

Case Study

Mr B is a 78-year-old man who has been known to mental health services for more than 40 years. He has a long-standing diagnosis of paranoid schizophrenia. It is characterised by paranoid and grandiose delusional beliefs, auditory hallucinations, agitation and aggression. In particular he hears a voice which tells him what to do and he feels compelled to comply. It has proved resistant to treatment. His insight as to his illness and the need for treatment is poor.

In 1987 (aged 40) following a period in which he reported feeling persecuted, followed and spied on, he went to a train station and pushed a complete stranger (a woman) under a train, killing her. Mr B reported that at the time he had been feeling agitated, tearful and without help. He had been drinking alcohol prior to the offence.

He was charged with murder and found guilty of manslaughter on the basis of diminished responsibility. He was sentenced to a hospital order with restrictions and has remained detained since that date.

He is currently detained in a Medium Secure Unit which specialises in providing care for older patients.

In 2022 (aged 73) he suffered a stroke and tests following this disclosed changes consistent with vascular dementia. This is progressive, not amenable to medication and has resulted in disabling cognitive and functional deficits along with increasing anxiety. He also has reduced mobility and requires a walking aid. Deterioration in the dementia has coincided with an escalation of psychotic symptoms.

Both of his diagnoses are aggravated by stress.

Mr B is treated with antipsychotic medication given by monthly injection, oral medication as required to manage anxiety and side effects. He also benefits from expert nursing care and occupational therapy. Finally, 2 important aspects of his treatment are the relational and procedural security provided by the hospital and testing on leave (s.17) to any proposed future placement.

Tribunal Proceedings

The matter has been referred to the tribunal by the Secretary of State for Justice as it has not been reviewed in the proceeding 3 years.

Mr B has been found to lack capacity and has had a legal representative appointed by the tribunal to act in his 'best interest'.

At the hearing the detaining authority argue that Mr B should continue to be detained in hospital because he remains potentially a high risk to others. He lacks insight as to his offending behaviour, illness and the need for treatment. He did not accept that he

had a mental disorder or that he required medication. His level of anxiety causes him to pace the unit though he can be redirected to the quiet lounge. The stress of any move along with his worsening dementia is likely to increase his psychotic symptoms. If he were to be moved a significant period of testing would be necessary to assess his ability to manage the inevitable stress of a move and whether a move increased the risks, he presented.

Mr B's representative sought a conditional discharge arguing that he could be managed at a suitable care home and that this would be the least restrictive option. His liberty would still be restricted but this could be managed with authorisation from the Court of Protection (DOLS) or a conditional discharge with deprivation of liberty. Mr B's representative argued that the stroke had reduced Mr B's likelihood of acting on his psychotic beliefs and his reduced mobility meant he was unlikely to be able to evade any supervising staff. It was further argued that it would not be necessary to test Mr B's response to a new environment, and that as soon as a suitable care home was identified he could be moved straight there.

The tribunal was told that Mr B's views about a move fluctuated. Sometimes he wanted to stay in hospital and sometimes he wanted to go to a care home.