BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

IN THE MATTER OF A DISPOSITION HEARING VIA CLOSED-CIRCUIT TELEVISION

HENRY MICKELOW

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
January 26, 2017

BEFORE:

ALTERNATE CHAIRPERSON:	B. Long
MEMBERS:	Dr. R. Stevenson, psychiatrist
	B. Walter (dissenting)

APPEARANCES:

ACCUSED/PATIENT:	Henry Mickelow
ACCUSED/PATIENT COUNSEL:	S. Taylor
DIRECTOR AFPS:	C. Sanford/Dr. W. Widajewicz
ATTORNEY GENERAL:	L. Mascolo

B. Long, Dr. R. Stevenson concurring:

INTRODUCTION AND BACKGROUND

[1] On January 26, 2017, the BC Review Board held an annual hearing in the matter of Henry Mickelow. At the conclusion of the hearing, the Board made a conditional discharge on the same terms as the order under review. Reasons were reserved.

[2] The accused is before the Board as a result of an NCRMD verdict of October 12, 1994 on two charges of assaulting a police officer. The index offences were committed on July 7, 1994 when the accused assaulted a sheriff, who was attempting to serve a driving prohibition on him, and an RCMP officer who subsequently attended following the assault on the sheriff.

[3] Mr. Mickelow's personal history has been reviewed in prior reasons for disposition and will not be repeated in any detail. In summary, he is 74 years old and has a lifelong history of refractory paranoid schizophrenia. He has never been able to develop any insight into the presence of his illness. Not surprisingly, he has a concurrent history of non-compliance with treatment.

[4] The accused's experience under forensic treatment is notable for the refractory nature of his illness and his persistent resistance to treatment. Efforts to reintegrate the accused into the community under conditional discharge were marked by numerous failures resulting in frequent returns to hospital and further orders of detention. However, since 2011, the accused has been able to reside in Nanaimo in the home of his daughter without further return to hospital under successive conditional discharges.

[5] Mr. Mickelow is provided with a considerable level of support through the combined efforts of the forensic outpatient treatment team, the John Howard Society, and Mr. Mickelow's daughter. This level of service has allowed the accused to remain in the community despite his absence of insight and resistance to treatment. Mr. Mickelow's daughter is employed full-time. She only resides in her home in Nanaimo for part of the year and spends the balance of her time with her husband who lives in Pennsylvania. She is dependent upon forensic services and community mental health agencies to provide care for the accused when she is absent.

[6] The accused last appeared before the Board on February 5, 2016. The reasons for disposition reviewed the persistence of the accused's persecutory delusions, his belief that psychiatric medications had no effect, and his unconcealed intention to cease

psychiatric medication. The Board acknowledged the accused's advancing years, but considered that he remained capable of inflicting physical harm. The Board noted that there were no geriatric psychiatric services in Nanaimo. The Board accepted that if the accused was absolutely discharged, his daughter would be unable to adequately care for him without the assistance consequent to forensic jurisdiction. The Board found that in such circumstances the accused would discontinue his medications and experience mental deterioration and increasing aggression. The Board concluded that the accused would thereafter be at foreseeable risk to act violently towards persons in his environment.

EVIDENCE AT THE HEARING

[7] The new evidence added to the disposition information consisted of reports from the accused's psychiatrist Dr. Widajewicz and case manager Ms. Sanford. The Board heard oral evidence from Dr. Widajewicz and Ms. Sanford.

[8] There have been no material changes in Mr. Mickelow's circumstances over the past year. He remains symptomatic and without any insight into his illness. He believes that psychiatric medication is poison. He does not conceal that he would cease all treatment if permitted to do so and that the only reason that he has been compliant with medication is to avoid potential return to FPH. He has also been resistant to treatment of his physical ailments that have had the potential for serious health consequences. The accused continues to adhere to historic delusions that focus on wealthy individuals, the mafia, and widespread Jewish conspiracies. He believes that people try to break into his home at night, but leave when he wakes up. He insists that he is worth billions of dollars. His speech is often infused with echolalia and clang associations.

