RPP 15

RPP S.37 S.41

The First-tier Tribunal (Health, Education and Social Care Chamber) Mental Health

The Tribunal Procedure (First-tier Tribunal) Health Education & Social Care Chamber Rules 2008

Case Number: MP/2010/19311
Date of Application: 3rd April 2009

Restricted Patient: Albert Laszlo Haines (born 2/12/1959)

A patient now liable to be detained under Section 37 Mental Health Act 1983
And subject to a Restriction Order under Section 41 Mental Health Act 1983

Responsible Authority: West London Mental Health Trust
Hospital: Broadmoor

Before:

HH Judge R.J. McGregor-Johnson (Judge)
Dr. G.S. Feggetter (Tribunal Medical Member)
Mr J. Kinsella (Tribunal Member)

Sitting at Field House on 27th and 28th September 2011
Name of Tribunal Clerk: Beth Partner

Rule 34 Preliminary Medical Examination

The Tribunal Medical Member undertook an examination of the patient and the patient's records, in accordance with Rule 34, on 25th September 2011.

Attendance and Representation

The Patient attended the hearing
The Patient: Aswini Weereratne
The Responsible Authority Vikram Sachdeva
The following persons also attended the hearing: the witnesses (as below), Penny Letts (AJTC), members of the press and public

Decision

The patient shall NOT be discharged from liability to be detained.

The decision was not announced at the hearing.

The Tribunal considered:

Oral evidence from Dr Romero-Urcelay, Ann White, Alice Froyle, Jonathan Watkins, Kim Lansiquot, Leigh Moore (brother)

Written evidence from Dr Payne, Dr Vermuelen, Dr Owoso, Dr Isherwood, Dr Das/Dr Sengupta, Dr Mulligan, Dr Romero, Dr Coxell, Natalia Mziba, Jimmy Lucas, Sophie Cordingly, Janice Ainsworth, Anne White, Salil Mazumdar, Therese Joseph, Mr Haines, Dr Lock, Dr Exworthy, Prof. Grubin, Jonathan Watkins, Kimberley Lansiquot

Other material, namely Statements of Secretary of State, medical records.

Legal Grounds for the Tribunal's Decision

1. The tribunal is satisfied that the patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to be liable to be detained in a hospital for medical treatment
2. The tribunal is satisfied that it is necessary for the health or safety of the patient and for the protection of other persons that the patient should receive such treatment.
3. The tribunal is satisfied that appropriate medical treatment is available for the patient.

Brief History and Summary of Key Issues, Evidence and Submissions

4. Mr Haines has been detained under s.37/41 Mental Health Act 1983 since October 1986, initially at Broadmoor Hospital, then between 1992 and 2008 at Three Bridges, and from early 2008 to date again at Broadmoor Hospital. The index offences were of attempted wounding, which occurred when he tried to attack a doctor and a nurse at the Maudsley hospital with a machete and a knife. The move back to Broadmoor took place after an incident at Three Bridges when having been placed in seclusion after arming himself with a fire-extinguisher as a weapon he climbed into a roof space.
5. Mr Haines was for many years found to be suffering from both mental illness and psychopathic disorder, but in 2008 under the law as it then stood he was re-classified as suffering only from psychopathic disorder.
6. More recently the opinion has been expressed that he does suffer from a mental illness, as well as from a personality disorder, but that is the subject of dispute. During 2011 partly by reason of re-organisation at Broadmoor Hospital, but also on clinical grounds he has been moved several times between wards.
7. Mr Haines asked the Tribunal to grant him an absolute discharge. On his behalf it was submitted that in the alternative we should grant a conditional discharge, which would have to be deferred. Mr Haines asked us to discharge him to his brother's house, or failing that to a hostel.
8. Dr Romero-Urcelay both in his reports and his oral evidence said that Mr Haines suffers from a personality disorder with prominent features of emotionally unstable personality disorder and antisocial personality disorder. This was the unanimous evidence from all of the psychiatric reports before us, including those of Dr Lock and Dr Exworthy who had been instructed on behalf of Mr Haines in 2007 and 2009 respectively. It is described as early-onset, pervasive, and interfering with relationships between himself, his family, society in general, and those who attempt to treat him. Mr Haines' childhood experiences of deprivation and abuse are regarded as highly significant in this regard, and the records demonstrate a conduct disorder in his early years. This personality disorder has manifested itself in the many incidents over the years which are fully

