No: 201804983 A1
IN THE COURT OF APPEAL
CRIMINAL DIVISION
[2019] EWCA Crim 1066

Royal Courts of Justice
Strand
London, WC2A 2LL

Thursday, 13 June 2019

B e f o r e:

LORD JUSTICE HICKINBOTTOM

MRS JUSTICE ANDREWS DBE
and
HIS HONOUR JUDGE MAYO
RECORDER OF NORTHAMPTON

R E G I N A
v
THOMAS FISHER

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Miss E Marshall QC appeared on behalf of the **Appellant**
Mr M Jewell QC appeared on behalf of the **Crown**

J U D G M E N T
(Draft for approval)

LORD JUSTICE HICKINBOTTOM: On any view, the death of Mrs Fiona Fisher was a tragedy. She was 51 years old and much loved by many family members and friends, who have been understandably devastated by her death.

Mrs Fisher was the Appellant's mother. She separated from and then divorced his father when he was about five years old, and both the Appellant and his sister Megan remained in her care, although spending time with their father on alternative weekends and in the school holidays. Mr Fisher remarried and both the Appellant and his sister developed a close relationship with their stepmother, Leigh Fisher.

Through his stepmother, the Appellant developed an interest in music, particularly the guitar; and in 2014 he decided to embark on a degree in the United States where Mrs Fisher and her parents (the Appellant's maternal grandparents) visited him. However, by Spring 2015 he began to take on small jobs in the music industry, neglecting his studies and beginning to use drugs. Regular contact with his family started to break down, and he received some psychiatric treatment whilst still in America. He was also diagnosed with early onset Dupuytren's Contracture, a condition in which the fingers become permanently flexed, which made playing the guitar difficult.

The Appellant returned to the United Kingdom in September 2015, and moved back into the family home with Mrs Fisher and his sister. It was clear to them that his behaviour had changed. He told his stepmother and sister that he had started to take drugs whilst in the US; and his sister noticed that he was drinking large amounts of alcohol and was stealing alcohol from shops.

Mrs Fisher became concerned about the Appellant and soon struggled to cope with his behaviour, in particular his demands for money, stealing, and the way he spoke to her. In November 2015 she threw him out of the house for a short while, and he went to live

with his father and stepmother. He soon returned to the family home, but began to accrue large gambling debts on Mrs Fisher's credit card and moved back to live with his father. He was still drinking heavily and shoplifting, although when living with his father and stepmother his behaviour stabilised to an extent. He had several outpatient psychiatric appointments during this period to deal with his drinking problem and anxiety, but was discharged in March 2016. With the assistance of his sister and grandfather, he was admitted to the Priory Clinic in March 2017, but failed to engage with the treatment programme and subsequently discharged himself.

He left his father's house and lived a somewhat itinerant life, staying with friends and acquaintances or in hostels, and sometimes living rough on the streets. His stepmother provided him with some financial support, but she stopped doing that when she discovered that he had been gambling with her money.

On 28 August 2017 he burgled his mother's house, and took her car which he then crashed. He was charged; and on 31 August 2017 he pleaded guilty to offences of burglary and aggravated vehicle taking, for which a community order with a drug rehabilitation programme was imposed, and he was disqualified from driving. On 20 September 2017 he pleaded guilty to two charges of shoplifting which had occurred prior to the burglary, and was given a conditional discharge. However, the following day he burgled his mother's house again whilst she was on holiday, and he stole jewellery and other valuables to the value of £20,000, for which he was sentenced to 16 months' imprisonment suspended for two years with an unpaid work requirement and a rehabilitation order. He returned to live in a hostel in London, and he complied with the order until March 2018, when he began smoking cannabis again.

On 20 April 2018, he arrived unexpectedly at the home of his maternal grandmother, whom he

had not seen for several months. His grandmother and her husband thought that he acted oddly and was not his normal self; but he had dinner, stayed the night, and then returned to London. Unfortunately, he had left his phone at their house, and he returned to collect it the next day, again staying the night. His grandmother rang his mother, and Mrs Fisher agreed to collect him the following day, which she did.

It was now Tuesday 24 April. Having collected the Appellant, Mrs Fisher took him to Pembury Hospital for a mental health assessment; but they told her that the Appellant should go to see his GP. He returned with Mrs Fisher to the family home where he spent the night, and he went to see his GP the following morning. The doctor did not prescribe any medication, but referred the Appellant for counselling. Mrs Fisher and the Appellant then went to Brighton for the rest of the day, where they had lunch and did some shopping. During the day, Mrs Fisher was as usual in regular contact with her mother, daughter and friends, and gave no cause for concern.

