of the difference between right and wrong and even appreciated that his actions were illegal", however, he "felt

compelled to threaten and harass the complainant to protect his son and believed he was justified in taking this course of action" (at para. 57).

Stage 2 Conclusion

[162] Here, as in *Oommen* and *Szostak*, Mr. Leclair's delusions compelled him to act the way he did. He thought he was in imminent danger of being killed by Michael Potter and Sharon Tobin, who he believed were part of a conspiracy to harm him. I accept that Mr. Leclair's mental disorder had become so severe at the time of the offence that it deprived him of the mental capacity to know that his actions were morally wrong. While he might have had the "intellectual capacity to know right from wrong", he lacked "the capacity to apply that knowledge to the situation at hand": *Oommen* at 523.

[163] As the evidence demonstrates, Mr. Leclair had become increasingly convinced that his life was in danger and that he was about to be killed – Dr. Morgan testified that "things [were] happening to him that he [did] not understand and [that were] … making him incredibly fearful for his own life". As Dr. Morgan wrote in his report, "[h]is fear was so severe that it overwhelmed his morals, and led to his acting violently to preserve his life".

[164] I find that Mr. Leclair lacked the capacity to know that his actions were morally wrong. As in *Oommen*, he "was deluded into believing that he had no choice but to kill" (at 523).

Disposition

[165] In conclusion, having considered all of the evidence, I find that Mr. Leclair has established on a balance of probabilities that he was suffering from a mental disorder when he committed the offences. I find his mental disorder rendered him incapable of knowing that his actions on July 21, 2018 were morally wrong.

[166] Therefore, I find that Mr. Leclair is not criminally responsible on account of mental disorder.

[167] I decline to exercise my discretion to hold a disposition hearing. Instead, I refer this matter to the Review Board pursuant to s. 672.45(1.1) of the *Code*. Accordingly, pursuant to s. 672.47(1) of the *Code*, the Review Board shall hold a hearing and make a disposition 45 days after this verdict has been rendered.

[168] I also order that Mr. Leclair be confined to the Forensic Psychiatric Hospital pending his disposition hearing, pursuant to s. 672.46(2) of the *Code*.

[169] I order that any transcript of the proceedings, a copy of these *Reasons for Judgment*, any other document or information related to the proceedings, and all exhibits filed with it be sent to the Review Board without delay pursuant to s. 672.45(1.1) of the *Code*.

[170] I wish to direct these comments to all of those who are present or have been impacted by this tragic event. I am mindful that this decision will not possibly remedy the feeling of pain and suffering you have endured and will continue to endure due to the horrible events that unfolded that evening, which resulted in the loss of Michael Potter and the vicious attack on Sharon Tobin.

[171] Mr. Leclair, the matter before me has come to an end. I have no doubt that these legal proceedings have been a long and difficult process for you personally. I wish you the best going forward.

[172] Thank you, counsel, we may adjourn.

“Devlin J.”