documented in the many reports before us. Mr Haines is described as aggressive and confrontational; he is controlling, both in conversation and physically; he has been the frequent target over the years of assaults by others, often in the context of his behaviour having provoked a violent reaction in others. Since Mr Haines' return to Broadmoor, he has consistently refused to engage in any form of psychological therapy. Dr Romero-Urcelay told us that Mr Haines has been fixated on the tribunal process, which chimed in with the observation of the medical member at the preliminary examination of Mr Haines being very rigid in his thought processes and wishing to control the interview.

9. As to mental illness, Dr Romero-Urcelay's evidence was that in his opinion Mr Haines suffers from a psychotic illness with persecutory delusions, certainly apparent in the last 2 years, possibly consistent with his earlier presentation, but not apparent in his first period in Broadmoor. He said that this illness affects Mr Haines' ability to recognise and accept the need for therapy for a personality disorder. In support of this diagnosis Dr Romero-Urcelay points to a period of improvement and stability when Mr Haines was receiving antipsychotic medication, was settled, and was engaging with therapy. However he fairly accepted that opinions differed. He agreed that anti-psychotic medication and mood stabilisers can be used for treatment of personality disorder to reduce arousal and allow a patient to engage with therapy.

10. In a report from previous RCs, Dr Sengupta and Dr Das, the opinion was given that on balance they took the view that the symptoms of pressure of speech, flight of ideas, irritability, agitation and paranoid ideation were in keeping with a diagnosis of schizo-affective disorder alongside that of a severe and enduring personality disorder. Dr Romero-Urcelay told us that he did not think that Mr Haines has a schizo-affective disorder, which he would expect to have been accompanied by more psychotic symptoms such as hallucinations, bearing in mind too that his delusional beliefs are fixed on a specific topic.

11. Dr Mulligan was asked by the trust to provide an independent review of the medical records and to report on Mr Haines' condition. Her task was hampered by his refusal on 2 occasions to meet her; this, he told the medical member, was because he believed that she needed the permission of Judge Westcott before she interviewed him. Her report is very lengthy, and quotes extensively from earlier reports. Her conclusion, in short, was that Mr Haines suffers from both a paranoid psychotic illness and a personality disorder. Her conclusions broadly mirror those of Dr Romero-Urcelay. She notes that Mr Haines's mental state is significantly better when he is on medication.

12. Ann White was Mr Haines' social worker until April 2011; she has also spoken to her successor. She described being unable to engage with Mr Haines, who would respond with abuse, and use aggressive, antagonistic and racist language to the ward staff. It was her evidence that in a hostel he would simply storm out and get into trouble. Whilst acknowledging his frustrations at being in the system for so long, her view was that he still needs to develop appropriate mechanisms to cope with these problems. She described Mr Haines as sabotaging moves by making progress but then as the next step approaches his mental state deteriorates. She accepted that recent records describe incidents of abuse, or verbal threats on 34 out of 80 days.

13. Alice Froyle is the Clinical Nurse Manager for Kempton Ward in the Personality Directorate where Mr Haines is currently. Her ward works closely with Epsom Ward, Mr Haines' previous ward. She described repeated threats which had to be de-escalated by staff; she described Mr Haines as intimidating, hostile, and not aware of when to back off; his mood fluctuates very quickly. In her view he would not comply with the conditions of a discharge: he had not done well in the somewhat less restrictive regime of a assertive rehabilitation ward, and needed to progress to that and then on to medium security.

14. Jonathan Watkins provided an independent social work report in 2009 and a

more recent facilities report. In that later report he was specifically not instructed to reassess Mr Haines. He said that in order to engage Mr Haines in treatment there has to be a starting point, having some regard to where Mr Haines himself wants to start [which is counselling for childhood abuse and bereavement]; since therapy is a progressive progress that approach would then allow other things to be addressed. He suggested that for Mr Haines there needs to be a light at the end of the tunnel, which might reduce his hostility. He considered it very significant that Mr Haines had successfully had unescorted leave while he was at Three Bridges, and suggested that it is necessary to work assertively towards plans to move Mr Haines back to medium security.