[9] The accused has continued to live in his daughter’s home in Nanaimo. There have been no changes to his support network consisting of his daughter, when she is not in Pennsylvania, the John Howard Society, and forensic services. The John Howard Society provides services through a forensic outreach team. These consist of various programs such as meals, recreational outings, transportation, and assistance with some activities of daily living. John Howard staff is well poised to communicate any changes in the accused's mental status to forensic services. Forensic support includes psychiatric treatment from Dr. Widajewicz combined with regular and sometimes frequent visits from Ms. Sanford, depending on the accused's immediate needs.

[10] It remains the case that in the event that the accused were not under the Board's jurisdiction, he would lose the services provided by the John Howard forensic outreach team and the forensic treatment team. There is no psycho-geriatric team in Nanaimo. Civil mental health agencies in the region would be unable to replicate anything near the level of service that is currently being provided. Mr. Mickelow's daughter is clear that she would be unable to care for the accused without these supports and consequently she strongly favours continuing forensic oversight.

[11] Dr. Widajewicz was questioned about the accused's capacity to cause physical harm. He acknowledged that Mr. Mickelow is aging, but was firm in his assessment that he retains the capacity to physically harm others. He stated that if Mr. Mickelow was not under the Board's jurisdiction, he would stop his psychiatric medication because he does not believe he is ill and sees no benefit from medication. He predicted that the accused's delusions would become substantially more intense within a matter of weeks. In such circumstances, the accused would be prone to misconstrue his environment and react aggressively towards persons in his immediate vicinity. He noted the accused is not tolerant of having his views challenged. Dr. Widajewicz added that the accused is presently not certifiable and would first have to experience considerable mental deterioration before any type of intervention from civil mental health agencies would ensue.

ANALYSIS AND DISPOSITION

[12] The Director, the Crown, and Mr. Mickelow were agreed that the Board should make a conditional discharge on the same terms as the last disposition.

[13] Although the Board is influenced by the positions of the parties, it is obliged to independently review the evidence of the accused's risk and make a disposition that is necessary and appropriate in the circumstances. The Board must take into account the safety of the public, the mental condition of the accused, the reintegration of the accused into society as well as the other needs of the accused. Unless the Board is of the opinion that the accused is a significant threat to public safety, it must make an absolute discharge. A significant threat to public safety means the risk of serious physical or psychological harm to members of the public resulting from conduct that is criminal in nature but not necessarily violent.

[14] Dr. Widajewicz's report of January 12, 2017 included a detailed risk assessment. He noted that Mr. Mickelow has a life long history of refractory mental illness. The accused will not voluntarily accept treatment and is only compliant in the face of threat of return to FPH. He has a history of dangerous behaviour apart from the index offences that include an attempted robbery of a store, reckless driving, disrupting traffic, sexually inappropriate conduct towards his daughter, and an assault on a nurse at FPH. In the absence of forensic jurisdiction, Mr. Mickelow would lose most of the supports that have allowed him to reside in the community. Dr. Widajewicz was firm in his opinion that if the accused was not compelled to submit to treatment, his mental state would deteriorate rapidly and leave him at foreseeable risk to act unpredictably and violently in the context of increased intensity of delusions.

[15] Dr. Widajewicz's opinion was not challenged and was consistent with the other evidence in the disposition information. In the circumstances, the Board was persuaded that this assessment continued to be an accurate appraisal of Mr. Mickelow's risk and therefore concluded that he remained a significant threat to public safety.

[16] It was common ground that the accused's risk was manageable under the terms of the existing conditional discharge. While the accused has no insight to his illness, he is willing to comply with forensic supervision. This has proved successful in preventing further dangerous behaviours. In all the circumstances, the Board agreed that a conditional discharge on the same terms as the last disposition was necessary and appropriate and ordered accordingly.

