Neutral Citation Number: [2020] EWCA Crim 598

Case No: 201901780 A2

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM WARWICK CROWN COURT
HIS HONOUR JUDGE LOCKHART Q.C.
INDICTMENT NO: T20177404

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 6 May 2020

Before:

Lord Justice Lindblom
Mr Justice Hilliard
and
His Honour Judge Flewitt Q.C.

- -

Between:

Thomas Westwood — **Appellant**

- and -

The Queen — **Respondent**

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- -

Mr Michael Duck Q.C. (instructed by **Penman Solicitors**) for the **Appellant**
Mr Peter Grieves-Smith (instructed by **the Appeals Unit of the Crown Prosecution Service**) for the **Respondent**

Hearing dates: 28 February and 12 March 2020

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Judgment Approved by the court for handing down

Lord Justice Lindblom:

Introduction

1. On 5 June 2018 in the Crown Court at Warwick, on an indictment charging him with murder, the appellant, Thomas Westwood, pleaded guilty to manslaughter by reason of diminished responsibility. That plea was accepted by the prosecution. The deceased was the appellant's mother, Susan Westwood.

2. On 16 April 2019, the appellant was sentenced by H.H.J. Lockhart Q.C. to an extended sentence of imprisonment of 21 years, comprising a custodial term of 16 years and an extension period of five years. The judge also made a hospital direction under section 45A of the Mental Health Act 1983 with a limitation direction that the appellant be subject to the special restrictions in section 41.

3. The appellant now appeals against sentence by leave of the single judge. He does so on two grounds: first, that the imposition of an extended sentence of imprisonment with a hospital direction under section 45A was wrong in principle, contrary, as it was, to the unanimous view of the psychiatrists involved in his case that the appropriate sentence was a hospital order under section 37 of the Mental Health Act and a restriction order under section 41; and second, that, if a sentence of imprisonment was appropriate, the custodial term of the extended sentence was manifestly excessive.

The hearing

4. The appeal came before us on 28 February 2020. In the course of argument on that day it became clear that the parties were not in a position to deal effectively with several questions arising from the appellant's grounds, on which clarity was lacking: in particular, the appellant's "retained responsibility" at the time of the offence, and the level of protection that would be provided to the public by the different regimes for release under the different modes of disposal available to the court – in particular, a hospital order under section 37 with a restriction under section 41 and an extended sentence of imprisonment with a hospital direction under section 45A.

5. We adjourned the hearing of the appeal to 12 March 2020, to give the parties a further opportunity to assist the court on these matters: whether, in the psychiatrists' opinion, the appellant was suffering from a psychotic episode at the time of the killing; whether, in their opinion, his "anger" – which was seen by the judge as a significant factor in his culpability – was itself a manifestation of his mental illness; the criteria for determining his release under the different sentencing regimes; and the likely arrangements, safeguards and management of risk that would then be in place. We requested a report from a probation officer of suitable experience. And we invited further submissions in writing from counsel before the hearing resumed.

6. The parties duly lodged a joint psychiatric report dated 6 March 2020, prepared by Dr J.P. Kenney-Herbert, a consultant forensic psychiatrist at the Tamarind Centre in Birmingham, who has been involved in the appellant's case since May 2018, and Dr Leela Sivaprasad, the appellant's responsible clinician at the Reaside Clinic in Birmingham, who has been involved in his case since July 2018; a "Disclosure Note" prepared by counsel for the

respondent, Mr Peter Grieves-Smith, dated 10 March 2020, which records the observations of Dr Sivaprasad on the likely arrangements following an offender's release from prison in a case where a hospital direction has been made under section 45A, in the light of the judgment of this court in *R. v Edwards* [2018] EWCA Crim 595 (in particular, paragraphs 16 to 30); a pre-appeal report dated 6 March 2020, prepared by Mr Steve Simpson, a probation officer employed by the National Probation Service in Coventry, which we have been able to consider against the guidance in a briefing document, "Mentally disordered offenders – the restricted patient system", jointly issued by the Ministry of Justice and H.M. Prison & Probation Service in December 2017; and the skeleton arguments of the appellant's counsel, Mr Michael Duck Q.C., and Mr Grieves-Smith, both dated 10 March 2020, taking account of the new material.

7. At the resumed hearing Dr Sivaprasad gave evidence, in the light of which both counsel made submissions. Before proceeding to hear that evidence and counsel's submissions upon it, we satisfied ourselves that the criteria for the admission of fresh evidence in section 23 of the Criminal Appeal Act 1968 were met and that it was in the interests of justice to admit it (see the judgment of this court in *R. v Edwards*, at paragraphs 31 to 33, and 34viii).

The facts

8. The appellant is now 48 years old. At the time of the offence he was 46. There is no dispute that he was then, and is now, suffering from paranoid schizophrenia and autism spectrum disorder. He had one previous conviction, in 2015, for an offence of using violence to enter premises, for which he had been sentenced to a community order.

9. At the time of her death Mrs Westwood was 68 years old. The appellant was living with her in her home, a bungalow in Cavendish Road, Coventry, which had only one bedroom. The appellant slept on the sofa in the living room. Neighbours often heard him and Mrs Westwood shouting at each other.

10. On 1 December 2017, at about 7.15 p.m., a neighbour saw the appellant and Mrs Westwood outside the house. The appellant seemed agitated and was talking to himself. Mrs Westwood suggested he should go inside. He became abusive towards her. A neighbour heard her say: "I told you not to have that drink". He swore at her. The neighbour urged him to calm down. Mrs Westwood said things were fine. The neighbour saw the appellant go inside and thought he had made to strike or push Mrs Westwood at the door.