However, from the next day (Wednesday 25 April), unusually, Mrs Fisher did not contact her family and friends, who became increasingly concerned, particularly because she was not answering her phone and text messages were being shown as not being delivered which suggested that her phone was off. Megan telephoned a neighbour of her mother's whom she knew well, and she told Megan that the Appellant had returned to the house that afternoon in Mrs Fisher's car. The neighbour had seen the Appellant arrive and, being worried for Mrs Fisher, she had asked him where his mother was, as (she said) they were going out that evening; but he said he did not know. She asked him if she should call the police, and he said she could if she liked and if they came to the house he would let them in. Megan and Mrs Fisher's mother then arrived at the house, but the Appellant would not answer the door.

The police were called and duly arrived. They found the front door locked, but the back door wide open. They went in and asked the Appellant where his mother was. The Appellant appeared exercised, to the extent that he was handcuffed. When asked who was in the house with him, he said his mother was there, "upstairs under the bed". When asked if she was okay, he replied: "No, she's not okay". The police searched the house and found Mrs Fisher under the bed. She was dead. She was in her night clothes and wrapped in a quilt. She had been stabbed once to the chest, where the knife was still embedded.

Mrs Fisher's car keys, rings and credit card were found in the Appellant's pocket, with a till receipt from a supermarket for firelighters and a newspaper purchased with Mrs Fisher's credit card at 11.35 that morning.

In addition, a later search of the house found a journal kept by the Appellant from January to April 2018. The journal was unguarded, that is it was clearly written with the intention that no one else should ever read it. In the view of Dr Duncan Anderson, a consultant psychiatrist instructed by the Appellant's solicitors, the entries appeared to be psychotic in nature, becoming increasingly disjointed over time. He concluded from the journal and the other evidence available to him that the Appellant came to believe with delusional intensity that his parents and grandparents, together with others, including the monarchy, the judiciary and "Russian girls", were responsible for wrecking his life by, amongst other things, making him gay, tormenting him sexually, and trying to kill him or make him commit suicide, as well as engaging in otherwise trivial matters such as changing his tobacco. The journal recorded that they did this by means of surveillance, by direct interference with his mind and by giving financial assistance to (and even by specially breeding) others to be better, more successful and happier than he. The journal said that whoever was carrying out these things deserved to die.

The Appellant's account of what had happened, as given much later to various psychiatrists, was that on the relevant evening his mother had cooked dinner at her house, which they ate before watching a film together. He went for a short walk, and when he got home he went straight to bed because he "felt cornered in his head". He did not speak to his mother, who went to bed at about 10pm. There is no evidence that he drank or took any drugs that evening. However, he said that he was "having conversations in his head", was "in the worst paranoid place", and was hearing "screaming metal music from a violent place in [his] head". He thought that his mother had been bad to him for years and was destroying him; and that she wanted him dead. He went to the kitchen, took a knife and went to his mother's bedroom, where she was asleep. He stood looking at her for about 15 minutes before stabbing her once to the chest. He then simply held her for some time – a couple of hours – before wrapping her in a duvet and putting her under the bed, where she was found by the police.

The following morning he said he had taken his mother's car and had "just driven around". He had bought the firelighters with the intention of setting fire to the house, although he said he was not trying to get away with the killing and in fact just stayed in the house on his return, drinking. A note was found in his pocket saying, "I should kill you for that, but I choose not to"; but he could not recall that note or what he may have meant by it.

As we have indicated, the Appellant was charged with the murder of his mother.

The Crown Court had the advantage of reports from three consultant psychiatrists, Dr Anderson to whom we have already referred; Dr Philip Joseph who was instructed by the Crown Prosecution Service; and Dr Roderick John Ley who was the Appellant's treating psychiatrist. Their reports are lengthy, but we can deal with their evidence quite briefly. They were broadly in agreement. They agreed that the Appellant was fit to stand trial and,

although he understood the nature of his conduct at the time and he retained an ability to exercise self-control, there was substantial impairment in his ability to form a rational judgment due to paranoid delusions he was experiencing about his mother. His abnormality in mental functioning resulted from a recognised medical condition of paranoid psychosis, probably paranoid schizophrenia. As a result, he remained responsible for the death, but his responsibility was substantially diminished as a result of his mental condition. They recommended that a plea of manslaughter would be appropriate.

Dr Joseph considered the Appellant's culpability for the death was in the medium range of the spectrum of diminished responsibility because, in addition to the mental illness, personality factors had been identified which suggested that the Appellant was emotionally unstable. However, he still considered that the death was largely attributable to the Appellant's psychotic illness, and it was very likely that he would not have killed his mother if he had not been experiencing paranoid delusions about her. Dr Ley considered the Appellant's responsibility in the low to medium range. In the addendum report, Dr Anderson agreed with that view.