[17] Lastly, although we have considered all the evidence on record, for the purpose of these reasons we only recite that evidence which is necessary to our decision.

MR. WALTER, DISSENTING:

[18] I take no issue with Mr. Mickelow’s diagnosis or that it preceded his 1994 index offence, when he was 51 years old, by at least a decade. The index offences themselves would not be considered at the very serious extreme of the violence spectrum. They basically consisted of pushing or grabbing, and dislodging an officer’s glasses. He was also convicted of an assault within FPH in 1998: *see Ex. 86, page 4.* In addition to his paranoid schizophrenia, Mr. Mickelow’s cognitive functioning was considered somewhat impaired and has been deteriorating over the past 22 years. On the other hand, he was also assessed as of above-average intelligence.

[19] I note that in earlier times Mr. Mickelow was actively managed by civil mental health resources and was characterized as responsive to treatment and with good insight. He has not been an abuser of alcohol or drugs: *Ex. 48*. He was discharged on conditions relatively quickly after his verdict, albeit briefly.

[20] As of 2000 or 2001 he was able to demonstrate small but significant improvements in his clinical progress including some abatement in both positive and negative symptoms. He continued to vehemently deny his diagnosis of schizophrenia, preferring to consider himself as bi-polar. He was considered able to care for himself and manage his diabetes: *Ex. 83*. Mr. Mickelow remained in custody until 2006. At his May 2005 hearing, Mr. Mickelow was characterized as “a very low risk to the public”: *Ex. 89*. His lack of insight and his unwillingness to voluntarily consume medication caused his continued detention.

[21] In March 2006, following visit leaves, Mr. Mickelow was conditionally discharged to reside with his daughter in Nanaimo. He was at that time free of overt symptoms and had adapted well into the community: *Ex. 95, par. 9*. In 2007, the Board commented that the basis for its jurisdiction over Mr. Mickelow was, despite his curmudgeonly presentation, close to speculative: *Ex. 98*.

[22] As a result of medication non-compliance, Mr. Mickelow decompensated in October 2007, and he was civilly committed. Another brief period of non-compliance around Easter 2008 did not occasion any untoward public behavior. Finally in March 2009, Mr. Mickelow was returned to FPH due to decompensation, where he remained until 2011.

[23] Mr. Mickelow has now been almost consistently in the community since 2011, with Forensic, John Howard Society and family support.

ANALYSIS AND DISPOSITION:

[24] The Tribunal’s first task is to determine whether the accused poses a significant threat to public safety as defined in s.672.5401 of the *Code*:

> **672.5401** For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public — including any victim of or witness to the offence, or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent.

[25] Since the promulgation of this amendment to the *Code,* in July 2014, the Board has consistently held that the jurisdictional threshold remains unaltered from the test set out in ***Winko***: *see* ***Baranyais***, ***Lacerte****.*

[26] Since these decisions a number of appellate decisions in Ontario and also BC have endorsed that interpretation.

[27] In ***R. v. Marzec****, 2015 O.N.C.A. 658*, the Ontario Court of Appeal specifically adopted the standard articulated at paras. 51 and 57 of ***Winko*** and granted the appellant an absolute discharge on the basis that the Board is not entitled to order conditional discharge out of an "abundance of caution that is not the legal test" (par. 33). Such an approach, it said, would erroneously place the onus on the appellant to prove that he is not a risk before he is entitled to an absolute discharge: *par. 30*.