11. At 8.37 p.m., the appellant telephoned the police to report that his mother had attacked him with a knife. When the police arrived, they found Mrs Westwood on the sofa. She was clearly dead. She had sustained a number of stab wounds to her chest, causing injuries to her heart and one of her lungs, and a rapid loss of blood. There were 18 areas of sharp force injury on her chest, and she also had defensive wounds on her arms. The pathologist who conducted the post-mortem examination was of the view that the force required to inflict those injuries was severe.

12. The appellant told the "999" operator and police officers who came to the house that his mother kept attacking him with knives and had wanted to slit his throat. In his interview with the police, he said that when he killed his mother he was acting in self-defence. But after he had been remanded in custody, he had told health care workers in the prison that he had killed his mother deliberately and had not acted in self-defence.

13. On the next day, 2 December 2017, while he was in police custody, the appellant was seen by two psychiatrists, Dr Read and Dr Holmes. They recorded the account he gave them of the offence. He had told them that his mother had come out of the room she was in "with a knife", and had been "in a mood". He said he made her a cup of tea. When he took it in, she "pulled a knife and started attacking him". He said he stopped it and called an ambulance. He said he had been taking his mirtazapine at night, and had "last taken his depot, Depixol 60 mgs weekly, on Wednesday [that] week and Tuesday the week before". He went on to say that after his mother had lunged at him with the knife, voices were saying "[Kill], kill, kill". He had taken the knife from her and was using it on her. He said he had been "defending himself".

14. The appellant appeared before the court at a preliminary hearing on 6 December 2017, when the court was told that the defence would be seeking a report on his fitness to plead. At the plea and trial preparation hearing on 1 February 2018, it having been confirmed that he was fit to plead, the appellant was arraigned and pleaded not guilty to murder. The defence told the court that it intended to seek a report addressing the question of diminished responsibility. On 25 May 2018, after psychiatric reports had been prepared, the prosecution indicated that it would be willing to accept a plea of guilty to manslaughter by reason of diminished responsibility. As we have said, the appellant entered that plea on 5 June 2018, which was the day on which his case had been listed for trial. On 3 August 2018, an interim hospital order was made under section 38 of the Mental Health Act, and on 15 August 2018, he was transferred from prison to the Reaside Clinic, where he remained until he was sentenced.

15. The impact of Mrs Westwood's death on her family was set out in a victim personal statement of the appellant's ex-wife, Amanda Blenkinson, which was read to the court at the sentencing hearing. As Ms Blenkinson said, "[the] whole family have had their hearts broken and the loss of Susan has left this family devastated".

Principles for sentencing an offender who suffers from a mental disorder

16. Where, as in this case, the offender suffers from a mental disorder, the options available to the sentencing court include a hospital order under section 37 of the Mental Health Act, with or without a restriction under section 41; a determinate or indeterminate sentence of imprisonment and direction for admission to hospital under section 45A; an interim order under section 38; and a determinate or indeterminate sentence enabling the Secretary of State to exercise his powers of transfer to a hospital under section 47 with or without a limitation order under section 49.

17. The correct approach to applying the statutory provisions has been considered by this court on several occasions, including *R. v Vowles and others* [2015] EWCA Crim 45, *R. v Ahmed* [2016] EWCA Crim 670, *R. v Markham and another* [2017] EWCA Crim 739, *R. v Edwards*, *R. v Rendell* [2019] EWCA Crim 621, and *R. v Fisher* [2019] EWCA Crim 1066.

18. In *R. v Vowles* Lord Thomas of Cwmgiedd C.J., giving the court's "guidance on the approach to be adopted", said (in paragraph 51):

> "51. It is important to emphasise that the judge must carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions. A judge must therefore consider, where the conditions in s.37(2)(a) are met, what is the appropriate disposal. In considering that wider

question the matters to which a judge will invariably have to have regard to include (1) the extent to which the offender needs treatment for the mental disorder from which the offender suffers, (2) the extent to which the offending is attributable to the mental disorder, (3) the extent to which punishment is required and (4) the protection of the public including the regime for deciding release and the regime after release. There must always be sound reasons for departing from the usual course of imposing a penal sentence and the judge must set these out."

19. As Lord Thomas went on to say (in paragraph 53), "[the] fact that two psychiatrists are of the opinion that a hospital order with restrictions under s.37/41 is the right disposal is therefore never a reason on its own to make such an order", and "[the] judge must first consider all the relevant circumstances, including the four issues we have set out in the preceding paragraphs and then consider the alternatives in the order in which we set them out in the next paragraph". He continued (in paragraph 54):

> "54. Therefore, … a court should, in a case where (1) the evidence of medical practitioners suggests that the offender is suffering from a mental disorder, (2) that the offending is wholly or in significant part attributable to that disorder, (3) treatment is available, and it considers in the light of all the circumstances to which we have referred, that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case, consider the matters in the following order:
>
> i) As the terms of s.45A(1) of the MHA require, before a hospital order is made under s.37/41, whether or not with a restriction order, a judge should consider whether the mental disorder can appropriately be dealt with by a hospital and limitation direction under section 45A.
>
> ii) If it can, then the judge should make such a direction under s.45A(1). …
>
> iii) If such a direction is not appropriate the court must then consider, before going further, whether, if the medical evidence satisfies the condition in s.37(2)(a) (that the mental disorder is such that it would be appropriate for the offender to be detained in a hospital and treatment is available), the conditions set out on s.37(2)(b) would make that the most suitable method of disposal. It is essential that a judge gives detailed consideration to all the factors encompassed within s.37(2)(b). …
>
> iv) We have set out the general circumstances to which a court should have regard but, as the language of s.37(2)(b) makes clear, the court must also have regard to the question of whether other methods of dealing with him are available. This includes consideration of whether the powers under s.47 for transfer to prison for treatment would, taking into account all the other circumstances, be appropriate."