15. Mr Watkins told us that he did not support a conditional discharge, which he considered to be too big a step, and because more work needs to be done successfully with Mr Haines before he could be discharged. He strongly urged a more flexible approach to engage Mr Haines in therapy.

16. Kim Lansiquot has acted as IMHA to Mr Haines since his re-admission in 2008. She described his frustration and upset at the frequent ward changes in early 2011, and about a hastily-convened CPA meeting.

17. Leigh Moore, Mr Haines's brother, offered accommodation for Mr Haines, and said that he would ensure attendance on doctors and social workers if required by any conditions, although he mentioned that he shared Mr Haines' dislike of social workers. He said that staff knew that Mr Haines did not like them, so they goaded him. If Mr Haines had a grievance in the community with a psychiatrist, he would speak to the doctor and ask for another, because it is Mr Haines's choice who he works with. He added that Mr Haines was not violent or aggressive outside of hospital.

18. Mr Haines submitted a detailed and very articulate statement which was the bulk of his evidence before us. He said that he did not want a conditional discharge because he would find it very difficult to comply; however he would comply if that was the only alternative to remaining in detention. He does not accept that he has either a personality disorder or a mental illness.

The Tribunal's Findings, Analysis and Conclusions with Reasons

19. The tribunal was satisfied that Mr Haines suffers from a mental disorder, namely a personality disorder. This was the unanimous evidence of all the psychiatrists whose written or oral evidence we considered, and their conclusions were based on the very extensive and detailed history of physical and verbal aggression. The index offences, although of course 25 years ago, were correctly described in our view by Mr Watkins as a very violent and dangerous event albeit one that fortunately did not lead to serious injury, and there have been numerous incidents since.

20. We considered that there is insufficient evidence at this stage from which we could safely conclude that Mr Haines also suffers from a mental illness. There has been a divergence of views: Dr Payne excluded it at the time of the last tribunal hearing, an assessment on 15th April 2011 by a SOAD doctor found the evidence insufficient, and there is disagreement between the conclusions of Drs Das and Sengupta and those of Dr Romero-Urcelay on the nature of any mental illness. We also considered that there is a risk of circular thinking in relying on the improvement to Mr Haines's mental state when in receipt of medication given that such medication can be effective in addressing some of the symptoms of personality disorder.

21. The unanimous medical evidence was that Mr Haines' mental disorder is of a nature that makes it appropriate for him to remain liable to detention in hospital for treatment. We accepted that evidence. We also concluded that it is also currently of a degree which makes detention for treatment appropriate. We were

mindful, as we were asked to be on Mr Haines' behalf, of the conclusions of the last tribunal to the effect that nature but not degree was made out. We also took into account the need to differentiate between the ongoing manifestations of the personality disorder and the temporary effects of de-stabilising events. We here have in mind the repeated ward moves during 2011 which can only be categorised as extremely unhelpful: plainly they had a very upsetting effect on Mr Haines. However in our judgment the frequency and intensity of the incidents of irrational, hostile, abusive and aggressive behaviour cannot simply be explained by understandable frustration at the length of detention or by a reaction to ward moves. Mr Haines plainly can be settled and pleasant, but this is almost invariably with those whom he sees as being on his side and doing what he wants. With anyone who does not fall into that category his behaviour is entirely different, and he invariably blames others for his own behaviour.

22. We concluded that detention in hospital remains necessary for Mr Haines' own health and safety. It is correct to say that any suicidal threats are now historic, but we noted that they occurred while he was in a less structured environment, including at a time when he was having a considerable amount of leave. We also concluded that outside hospital there would be a considerable indirect risk to his own safety due to retaliation by others caused by Mr Haines' behaviour towards them. It is a striking feature of the history that he is so often the target of attacks by other patients who cannot tolerate his verbal assaults and threats. Whilst we acknowledge the force of the submission on his behalf that this has to be seen in the context of being detained in hospital, we consider that this provocation of others is so much a current feature of his presentation that it would inevitably be repeated outside hospital.