[28] Similarly, in ***R. v. Carrick****, 2015 O.N.C.A 866*, the Ontario Court said:

> For present purposes, the most important point was that emphasized by the court in *Winko*, at para. 33:
>
> > The only justification there can be for the criminal law detaining a person who has not been found guilty (or is awaiting trial on an issue of guilt) is maintaining public safety. Once an NCR accused is no longer a significant threat to public safety, the criminal justice system has no further application.
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> The Board is tasked with determining whether an NCR accused poses a significant threat to public safety. An NCR accused is not presumed to be dangerous and bears no burden of proof in proceedings before the Board.
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> If the Board concludes that an NCR accused poses a significant threat, it is required to fashion a "necessary and appropriate" disposition pursuant to s. 672.54 – **which this court has held means the least onerous and least restrictive disposition**: *Ranieri (Re)*, 2015 ONCA 444 (CanLII), at para. 20. If, however, the Board concludes that an NCR accused does *not* pose a significant threat to public safety, it must order that he or she be discharged absolutely.
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> What constitutes a "significant threat to the safety of the public"? The term is defined in s. 672.5401 as "a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent." The likelihood of a risk materializing and the seriousness of the harm that might occur must be considered together. As the Supreme Court noted in *Winko* (in discussing s. 672.54), at para. 57:
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> > **[T]he threat posed must be more than speculative in nature**; it must be supported by evidence. The threat must also be "significant", both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. **A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold**. Finally,

> the conduct or activity creating the harm must be criminal in nature. [Citations omitted.]
>
> In short, the "significant threat" standard is an onerous one. An NCR accused is not to be detained on the basis of mere speculation. The Board must be satisfied as to both the existence and gravity of the risk of physical or psychological harm posed by the appellant in order to deny him an absolute discharge. *(paras. 13-17)*
>
> (emphasis added)

[29] In ***Carrick***, the Court noted that there was a substantial risk, even likelihood that the accused would abuse alcohol, drugs and even commit offences, that he was unlikely to change; yet the Court concluded:

> Given the history of the appellant's detention and the state of the expert evidence, the Board needed to do more than simply assert that the appellant continues to pose a significant threat to the safety of the public. It had to address the conflict in the evidence and explain why it was satisfied that the appellant poses a significant threat. In my view, its failure to do so renders its decision unreasonable. (*para. 43*)

[30] More currently in ***Calles***, 2016 BCCA 318, the BCCA affirmed:

> A significant threat to public safety is defined in s. 672.5401 of the *Criminal Code* to mean "a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent". **The threat posed must be more than speculative and be supported by the evidence. It must be significant "both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community** and in the sense **that this potential harm must be serious**. A **minuscule risk** of **grave harm** will not suffice", nor will **a high risk of trivial** harm: *Winko*, at para. 57 *(para. 15)*
>
> (emphasis added)

[31] Mr. Mickelow's lack of insight, his refractory diagnosis, and his persistent conspiratorial and persecutory delusions do not render him aggressive. He is not bothersome in the community. He has shown no physical violence since 1998. He has functioned in the community with support since 2011.

[32] Mr. Mickelow's daughter, who provides him with accommodation, has been absent for periods of up to six months. The evidence is that Mr. Mickelow is able to attend to his daily living needs. His physical health is deteriorating possibly due to COPD. Despite his distrust of authority and of physicians, he has been medication compliant and mood appropriate. He consumes his prescribed medications independently.

[33] Mr. Mickelow has previously experienced changes of treatment teams. I am not convinced that he could not be transitioned to, and work with, a community mental health team. I have not been provided with persuasive evidence that the lack of access to specific geriatric psychiatric resources should be a barrier to discharge. In fact, I do not recall ever being presented with evidence that such a resource would be available to any accused. That said, I note even the smaller city of Duncan has such a resource.

[34] I do not consider this an obstacle. I am not persuaded that management of an accused's needs and residual threat can or should be the sole responsibility of AFPS: *see* ***Lajoie***.

[35] Finally, I do not equate the speculative capacity of an elderly, medically diminished person who is also losing his eyesight, to theoretically inflict harm with "significant threat" as defined. If anything, Mr. Mickelow is a low risk of trivial harm. His resistance to medical intervention for his physical ailments does not alter this equation.

[36] I am therefore unable to find that Mr. Mickelow meets the jurisdictional threshold. Irrespective of what may serve his best interests, the law requires me to discharge him absolutely.

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