20. In *R. v Edwards*, Hallett L.J., giving the judgment of the court, made these observations about the approach indicated in *R. v Vowles* (in paragraph 12):

> "12. … Section 45A and the judgement in *Vowles* do not provide a 'default' setting of imprisonment, as some have assumed. The sentencing judge should first consider if a hospital order may be appropriate under section 37(2)(a). If so, before making such an order, the court must consider all the powers at its disposal including a

> s.45A order. Consideration of a s.45A order must come before the making [of] a hospital order. This is because a disposal under section 45A includes a penal element and the court must have 'sound reasons' for departing from the usual course of imposing a sentence with a penal element. Sound reasons may include the nature of the offence and the limited nature of any penal element (if imposed) and the fact that the offending was very substantially (albeit not wholly) attributable to the offender's illness. However, the graver the offence and the greater the risk to the public on release of the offender, the greater the emphasis the judge must place upon the protection of the public and the release regime."

21. Hallett L.J. went on to say (in paragraph 14):

> "14. … [As] important as the offender's personal circumstances may be, rehabilitation of offenders is but one of the purposes of sentencing. The punishment of offenders and the protection of the public are also at the heart of the sentencing process. In assessing the seriousness of the offence, s.143(1) of the Criminal Justice Act provides that the court must consider the offender's culpability in committing the offence and any harm caused, intended or foreseeable. Hence the structure adopted by the Sentencing Council in the production of its definitive guidelines and the two pillars of sentencing: culpability and harm. Assessing the culpability of an offender who has committed a serious offence but suffers from mental health problems may present a judge with a difficult task but to comply with s.142 and the judgment in *Vowles*, he or she must attempt it."

22. She compared the "release regimes under s.37/41 and s.45A", focusing in particular on the "Provision of after-care services", "Offenders with MAPPA eligibility", "Consultant (Forensic) Psychiatry as opposed to Consultant (Clinical) Psychiatry", and "Licences" (in paragraphs 16 to 30). She then acknowledged (in paragraph 30) that "the conclusion expressed in *Ahmed* that the regime under ss.37 and 41 would necessarily provide a regime best suited to protect the public as opposed to a post s.45A licence regime was confined to the facts of that case". The observations made there were "not of any general application". The "conclusion as to which regime will better protect the public will depend on a careful assessment of the facts of an individual case" (see also *R. v Rendell*, where Thirlwall L.J. said, at paragraph 52, that "[the] question of whether the section 37/41 regime or section 45A … regime best protects the public is a matter of fact in each case").

23. Drawing together the principles to be taken from the statutory provisions and the relevant case law, Hallett L.J. said (in paragraph 34):

> "34. …
>
> i. The first step is to consider whether a hospital order may be appropriate.
> ii. If so, the judge should then consider all his sentencing options including a s.45A order.
> iii. In deciding on the most suitable disposal the judge should remind him or herself of the importance of the penal element in a sentence.
> iv. 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.

v. 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.
vi. If the judge decides to impose a hospital order under s.37/41, he or she must explain why a penal element is not appropriate.
vii. The regimes on release of an offender on licence from a s.45A order and for an offender subject to s.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 by the parties in the cases before us. Each case turns on its own facts.
viii. 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 s45A order he or she should lodge a s23 application. If the evidence is the same as was called before the sentencing judge the court is unlikely to receive it.

…".

24. She stressed that this court is "an appellate not a review court". Its task is to decide "whether the sentence imposed was manifestly excessive or wrong in principle" (paragraph 35).

The sentencing guidelines

25. The Sentencing Council Guidelines for Manslaughter by Reason of Diminished Responsibility, came into force on 1 November 2018. They indicate a staged approach to sentencing, in a series of steps.

26. Step 1 requires the sentencing court to determine "what level of responsibility the offender retained" – whether "high", "medium" or "low". As this court has recently observed in *R. v Rodi* [2020] EWCA Crim 330 (at paragraph 25), "[that] assessment is a matter to be weighed by the judge upon his or her view of the circumstances of the killing and the medical evidence which may bear on the question"; and "[where] the offender exacerbates the mental disorder by voluntarily failing to follow medical advice, this may increase responsibility; but in considering the extent to which the offender's behaviour is voluntary, the extent to which the mental disorder has an impact on the offender's ability to exercise self-control or engage with medical services will be relevant". Step 2 requires the appropriate starting point and category range to be established. In step 3 consideration must be given to the dangerousness provisions of the Criminal Justice Act 2003. Step 4 requires the court to look at possible disposals under the Mental Health Act. It should consider "all sentencing options including a section 45A direction" and the importance of a "penal element", having regard to the level of responsibility assessed in step 1. When a "penal element" is appropriate and the mental disorder can be appropriately dealt with by a direction under section 45A, such a direction should be made. Step 5 requires the court to consider whether the sentence should be adjusted to ensure that it meets the objectives of punishment, rehabilitation and protection of the public in a fair and proportionate way. The remaining steps include, in step 6, the giving of appropriate credit for a guilty plea.

The psychiatric reports before the judge

27. By the time the judge came to pass sentence on 16 April 2019, a number of psychiatric reports had been prepared. Dr N.M.J. Kennedy, a consultant psychiatrist at Orsborn House in Birmingham, who was instructed on behalf of the appellant, had prepared reports dated 16 May 2018, 1 August 2018 and 21 March 2019. Dr Kenney-Herbert, instructed on behalf of the prosecution, had prepared a report dated 10 May 2018. And Dr Sivaprasad had prepared a report dated 30 July 2018, subsequent reports requesting extensions of the interim hospital order, and ultimately a report for the sentencing hearing, dated 7 March 2019.