In the light of the psychiatric evidence, the prosecution accepted the Appellant's plea to manslaughter. In addition, the Appellant pleaded guilty to two further minor counts, namely (i) fraud arising out of using Mrs Fisher's credit card to make the purchases we have described, and (ii) driving his mother's car whilst disqualified, in the circumstances which we have again described. In addition, the Appellant accepted that he drove that car whilst not insured. In committing these offences, the Appellant was also in breach of the suspended sentence imposed for the second burglary of his mother's house.

The Appellant appeared for sentence at Lewes Crown Court before Her Honour Judge Laing QC

on 1 November 2018. Coincidentally, that was the day on which the Sentencing Council's Definitive Guideline for Manslaughter came into effect. The judge was clearly not only aware of it, she expressly applied it. Although the guideline substantially reflects the approach taken by this court in relation to sentencing in such cases as this in (most recently and most authoritatively) Edwards [2018] EWCA Crim 595; [2018] 2 Cr App R (S) 17, that was of course the right focus.

For manslaughter by diminished responsibility, the first step in the sentencing procedure under the guideline is to assess the degree of responsibility which the offender retained. Judge Laing did this with particular care. She reviewed the psychiatric evidence, noting that the psychiatrists were in substantial agreement that whilst the Appellant retained some responsibility – hence his plea to manslaughter – there was a substantial impairment of his ability to form rational judgments, and the death would not have occurred but for his paranoid delusions. Although drug use may have been involved in his early psychiatric problems, they agreed that by 2018 the paranoid psychosis could not be classified as drug-induced. In addition, as we have said, there was no evidence that he had taken drugs or drink on the day of his mother's death.

The judge, rightly, said that the assessment of retained responsibility in cases such as this is very difficult. She expressly took into account the history of the Appellant's relationship with his mother, which included aggression towards her, although no physical violence. Balancing all of the matters, the judge concluded that she could not justify a categorisation of his culpability "other than in the lower range", i.e. the lowest category of retained responsibility within the guideline. That careful assessment is unimpeachable.

As step two, that assessment of retained responsibility gives a sentencing starting point of seven years with a range of three to twelve years. The judge expressly recognised that. She did

not consider there were any particular aggravating features which increased the seriousness of the offence in terms of culpability. In a case of manslaughter, as the guideline emphasises, “harm” will always be of the utmost seriousness.

Step three required by the guideline is consideration of "dangerousness" under the criteria set out in Chapter 5 of Part 12 of the Criminal Justice Act 2003, namely whether there is a significant risk to members of the public of serious harm occasioned by the commission of further offences. The judge, in our view again rightly, considered that the reduction in the obvious risk to the public posed by the Appellant was dependent upon his response to treatment for his mental condition, and it was not then known what that response would be or when or how complete his recovery would be. She clearly and correctly considered that the dangerousness criteria were satisfied. As the judge noted from the psychiatric evidence, there remained a risk of a further psychotic episode, particularly if the Appellant failed to take his psychotic medication and/or used illicit drugs again. It was and still is simply not possible to say if and when the risk of him causing serious harm to members of the public will be reduced to an appropriate level.

We do not consider the judge's approach to steps one to three of the guideline to be controversial or her conclusions to be in any way impeachable.

Step four concerns "Consideration of mental health disposals (Mental Health Act 1983)". Before we come to the terms of the guideline, we should refer to the relevant available disposals under the provisions of that Act. Statutory references in this part of the judgment are to the Mental Health Act 1983 unless otherwise appears.

Where an offender suffers from a mental disorder, the court has a number of sentencing options. First, if it considers that it is, "the most suitable method of disposing of the case", the court may make a hospital order under section 37 with or without a restriction order under section 41.

Those sections provide:

"37. Powers of courts to order hospital admission or guardianship

(1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law... and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order....

....

(2) The conditions referred to in subsection (1) above are that–

(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that either—

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or

(ii) ...

and

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section."

"41. Power of higher courts to restrict discharge from hospital

(1) Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section... and an order under this section shall be known as a 'restriction order'.

(2) A restriction order shall not be made in the case of any person unless at

least one of the registered medical practitioners whose evidence is taken into account by the court under section 37(2)(a) above has given evidence orally before the court.