23. It was submitted on his behalf that Mr Haines would be no threat to others outside hospital, essentially because his antipathy to mental health professionals arises from his detention, and because his confrontational attitude is insufficient to justify a finding that detention is necessary for the protection of others. We cannot accept that submission. Mr Haines plainly sees himself entirely as a victim, and is not prepared to acknowledge any form of authority. He is prepared to live only on his own terms and regardless of the wishes or requirements of others. When thwarted he has either perpetrated violence on others or has tried to incite violence. We are satisfied that unless detained in hospital for treatment he would be unable to contain his anger and aggression, and that detention is necessary for the protection of others.

24. The tribunal is satisfied that appropriate treatment is available for Mr Haines in Broadmoor Hospital. We are of course alive to the fact that it is not our function to direct what that treatment should be, but the following is clearly available. Firstly, medication. We have already noted the evidence that medication may be appropriate to treat personality disorder in order to reduce the level of arousal and to help Mr Haines to engage in therapy: that evidence can be found in Dr Lock's report at page 23 where he says "In my opinion there is good evidence that emotionally unstable personality disorders can be effectively treated both with pharmacological and psychological methods", in the NICE guidelines, in the SOAD report from April 2011 and in Dr Romero-Urcelay's evidence to us. In that regard it may be rather less significant to decide whether Mr Haines does suffer from a mental illness.

25. Secondly, therapy is available, and Dr Romero-Urcelay would wish to consider DBT. In his evidence he acknowledged that an important part of any therapy must be to address the PTSD stemming from Mr Haines's childhood experiences and bereavements: plainly in our judgment tackling that will require considerably more than simply counselling as Mr Haines himself envisages. Of course Mr Haines himself needs to do more to engage (as Dr Lock pointed out), but we also considered that there was much force in Mr Watkins' opinion that the treating team will need to find a way in – a lever as he put it – even if that

means starting on Mr Haines' own terms. In a sense there needs to be a similar logic to that where Mr Haines sees a conditional discharge as the way out of detention – he needs to be offered a clear pathway and to understand that progress through engaging with the treating team will provide that pathway.

26. In the light of these findings we were not able to accede to the submissions that we should grant either an absolute or a deferred conditional discharge. Mr Haines has not progressed enough in being able to control his anger and aggression not to require detention, and he is unable to recognise the need for continuing treatment. In the community there would in addition be a clear risk of a misuse of alcohol and drugs. He is incapable of coping with anyone perceived to be in authority. In his own evidence Mr Haines very frankly acknowledged that he would have great difficulty in complying with conditions, and would be likely to fail: we are satisfied that in his current presentation he would be unable to comply.

27. Plainly these tribunal proceedings, being greatly extended by the issue of whether the hearing should be in public, have dominated Mr Haines' life in the last two years or so, really to the exclusion of everything else. It is in nobody's interest that Mr Haines should have to be detained, whether in high or medium security, for a day longer than absolutely necessary. In our judgment detention does remain necessary, and we conclude by observing that it is likely to remain so unless the treating team are able to find a way of engaging Mr Haines, and that this will require an equal commitment by Mr Haines himself.

Judge: HH Judge R.J McGregor-Johnson

Date: 30th September 2011

Notice

A person seeking permission to appeal must make a written application to the tribunal for permission to appeal. An application for permission must:

a. identify the decision of the tribunal to which it relates;

b. identify the alleged error or errors of law in the decision; and

c. state the result the party making the application is seeking.

An application for permission must be sent or delivered to the tribunal so that it is received no later than 28 days after the latest of the dates that the tribunal sends to the person making the application:

a. written reasons for the decision;

b. notification of amended reasons for, or correction of, the decision following a review; or

c. notification that an application for the decision to be set aside has been unsuccessful. (Note: This date only applies if the application for the decision to be set aside was made within the initial 28 day time limit, or any extension of that time previously granted by the tribunal.)

If the person seeking permission to appeal sends or delivers the application to the tribunal later than the time required then:

a. the application must include a request that the tribunal extends the time limit under Rule 5(3)(a), and give the reason(s) why the application was not provided in time; and,

b. unless the tribunal extends time for the application to be made, a late application cannot be admitted.