28. In his report of 10 May 2018, Dr Kenney-Herbert said the appellant's paranoid schizophrenia had been "characterised by paranoid thinking and delusions, auditory hallucinations, erratic behaviour, grandiose delusional beliefs [and] emotional dysregulation" (paragraph 127). It was "complicated by a high level of anxiety, a deterioration in his ability to cope and work and significant misuse of alcohol and other substances" (ibid.). Dr Kenney-Herbert thought it was likely that the schizophrenic illness was "only partially controlled by medication for much of the time". There had been "multiple contacts" between the appellant and mental health and other services in the months leading up to the offence. His mother had called the mental health services on several occasions because of her concerns about his mental state. The appellant himself telephoned the crisis resolution team on the 30 October 2017. He said he had raised his fists to his mother, though he denied actually hitting her. Although it appears that mental health services were trying to discharge him in the months leading up to the offence, Dr Kenney-Herbert thought he was "in fact in need of more support and treatment at that time" (ibid.). He was "clearly experiencing paranoia with delusional intensity" about what was going on in his own flat, "blaming his mother or others for breaking in and carrying out menial acts of vandalism or theft". He was "unstable in his ability to control his emotions and erratic in his behaviour" (paragraph 130).

29. In his report of 16 May 2018, Dr Kennedy described the appellant's long history of contact with mental health services, dating back to the late 1990s (pages 13 to 20). Even at that time, "paranoid delusions" had been noted and he had been prescribed anti-psychotic medication (page 14). He had an established diagnosis of "paranoid schizophrenia" from which he continued to suffer (page 15). Dr Kennedy referred to the account the appellant had given to Dr Read and Dr Holmes on 2 December 2017 (pages 22 and 23). He noted that the appellant had described people "breaking into his flat" each night in the period leading up to the offence. The description he gave was "entirely consistent" with "paranoid delusions". As for the offence itself, a common theme in all the accounts he gave was "persecutory beliefs concerning his mother" (page 27). Dr Kennedy was satisfied that he had been suffering from "hallucinations and paranoid delusions", and that his "abnormality of mental functioning would have impaired his ability to form a rational judgment and exercise self-control" (page 28). There was evidence to suggest that his "ability to understand the nature of his conduct was impaired", because he was "clearly influenced by paranoid delusions" (page 29).

30. In her report of 30 July 2018, Dr Sivaprasad noted that the appellant had said his "voices" were present "now and again" and particularly when he was due to be given an injection. He said the voices encouraged him to be violent (paragraph 79). As well as paranoid schizophrenia, Dr Sivaprasad referred to the appellant's "[long-standing] drug and alcohol use" until a few years before, and to "potential cognitive damage as a result of drug and alcohol use" (paragraph 97 and 98). He also appeared to have "[long-standing] personality

related difficulties with dissocial and paranoid traits". He reported "anxiety symptoms amounting to panic attacks for several years" (paragraph 98).

31. In his report of 1 August 2018, Dr Kennedy recommended that the appellant be admitted for a period of in-patient assessment at the Reaside Clinic (paragraphs 4 and 5). As we have said, he was admitted there on 15 August 2018.

32. In her report of 23 November 2018, Dr Sivaprasad noted that the appellant exhibited "several features of an Autism spectrum disorder (paragraph 6).

33. In her report of 7 March 2019, Dr Sivaprasad said (in paragraphs 223 and 224):

> "223. Following a thorough inpatient assessment for over 6 months, it is my view that the most suitable method of disposing of the case with regards to Mr Westwood is by means of a Hospital order under Section 37 of the MHA 1983 having regard to all the circumstances including the nature of the offence, the character and antecedents of the offender, and to the other available methods of dealing with him.
>
> 224. If a Hospital order under Section 37 … is made by the Court … , I would support additional consideration by the Court for a Restriction order under Section 41 of the MHA 1983 to also be made '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' and it therefore being 'necessary for the protection of the public from serious harm so to do'."

34. Dr Sivaprasad did not address the possibility of a hospital and limitation direction under section 45A of the Mental Health Act.

35. In his report of 21 March 2019, Dr Kennedy said (in paragraph 7 under the heading "Opinion"):

> "7. He has substantial rehabilitation needs which can only be addressed on an inpatient basis. If and when he gets to the point that he is suitable for transfer to a non-hospital environment it is … more likely than not that any gains in social functioning would be lost were he to be returned to a prison environment."

and (in paragraph 9):

> "9. In my opinion the most important factor in his commission of the offence were the positive and negative symptoms of schizophrenia which were not controlled and his social situation which his mother was doing her best to support him with."

36. Dr Kennedy recommended that the appellant was made subject to a hospital order with a restriction order, under sections 37 and 41 of the Mental Health Act (paragraphs 10 to 12). He went on (in paragraph 13) to explain why, in his opinion, such a disposal afforded better protection to the public than a hospital and limitation order under section 45A:

> "13. I would respectfully recommend that in the medium to long term this disposal affords better protection to the public. If returned to prison under the terms of a hybrid order (Section 45A) there would be a significant risk to Mr Westwood's health and safety and to the safety of officers and inmates arising from the nature of Mr Westwood's illness and the deficits in functioning he has accrued over the years

> (it is, sadly, unlikely that he will ever return to the level of functioning he enjoyed prior to the onset of his illness). A Section 41 Conditional Discharge would be the best way of mitigating his risk to others and to himself on his eventual return to the community."