(3) The special restrictions applicable to a patient in respect of whom a restriction order is in force are as follows-

(a) none of the provisions of Part II of this Act relating to the duration, renewal and expiration of authority for the detention of patients shall apply, and the patient shall continue to be liable to be detained by virtue of the relevant hospital order until he is duly discharged under the said Part II or absolutely discharged under section 42, 73, 74 or 75 below

...

(c) the following powers shall be exercisable only with the consent of the Secretary of State, namely–

(i) power to grant leave of absence to the patient under section 17 above;

(ii) power to transfer the patient in pursuance of regulations under section 19 above... ;

and

(iii) power to order the discharge of the patient under section 23 above; and if leave of absence is granted under the said section 17 power to recall the patient under that section shall vest in the Secretary of State as well as the responsible clinician; and

(d) the power of the Secretary of State to recall the patient under the said section 17 and power to take the patient into custody and return him under section 18 above may be exercised at any time; and in relation to any such patient section 40(4) above shall have effect as if it referred to Part II of Schedule 1 to this Act instead of Part I of that Schedule."

If a restriction order is made under section 41, the First-tier Tribunal (Mental Health Chamber) ("the FtT") decides when the offender should be released from the hospital order, either conditionally or unconditionally.

Second, if the court is satisfied that the offender is suffering from a mental condition which is

such that it may be appropriate to make a hospital order, it can make an interim hospital order under section 38 whilst that appropriateness is being considered.

Third, it is open to the court to sentence the offender to a determinate or indeterminate sentence of imprisonment and leave it to the Secretary of State to exercise his administrative power under section 47 to transfer the prisoner to a hospital if he considers that (i) the prisoner is suffering from a mental disorder; (ii) the mental disorder is of a nature and/or degree that it is appropriate for him to be detained in hospital for medical treatment; and (iii) appropriate treatment is available for him. Whether such a direction is made is entirely in the hands of the Secretary of State.

Fourth, under section 45A, when considering a hospital order under section 37, if (i) the court is satisfied that the offender is suffering from a mental disorder; (ii) that mental disorder makes it appropriate for him to be detained in a hospital for medical treatment; and (iii) appropriate medical treatment is available, the court has power to impose a sentence of imprisonment but make directions under section 45A(3), which provides:

> "The court may give both of the following directions, namely—
>
> > (a) a direction that, instead of being removed to and detained in a prison, the offender be removed to and detained in such hospital as may be specified in the direction (in this Act referred to as a 'hospital direction'); and
> >
> > (b) a direction that the offender be subject to the special restrictions set out in section 41 above (in this Act referred to as a 'limitation direction')."

Where an indeterminate sentence is imposed with a hospital order with a limitation direction made under section 45A(3)(b), and the responsible clinician or the FtT notifies the Secretary of State that he no longer requires treatment in hospital under the 1983 Act or that no effective treatment for his disorder can be given at the hospital to which he has

been removed, the Secretary of State will normally simply remit him to the prison estate under section 51, unless his tariff has expired. Where the tariff has expired, the Secretary of State may notify the FtT that he should be conditionally discharged, in which case he is subject to mental health supervision and recall in the usual way; but the Secretary of State can, and in practice usually does, refer the offender to the Parole Board as with any other post-tariff indeterminate sentence prisoner.

Step four of the sentencing guideline deals the correct approach to identifying the appropriate sentence in a particular case. It provides as follows.

> "Consideration of mental health disposals (Mental Health Act 1983)
>
> Where:
>
> (i) the evidence of medical practitioners suggests that the offender is currently suffering from a mental disorder,
>
> (ii) treatment is available, and
>
> (iii) the court considers that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case,
>
> the court should consider all sentencing options including a section 45A direction and consider the importance of a penal element in the sentence taking into account the level of responsibility assessed at step one.
>
> Section 45A hospital and limitation direction
>
> (a) Before a hospital order is made under section 37 (with or without a restriction order under section 41), consider whether the mental disorder can appropriately be dealt with by custody with a hospital and limitation direction under section 45A. In deciding whether a section 45A direction is appropriate the court should bear in mind that the limitation direction will cease to have effect at the automatic release date of a determinate sentence.
>
> (b) If a penal element is appropriate and the mental disorder can appropriately be dealt with by a direction under section 45A, then the judge should make such a direction. (Not available for a person under the age of 21 at the time of conviction).

Section 37 hospital order and section 41 restriction order

(c) If a section 45A direction is not appropriate the court must then consider (assuming the conditions in section 37(2)(a) are satisfied) whether the matters referred to in section 37(2)(b) would make a hospital order (with or without a restriction order under section 41) the most suitable disposal. The court should explain why a penal element is not appropriate."

Therefore, under the guideline, the sentencing court should consider all sentencing options, and determine whether a custodial sentence with a section 45A direction is appropriate; and, if not, whether a restricted hospital order under sections 37 and 41 is the most suitable disposal.

That guideline to a large extent, unsurprisingly, reflects the principles drawn from the authorities by this court in Edwards at [34], as follows:

"Finally, to assist those representing and sentencing offenders with mental health problems that may justify a hospital order, a finding of dangerousness and/or a section 45A order, we summarise the following principles we have extracted from the statutory framework and the case law.

1) The first step is to consider whether a hospital order may be appropriate.

2) If so, the judge should then consider all his sentencing options including a section 45A order.

3) In deciding on the most suitable disposal the judge should remind him or herself of the importance of the penal element in a sentence.

4) To decide whether a penal element to the sentence is necessary the judge should assess (as best he or she can) the offender's culpability and the harm caused by the offence. The fact that an offender would not have committed the offence but for their mental illness does not necessarily relieve them of all responsibility for their actions.

5) A failure to take prescribed medication is not necessarily a culpable omission; it may be attributable in whole or in part to the offender's mental illness.

6) If the judge decides to impose a hospital order under section 37/41,

he or she must explain why a penal element is not appropriate.

7) The regimes on release of an offender on licence from a section 45A order and for an offender subject to section 37/41 orders are different but the latter do not necessarily offer a greater protection to the public as may have been assumed in Ahmed and/or or by the parties in the cases before us. Each case turns on its own facts.

8) If an offender wishes to call fresh psychiatric evidence in his appeal against sentence to support a challenge to a hospital order, a finding of dangerousness or a section 45A order he or she should lodge a section 23 application. If the evidence is the same as was called before the sentencing judge the court is unlikely to receive it.

9) Grounds of appeal should identify with care each of the grounds the offender wishes to advance. If an applicant or Appellant wishes to add grounds not considered by the single judge an application to vary should be made."

As reflected in both the guideline and Edwards, a number of differences between the sentencing options for an individual with a mental disorder, who has committed a serious offence, can be identified.

First, a section 37 hospital order (with or without a section 41 restriction) is not concerned at all with punishment, whilst a sentence of imprisonment with a section 45A hospital direction has a penal element.

Both Edwards and the guideline emphasise that, whilst rehabilitation and protection of the public are important elements of any sentence of an offender with a mental disorder, punishment may also play a part. One of the statutory purposes of sentencing is punishment (see section 142 of the Criminal Justice Act 2003); and there are cases where the defendant's criminality warrants a particular period in detention despite any medical condition he may have. As described by this court in Cooper [2010] EWCA Crim 2335 at [16]-[17], the purpose of section 45A is to give the sentencing regime flexibility. In particular, when sentencing an offender with a mental disorder, the court is not faced with the stark choice between ordering detention in hospital for treatment or imprisonment. Section 45A thus

allows an offender to be directed to hospital by the court but, if he recovers or is found to be untreatable during that period, then he is remitted to prison to serve the balance of that time. In determining the most suitable sentencing disposal, the court must therefore bear in mind the importance of the penal element in a sentence as well as the rehabilitation and protection of the public (see Edwards at [34(3)]). That is clearly still so after the introduction of the guideline.

However, whilst in a particular case the punitive element of a sentence is or may be important, we would say that, even if a fixed period in detention were considered appropriate for a particular crime by way of punishment, where that period (which would be the minimum term of any indeterminate sentence) is clearly going to be less than the treatment period that will result in the risk posed by the offender being reduced to an acceptable level to allow any form of discharge from hospital, then punishment as a discrete purpose of sentence of imprisonment with a section 45A loses its force; because, whichever route is taken, the offender will spend the appropriate custodial period in the same hospital and generally in the same circumstances.

Second, Dr Anderson said that it is not true to say that there are no differences in the regimes whilst the offender is in hospital. For example, under a section 37/41 order, an application can be made to the Secretary of State for escorted and unescorted leave, something which cannot be done under the section 45A regime. Under that regime, in effect, barring an emergency, the offender simply cannot leave the hospital at all. In some cases, the ability for a patient to have such leave is an important element in their eventual rehabilitation back into the community.

Third, there are clear differences between the regimes so far as release, aftercare and recall are concerned. In addition to submissions, we have today again heard helpful oral evidence

from Dr Anderson on these differences.