The sentencing hearing

37. The judge sentenced the appellant without a report prepared by the Probation Service, and, it seems, had not been asked by either prosecution or defence counsel to consider requesting such a report. No criticism attaches to him for taking that course. He was entitled to proceed as he did. But as we have said, we have had the benefit of a probation officer's pre-appeal report.

38. At the sentencing hearing Dr Sivaprasad gave evidence. She was asked about the degree of responsibility retained by the appellant when he committed the offence. She identified five factors that she thought should be considered. The first was the appellant's "disposition or his personality". Dr Sivaprasad observed that "even if there were some unusual features of his personality[,] he functioned well until mental illness came [on board] in his mid-twenties". The second factor was his alcohol and drug use, which, in her opinion, "[did not] seem to have been a significant issue at the time" of the offence. The third factor was "the stresses that might come from living with a significant other", which it seemed to Dr Sivaprasad had not "caused too many problems in the past if [the appellant] was mentally well and [not] using significant drugs or alcohol". The fourth factor was "psychological stress", which seemed to have had "quite an impact on [the appellant] throughout his life". And the fifth factor was the appellant's "mental illness". Dr Sivaprasad said "[it] seems to be primarily the onset of mental illness that seems to have caused this decline …". Given the opportunity to offer her own view on the appellant's "retained responsibility", and in particular whether she was able to put it at "a level of low, medium or high", she expressed no opinion. She did, however, point out that both the appellant and his mother had "made several attempts to contact mental health services but also a whole host of other agencies to highlight the issues and the difficulties that they were having". When asked to explain why she favoured the making of orders under section 37 and section 41 of the Mental Health Act, as she had indicated in her report of 7 March 2019, Dr Sivaprasad referred to the appellant's "psychotic illness", for which she said, "he needs very robust treatment", adding that it was "debatable … whether he will return to a 100 per cent functioning".

39. In cross-examination by Mr Duck, Dr Sivaprasad agreed with the view expressed by Dr Kennedy in his report of 21 March 2019 (at paragraph 9) that "the most important factors in his commission of the offence" were "the positive and negative symptoms of schizophrenia which were not controlled and his social situation …". She also agreed with Dr Kennedy's opinion (at paragraph 5) that "[in] prison it is likely that his mental health would deteriorate", and (at paragraph 6) that "he requires treatment in hospital for the foreseeable future". This, she accepted, was not a case of "a sudden manifestation of mental health difficulties; they had been in existence for a considerable period of time". She also confirmed her agreement with the view expressed by Dr Kennedy (at paragraph 7) that the appellant had "substantial rehabilitation needs which can only be addressed on an inpatient basis", and that "[if] and when he gets to the point that he is suitable for transfer to a non-hospital environment" it was "more likely than not that any gains in social functioning would be lost were he to be returned to a prison environment".

40. Dr Sivaprasad was asked by the judge whether, if the appellant's treatment continued to go well, "the focus of the section 37 and section 41 orders" she was enjoining him to make "are to do with treatment and rehabilitation". She confirmed that this was so. The judge then asked her what would be her "best estimate of when [the appellant] would be fit for consideration of phased release into the community" if he continued to improve at the present rate. She said this was "a difficult question to answer". But when asked to assume "it all goes really well" and to say when she thought the appellant "would go back into the community", she said she would "anticipate something like five years".

41. Dr Sivaprasad was not asked to consider the level of the protection provided to the public by the different release regimes for, on the one hand, a hospital order with a restriction order under sections 37 and 41 and, on the other, an extended sentence of imprisonment with a hospital and limitation direction under section 45A.

The judge's sentencing remarks

42. In his careful sentencing remarks, the judge said the case was "a tragedy for all involved". The appellant's mental health overlay the offending, but his culpability "at first blush" was "high". He had a "long-standing mental health problem". But in the judge's view "anger was the primary and driving reason why [he] killed [his mother]". He must have intended to kill her, but his responsibility had been diminished to a degree to be determined.

43. The judge acknowledged that he must follow the guidance given by the Court of Appeal in *R. v Edwards* and *R. v Rendell*, and that he must consider the Sentencing Council sentencing guideline for the offence of manslaughter. He then went step-by-step through the exercise required.

44. On step 1, the assessment of "the degree of responsibility retained", he said he must decide if, and to what extent, the appellant's "actions and omissions contributed to the seriousness of his mental disorder at the time of the offence". The medical evidence "reduced [his] responsibility by a significant margin". On the day of the offence there was "evidence of significant impairments of [his] responsibility". It was, the judge said, "absolutely clear" that he was "suffering from paranoid schizophrenia and/or schizo-affective disorder, and some other conditions". And in the opinion of Dr Sivaprasad and Dr Kennedy, "the most important factor in the causing of the offence was [his] mental health condition[,] which was paranoid schizophrenia".

45. The judge went on to say:

> "… This is a matter of judgment. Whilst your abnormality of mental functioning was grave and longstanding, in my judgment, your medical condition did not cause this offence. It was, as the psychiatrists opine, an important factor, but it was certainly not the sole cause. You were not told by voices linked to your condition, to kill your mother, your condition did not impair your ability to understand the nature and consequences of your actions. You understood those immediately.
>
> This offence was caused by anger with your mother. You had been angry with her in the past, and on the day before this incident. Whilst this was not pre-planned, there was previous violence between you. The recognised medical condition meant that you were likely to attack your mother when stressed, and that once this attack,

> generated by anger, began, you were not able to exercise your self-control. That, in my judgment, is the significant impact of your condition."