(i) When subject to a restricted hospital order, for release, the offender only has to satisfy the FtT that his mental health poses no unacceptable risk to the public; whereas, in the case of a section 45A direction, where there is an indeterminate sentence, as well as satisfying the FtT as to that, he must also satisfy the Parole Board that he poses no such risk for any reason. That was emphasised by this court in Vowles [2015] EWCA Crim 45; [2015] 2 Cr App R (S) 6 where, at [21], Lord Thomas of Cwmgiedd CJ said of a section 45A direction:

> "The advantage of making such an order in an appropriate case is that an offender sentenced to an indeterminate or long determinate sentence can immediately be directed to have treatment in hospital, but the timing of his release is subject to the decision of the Parole Board which has to take a much wider view of the risks to the public than the [FtT]."

(ii) Unlike a hospital order, under section 45A, there is the possibility of a patient being released from hospital care back into the prison estate before release into the community – although Dr Anderson accepted that in most cases that is more hypothetical than real, because a responsible clinician is unlikely to agree to the release of a patient back into the prison estate in those circumstances if that may result in a deterioration of his condition.

(iii) Dr Anderson said that where the tribunal conditionally discharges a patient under section 37/41, it will attach appropriate and often rigorous conditions to the discharge, such as a requirement to spend every night at a particular address, a requirement to meet with the mental health team on sometimes a very frequent basis, compliance with a therapeutic regime (which will in most cases include the patient's compliance with medication), abstinence from non-prescribed drugs or

excessive consumption of alcohol, and a requirement to engage in psychological treatment in appropriate cases. The conditions may include testing arrangements to ensure compliance with any therapeutic regime and an abstinence from illegal drugs and alcohol if necessary. It is less likely that the Parole Board would impose such carefully tailored (and helpful) conditions to a release on licence from an indeterminate sentence.

(iv) Section 117 requires the responsible aftercare bodies, in cooperation with the relevant voluntary agencies, to provide aftercare for patients detained under section 37 or section 45A; and the Parole Board has the power to impose conditions on release which might include conditions as to mental health support. Therefore, it cannot simply be assumed that, once the offender is in back in the community, a section 37/41 order will necessarily provide a regime best suited to protect the public as opposed to a post-section 45A licence regime; nor that the former will provide a regime best suited to the rehabilitation requirements of the individual prisoner. Each regime contains provisions designed to ensure that the public is appropriately protected from the risks that an offender with a mental health condition may pose. Edwards emphasised (at [30]) that each case will depend on its own facts.

(v) However, Dr Anderson considered the aftercare arrangements under a restricted hospital order to have distinct advantages. On conditional discharge, under such an order, a mental health team led by a psychiatrist and a social worker supervisor (each of whom has to prepare a report each three months), together with a community psychiatric nurse, a psychologist if relevant, and peer workers, will supervise the individual and ensure (e.g.) compliance with medication and that his mental state is not deteriorating. Under a life licence as part of an indeterminate sentence, the

supervisor will be a probation officer, who, Dr Anderson said, is less likely to notice and/or elicit detriments to an individual's mental state, let alone ensure that any symptoms are properly and promptly treated.

(vi) Recall under an undischarged section 41 restriction can only be made on the basis of a failure to comply with a mental health support package and/or collapse of mental health; whereas recall for breach of a life licence may be on wider grounds, such as the commission of another offence unrelated to the offender's state of mental health. Where past offending is related to the offender's mental condition, it may be unnecessary and disproportionate that he faces the risk of being recalled to prison if he commits another, perhaps minor offence unrelated to his mental condition.

(vii) Recall under an undischarged section 41 restriction can be made by the responsible clinician and is to the relevant hospital; whereas recall for breach of a life licence is made by the Secretary of State and is, at least initially, to a prison. Dr Anderson said that there were a number of advantages to the former course. First, a recall can be made quicker, because it could be effectively made by a simple telephone call by the responsible clinician. Under the indeterminate sentence provisions, recall is made by the Secretary of State and that may take some time, particularly if the reason for recall is what may be perceived as a modest deterioration in the individual's mental wellbeing. Second, recall will be to prison (at least until a transfer direction can be made), rather than to hospital; and a transfer direction may take some time. The former regime may therefore avoid situations in which the risk posed by an offender may increase, or an offender's mental condition might worsen, because of delay in recalling and re-hospitalising him

In short, Dr Anderson's evidence was that the section 37/41 regime, generally and in the

Appellant's particular case, has significant advantages over the section 45A regime, both during the course of detention and on release and afterwards.

Judge Laing anxiously considered step four of the guideline procedure. We should emphasise that she did not have the advantage of the evidence we have heard today from Dr Anderson. Given the risk that the Appellant's treatment would not prevent a recurrence of psychotic episodes, and that that risk was for an indeterminate period, she said:

> "I am satisfied that the best protection of the public would be by the imposition of a life sentence, but I will combine that with a section 45A direction."

In terms of minimum term, the judge said that she would have imposed a determinate sentence of six years after a trial, and thus four years on a guilty plea. Hence, she imposed a life sentence with a minimum term to be served of two years with a section 45A direction. In relation to each of the other matters, including the breach of the suspended sentence, she imposed one month concurrent. In addition, she imposed (i) a driving disqualification for a year for driving whilst disqualified; (ii) six points endorsement to the Appellant's driving licence for the offence of driving without insurance; (iii) a restraining order preventing the Appellant from contacting named family members for five years; and (iv) a victim surcharge of £170.

Before us for the Appellant, Miss Eloise Marshall QC submits that the judge erred in imposing a life sentence with a section 45A direction rather than an order with restriction under sections 37 and 41. On the basis of the psychiatric evidence, the Appellant's responsibility was placed in the lowest category, and that level of culpability was also reflected in the tariff of two years. In terms of future risk, whilst she accepted that a life sentence may be appropriate where an offender poses a risk for an indeterminate period, she submitted that

such an order was not appropriate in this case, for the following reasons.

First, the Appellant had no history of violence. The psychiatrists were agreed that but for his psychotic delusion, the offence would not have occurred. Dr Anderson this morning also gave the opinion that if the Appellant had been therapeutically treated at the time for his condition, then he would not have had those delusions and again the offence would not have occurred.

Second, the judge erred in putting weight on Dr Ley's assertion in his oral evidence to her that the average period of supervision for those subject to a restricted hospital order under sections 37 and 41 was between five and ten years, compared with the risk posed by the Appellant was for an indeterminate period which may well exceed ten years. She sought to rely on a further statement from Dr Ley in which he explains that the period of a section 37/41 order may be substantially longer than ten years, the five to ten year range being an "arbitrary" figure given in his oral evidence. She also seeks to rely upon the oral evidence today of Dr Anderson, which on this point was essentially to the same effect.

Third, the Appellant has responded well to treatment and he now has personal insight into both his condition and his offending, which was completely absent at the time. In his supplementary report dated 22 November 2018, as supplemented further by his oral evidence before us, Dr Anderson has set out the likely regime, timescales and outcome. He considers it likely that the Appellant will remain in a secure hospital for four to five years, or longer if there is any recurrence of his psychotic symptoms, drug use or other concerns about the risk he poses. He would then be subject to a discharge hearing before the FtT, which would determine whether to release him on condition that, for example, he met his supervising team regularly, was compliant with his medication, and lived at a particular address. If the Appellant were the subject of a section 37 order with

a section 41 restriction without time limit, it would be possible for him to apply for an unconditional discharge in due course, but given his condition and the need for chronic medication, Dr Anderson considers it likely that the Appellant would never be given an absolute discharge which would allow him to end contact with the mental health services. In any event, he thinks it very unlikely that any application would be made in the Appellant's case within a period of five to ten years from conditional discharge. This puts the five to ten year figure used by Dr Ley into its true context.

Fourth, each of the three psychiatrists recommended a disposal by way of a section 37 hospital order with a section 41 restriction without time limit. Before us today, Dr Anderson has confirmed that recommendation, on the basis that, compared with such an order,a lfe sentence with a section 45A direction adds nothing in terms of the safety of the public, and that a hospital order is substantially better in terms of the rehabilitation of the Appellant for the reasons that we have given. As we have indicated, it does not add to the appropriate penal element of the sentence. Miss Marshall submitted that a restricted hospital order under sections 37 and 41 was the appropriate disposal and the judge erred in imposing a life sentence with a section 45A direction on the erroneous factual basis that because he may be absolutely discharged from a section 37/41 order within the course of the next five to ten years, it was only a section 45A order that would properly protect the public.

Fifth, she submitted that the sentence imposed was manifestly excessive because of the life licence, which would mean that his recall to a prison could be triggered by an unrelated and possibly minor offence.

We consider that there is considerable force in these submissions. As Miss Marshall emphasised, the judge found that the Appellant's retained responsibility for this offence fell into the lowest category. She did not deal directly with whether any punitive element in

the sentence would be appropriate, but in imposing a two year tariff, which was clearly much less than the period that would be required for his treatment in a secure hospital, for the reasons we have given, the punitive element within the sentence in fact imposed has no dependent force. Whatever happens, the Appellant will spend the whole of that period in a secure hospital.

In those circumstances, within the terms of the guideline, even if it can be said that a penal element is appropriate, we are persuaded that it cannot be said that the mental disorder can appropriately be dealt with by a direction under section 45A. That is because of the advantages in terms of rehabilitation for the Appellant by a hospital order coupled with a section 41 restriction.