46. The appellant's attempts "to minimise his wrongdoing, and to conceal [his] actions" – "behaviour [that] endures" – indicated to the judge a "higher degree of culpability". Part of the cause of the offence, for which the appellant bore "some significant responsibility", was his "failure to go to receive [his] medical treatment". He "knew the risks".

47. The judge concluded that he "retained a medium to high level of responsibility for [the] killing". The "harm", as in all cases of manslaughter, was inevitably "of the utmost seriousness".

48. In step 2, the judge had to determine the starting-point and the category range. If the appellant's responsibility was "medium" the starting-point was 15 years' imprisonment with a range of 10 to 25 years. This case, said the judge, was "towards the upper end of that scale". The "[aggravating] features" were the admitted "history of violence or abuse" towards his mother, her vulnerability, and the use of a weapon. The "[mitigating] features" were that the appellant had "no relevant previous convictions", the offence was "not pre-planned", and he had "made attempts … to seek assistance for [his] mental disorder".

49. On step 3, the judge had to consider "dangerousness". He had come to the view that a life sentence was not warranted. There were other methods of disposal that would keep the public safe. The appellant was "dangerous". This offence had been "caused by anger, which [he] could not completely control, due to [his] condition". There was no guarantee that this would not occur again, nor could the judge say when the risk would end. Dr Sivaprasad had said he would require "long-term, if not life-long, treatment and supervision for this severe and enduring mental illness". The judge was also of the view that "a determinate sentence would offer no proper protection". Any sentence of imprisonment would therefore have to be an extended sentence.

50. On step 4, "mental health disposals", the judge acknowledged that the psychiatrists had agreed that "a hospital order with a restriction [was] the proper way forward". They had all supported a disposal under section 37 and section 41. Having referred to *R. v Edwards*, the judge said he had first to consider "whether a hospital order might be appropriate", and if so, he then had to consider "all … sentencing options, including a section [45A] order". He acknowledged Dr Sivaprasad's view (in her report of 7 March 2019) that "the most suitable method of disposing of this case is by way of a section 37 order …", with "a restriction under section 41".

51. The judge said that in this case a "penal element" was "important". The appellant had acted in a "very violent manner" towards his mother, he had been "angry with her, and as a result of [his] condition, he more readily lost control". He had "not taken [his] medication, something [he] knew would place her at greater risk". His attack on her had been "savage and sustained".

52. The regimes on release for an offender on licence from a section 45A order and for an offender sentenced under sections 37 and 41 were different, but, said the judge, the latter "does not necessarily offer greater protection to the public". Dr Sivaprasad's evidence was that the appellant was improving and, if all went well, it might be hoped that, "at earliest, attempts would be made to reintegrate [him] into the community in five years or so". Before a hospital order was made, the judge reminded himself, the sentencing guidelines required him to consider whether the appellant could be appropriately dealt with by

imprisonment with a hospital limitation direction under section 45A. It was here, he said, that "the real issue" in the case arose. He had to decide if an extended sentence with a hospital limitation direction was appropriate, or a hospital order under sections 37 and 41. Where, as here, a "penal element is appropriate", he should impose an extended sentence with a hospital limitation direction if the mental disorder and the risk arising from it could appropriately be dealt with in that way. The limitation direction would cease to have effect at the release date.

53. He continued:

> "In my judgment, and having heard the evidence, I am satisfied that this is a case where a hospital limitation direction is appropriate. I am led to understand that, notwithstanding the fact that, under a section 41 restriction, you may receive life-long treatment, and you may be called back at any time, the emphasis under such an order is managing the risk, and seeking treatment and rehabilitation. I do not consider that this reflects the need here for a penal element.
>
> Further, the evidence means that the likely time from now to attempts to reintroduce you to society will mean that, in all likelihood, properly treated and managed, in a matter of a very few years, you will be released under supervision from hospital. In my judgment, the length of the extended sentence that is appropriate will be that the public can and should be protected from you for a long period."

54. On step 5, the "[factors] that warrant adjustment to the sentence", the judge found an "upper level of medium culpability", which would be reflected in the starting point for the extended sentence.

55. On step 6, "[credit] for plea", the judge said the appellant had known shortly after the offence that he had committed it. He had made admissions "quite early on" that he had not acted in self-defence. He had been fit to plead and to stand trial. Though he had awaited the psychiatric reports, a trial was in prospect "until close to the date of the hearing and self-defence was said to be the issue". The judge therefore concluded that full credit for the appellant's guilty plea could not be given. He would give credit of 20%.

56. Taking a starting point of 20 years, which he reduced by 20% to 16 years, the judge said that, having made the finding of dangerousness, he "must act to protect the public", and the term he had arrived at must be subject of an extension for five years. There could be "no clear view as to when [the appellant would] cease to present a danger". His condition needed to be treated by continued detention in the Reaside Clinic. A restriction under section 41 was appropriate. And "the appropriate order to ensure [the appellant's] continued treatment" was a "hospital limitation direction, pursuant to section [45A]".

The further psychiatric reports prepared in February 2020

57. Shortly before the hearing of the appeal, two further reports were prepared: a report prepared by Dr Kenney-Herbert, dated 22 February 2020, and a report prepared by Dr Sivaprasad, dated 24 February 2020. They had interviewed the appellant together on 21 February 2020.

58. In his report of 22 February 2020, Dr Kenney-Herbert said the appellant's case was "complex". When sentence was passed, it was "not possible to understand the full

complexity of his mental health issues and his likely response to treatment". He was "certainly a long way off being able to be considered for discharge from hospital" (paragraph 16). Though he had made "good progress" since being sentenced, he was "likely to require treatment in hospital for some years yet" (paragraph 17). Dr Kenney-Herbert concluded (in paragraph 18):

> "18. I would support that he be detained under Section 37/41 of [the Mental Health Act]. He clearly has a mental disorder of a nature and severity to warrant his detention in hospital. In my opinion if he is returned to prison he is likely to be highly vulnerable to further assaults, is unlikely to be able to progress and engage in appropriate offender treatment programmes and will remain at significant risk to himself and others. The risk will be more effectively managed in a mental health setting, whether in hospital or the community, for the foreseeable future, if not for the rest of his life. Appropriate medical treatment is available in hospital for [him]."

59. In her report of 24 February 2020, Dr Sivaprasad said the appellant had "made fairly significant progress since … his admission to the Reaside [Clinic]" (paragraph 66). It was, she said, "currently not possible to quantify the length of his treatment within a hospital setting" (paragraph 68). She remained of the view that "the most suitable method of disposing of the case … is by means of a Hospital order under Section 37 of [the Mental Health Act]" (paragraph 73). If such an order were made, she would "support additional consideration by the Court for a Restriction order under Section 41 … to also be made" (paragraph 78). She added (in paragraph 79):

> "79. [The appellant] will require long term if not life long treatment and supervision from mental health services for his severe and enduring mental illness. He will need to remain an inpatient in forensic mental health services for the foreseeable future. … ."

The joint psychiatric report of 6 March 2020

60. In their joint report of 6 March 2020, Dr Kenney-Herbert and Dr Sivaprasad dealt first with the "[the] extent to which [the appellant] needs treatment for the mental disorder from which [he] suffers". They said that "[due] to his multiple difficulties, the complex interplay between them and the length of time he has experienced them, it is difficult to anticipate how successful and responsive [his] treatment is likely to be". He was "likely to make slow progress over a protracted period of time" (paragraph 25). It was "currently not possible to quantify the length of his treatment within a hospital setting" (paragraph 26). He would "require long term and most likely life-long treatment and supervision from mental health services for treatment for his severe and enduring mental illness (paranoid schizophrenia/schizoaffective disorder) and management of other mental health issues/disorders such as cognitive deficits, substance use, post traumatic stress and dispositional issues".

61. The agreed conclusions were these (in paragraphs 193 and 194):

> "193. In our opinion, [the appellant] requires ongoing assessment and treatment in a secure mental health inpatient facility via a specialist forensic multidisciplinary team comprising of medical, nursing, psychology, occupational therapy, speech and language, pharmacy and social work professionals for the foreseeable future.

194. Such specialist, multidisciplinary and intensive input over a significant length of time would not be feasible for him in a prison setting at the present time."

62. On "[the] extent to which [the appellant's] offending is attributable to the mental disorder", Dr Kenney-Herbert and Dr Sivaprasad referred to accounts given by members of his family after he had been "discharged from mental health services" in October 2017. These had referred to him "re-establishing contact with mental health services and re-starting antipsychotic medication", but indicated that after he had returned to live with his mother, "things went from bad to worse in terms of his mental health as well as his risk issues" (paragraph 57). They continued (in paragraph 58):

"58. Their accounts of him at the time strongly suggest he was experiencing active psychotic symptoms" He could not be reasoned with and became extremely angry if challenged, contradicted or if disagreed with in any way. He would fly into a rage, damage property, be 'vile' to his mother, call her names and at times pin her down/pick up a knife to her."

63. They referred also to the appellant's interview with Dr Reed and Dr Holmes on 2 December 2017, the day after the killing, in which he had said that "after [his mother] had lunged at him with the knife … the voices were saying "kill, kill, kill"" (paragraph 71). Dr Reed had noted that "there were some inconsistencies in his reporting, but this did not seem to be deceptive" (paragraph 87).

64. Again, the conclusions were agreed (in paragraphs 195 to 198):

"195. In our opinion, his offending in relation to the death of his mother was largely attributable to his mental disorder i.e. paranoid schizophrenia/schizoaffective disorder.

196. From the available records, his personal account, the family's reports to Dr Sivaprasad and mental health assessments following the offence, [he] was floridly psychotic at the time of his mother's death. …

197. There were significant stresses associated with his living situation and relationship with his mother for several months in the lead up to his mother's death; however these two issues appear to have significantly underpinned and influenced by his mental illness at the time.

198. … Introduction of antipsychotic medication (clozapine) … has resulted in a significant reduction in his psychotic symptoms in Reaside Clinic and a marked reduction in his risks to others."

65. On the question of whether the appellant was "suffering from a psychotic episode at the time of the killing", Dr Kenney-Herbert and Dr Sivaprasad said that at the time of his discharge from mental health services in October 2017, and despite having "not [been] deemed to be actively psychotic" by them, it is clear that he was "actively psychotic … but struggled to communicate his difficulties" (paragraph 190). The conclusions were (in paragraphs 207 to 209):

"207. It is … our opinion … that [the appellant] had been partially treated for psychosis in the community for some time, probably years. Leading up to the … offence … he was clearly showing signs of an unstable mental state consistent with an acute

psychotic exacerbation of his longstanding psychotic (schizophrenic) illness that was not adequately treated.

208. The fact that he fluctuated, was volatile and at times aggressive and threatening and he himself reported this are all in keeping with him being psychotic leading up to and at the time of the … offence. He attempted to seek help on multiple occasions as did his mother in the weeks prior to the offence. He was not particularly good at explaining why he needed help and we now believe this relates to his autism spectrum condition/characteristics impairing his communication skills.