In terms of the release provisions, we accept that there may be cases in which the Parole Board might play a discrete role over and above that played by the FtT, but in the Appellant's case there is no evidence to suggest that but for his mental condition he poses any risk to the public. The psychiatrists are agreed that that is the case. In those circumstances, it seems to us that the Parole Board would be bound to follow the recommendation of the clinicians and the tribunal as to release. In any event, we do not consider that the introduction of the Parole Board into the release procedure in the Appellant's case would do anything to enhance public safety. The judge, of course, did not suggest otherwise.

On the other hand, for the reasons given by Dr Anderson, a hospital order with a restriction has significant benefits so far as the rehabilitation of the Appellant is concerned. The judge appeared concerned about the length of time the Appellant might be detained in a secure hospital and the subject to recall under that regime. In our view, insofar as she considered that Dr Ley was saying that the Appellant might be absolutely discharged within five to ten years, that was not so. He merely said that an application for absolute discharge is "not

usually considered in serious cases, for somebody has been released for maybe five to ten years from release from hospital"; in other words, that an application for absolute discharge is not usually even considered until five to ten years after conditional discharge. Even then, that is a generalisation which clearly might not apply in a particular case. As Dr Anderson's evidence made clear, in cases such as this, a patient is very rarely absolutely discharged from the section 41 restriction order (so that the section 37 order continues in effect), because of the importance of compliance with chronic treatment and the possibility of relapse if the patient is left without proper mental health supervision once he has been discharged from hospital under the type of conditions we have described above.

In those circumstances, although we admit the additional oral evidence of Dr Anderson, we do not consider it is necessary for us formally to admit the additional evidence of Dr Ley confirming what he had meant in his oral evidence, which we heard *de bene esse* – although it comes as some comfort that it confirms the position as we had understood it and as in substance set out by Dr Anderson.

For those reasons, we do not consider that the life sentence imposed does enhance the protection of the public, and a restricted hospital order will ensure that any release and aftercare is properly focused on the mental health condition of the applicant and importantly is supervised by the responsible clinician. It will, as we have described, also reduce delays in release and indeed, if necessary, any recall.

In our view, that the judge therefore did unfortunately err in imposing the sentence that she did. We consider that a life sentence with a direction under section 45A was not a disposal under which the Appellant's mental disorder could appropriately be dealt with in guideline terms. The appropriate sentence – the most suitable disposal – is a section 37 order with a section 41 restriction without limit of time. Dr Anderson in his evidence confirmed that

the formal requirements for those orders had been complied with, and of course the Appellant has an available place, namely where he is now, in the Hellingly Unit.

We shall therefore allow this appeal and revoke all of the sentences of imprisonment. We shall replace the sentence of life imprisonment with a section 45 direction, with a hospital order under section 37 and a restriction order under section 41 without time limit. There shall be no separate penalty in respect of the other offences, including the breach of the suspended sentence, which we shall simply make no order.

We should also deal with three minor and consequential orders.

First, the judge imposed a 12 month disqualification from driving. Given that she imposed a sentence of imprisonment, the judge should have considered an extension of the disqualification under section 35A of the Road Traffic Offenders Act 1988, and in any event pronounced the disqualification in line with the guidance of this court in Needham [2016] EWCA Crim 455 at [31] and [47]-[50]. However, on the basis that the appropriate substantive sentence is to be a restricted hospital order, we consider the disqualification does not need to be changed. In the light of the order that we have substituted, it is appropriate.

Second, the judge imposed six penalty points for driving without insurance. In accordance with section 44 of the Road Traffic Offenders Act 1988, if a period of disqualification is imposed, no penalty points in respect of other offences committed on the same occasion should be endorsed. We revoke those penalty points.

Third, the judge imposed a victim surcharge of £170, which does not apply to a hospital order. We revoke that order.

Finally, we think it is only right that we should commend the judge's analysis under the then very new guideline. In our judgment, the error into which she was led resulted from a lack of

evidence as to the difference in regimes that we have so helpfully heard from Dr Anderson, both generally and in relation to this particular Appellant. Edwards makes very clear that consideration of an appropriate sentence in a case such as this is highly fact sensitive, and it is important that the sentencing judge is provided with appropriate evidence which will enable him or her to come to an informed decision as to whether a term of imprisonment with a section 45A direction, or a hospital order under section 37 with a restriction, or some other sentence is appropriate.

Epiq Europe Ltd hereby certify that the above is an accurate and complete record of the proceedings or part thereof.

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