209. … It is difficult to understand the logic behind the decision to discharge him when he was showing signs of mental instability due to his schizophrenic illness and was reporting aggression towards his elderly mother."

66. Considering whether the appellant's "expression of anger" was "to be regarded as a manifestation of his illness rather than a free-standing factor", Dr Kenney-Herbert and Dr Sivaprasad referred again to his interview with Dr Reed and Dr Holmes on 2 December 2017, and said it was "noteworthy that [they] did not regard him as deceptive or somehow manipulating the situation when they spoke to him" (paragraph 181). In their opinion it was "likely if he said he was experiencing voices at the time, that he was, and they may well have been telling him to kill" (paragraph 182). The main conclusions here were these (in paragraphs 203 to 205):

"203. It seems clear that over the years when he has been more acutely psychotic he has posed a risk of threats, aggression towards property, verbal and physical aggression and expressions of anger towards others. This seems to be most likely linked to paranoid delusions, auditory hallucinations and a sense of threat. This has likely contributed to him misinterpreting or misattributing the motivations of others as if they are somehow threatening him.

204. Whilst it is of course likely that at times [the appellant] would become angry for reasons unrelated to his mental illness, it does seem that when he is psychotic and feeling threatened his anger is more likely to be expressed and potentially associated with aggressive language and actions.

205. In conclusion the expression of anger by [the appellant] has been, in our opinion, a significant manifestation of his mental illness on multiple occasions and particularly around the time of commission [of] the … offence."

67. As for "[the] protection of the public including the regime for deciding release and the regime after release", Dr Kenney-Herbert and Dr Sivaprasad referred (in paragraphs 121 to 129) the guidance in "Mentally disordered offenders – the restricted patient system" (December 2017).

68. They said that if the appellant were subject to orders under sections 37 and 41, he would "remain in a secure inpatient unit for the foreseeable future in order to receive the necessary treatment and rehabilitation …" (paragraph 130). "Annual Statutory Reports" would be provided to the Secretary of State (paragraph 131). The appellant would be "subject to the Multi Agency Public Protection Arrangements (MAPPA)" (paragraph 132). If the time came when he was considered ready to begin "rehabilitation into the community", an application for "escorted community leaves" would be submitted to the Secretary of State (paragraph 134). And if consideration was later given to his readiness for "unescorted

community leaves", a similar process would follow (paragraph 135). Ultimately, "[following] yet another significant length of time involving [him] presenting in a settled manner, being tested out on unescorted leaves, and completing all outstanding areas of work prior to the clinical team considering him safe to be managed in the community, the clinical team can directly approach the Secretary of State or [the appellant] can apply for a [First-tier Tribunal] hearing to consider discharge into the community" (paragraph 136). Decisions about his "supported accommodation" would be "carefully considered by his clinical team …". The Probation Service would have no statutory role in this process (paragraph 137).

69. The appellant's ultimate discharge would "almost inevitably involve a conditional discharge … over the initial few to several years with conditions stipulating where he resides (supported accommodation), the need to take psychotropic medication as prescribed, the need to comply with his psychiatric supervisor (usually a social worker and Approved Mental Health Professional) as outlined by his clinical team and need to subject to random alcohol and drug testing as required by the clinical team" (paragraph 138). He would "remain under the care of a forensic mental health team at Reaside clinic with conditions attached to his management plan …" (paragraph 139). If there were "concerns … about [his] mental state and associated risks to self and/or others whilst he is in the community, his clinical team in working hours or the on-call team out-of-hours based at Reaside clinic (a service he will be under for the foreseeable future …) will ensure he is reviewed by mental health professionals from the service as soon as possible (within 2 to 3 hours)" (paragraph 142). If it were "deemed that his mental health and associated risks cannot safely be managed in a community setting, he will be considered for a recall to hospital … under Section 41 …" (paragraph 143). The Secretary of State would be "contacted via the Mental Health Casework Section … at [Her Majesty's Prison and Probation Service] to request a recall warrant which can be obtained within minutes …" (paragraph 144).

70. As for the regime under section 45A, Dr Kenney-Herbert and Dr Sivaprasad expected that the appellant would also "remain in a secure inpatient unit for the foreseeable future" for "the necessary treatment" (paragraph 146). Once returned to prison, he would be "referred to the mental health Inreach team … for ongoing mental health input", but "they cannot compel him to accept treatment … if he does not wish to comply". Should there be a serious deterioration in his mental health, he could be "referred to hospital for inpatient care" (paragraph 150). After his release, decisions about his accommodation and licence conditions would be made by the Probation Service (paragraph 152). At a time nearer to his release, he "should be considered for referral to mental health services for ongoing mental health follow up in the community", but "they cannot compel him to accept treatment including medication and blood tests if he does not wish to comply". If his mental health deteriorated significantly, he could be "considered for inpatient hospital care voluntarily or via detention under the Mental Health Act … after a formal Mental Health Act assessment involving an AMPH and 2 Doctors" (paragraph 153).

71. Dr Kenney-Herbert and Dr Sivaprasad concluded (in paragraphs 200 and 201):

> "200. In our opinion, a Section 37/41 Hospital order with a Restriction order … would be the most suitable method of disposing of the case … having regard to all the circumstances including the nature of the offence, the character and antecedents of the offender, and to the other available methods of dealing with him.

201. It is also our view that a disposal under Section 37/41 and the regime associated with it, pre and post discharge from hospital, will afford optimal protection of the public over other available regimes based on our opinion that his active mental illness was largely responsible for his actions leading to the death of his mother. The restrictions that apply under Section 41 last indeterminately in hospital and in the community."

The "Disclosure Note"

72. Mr Grieves-Smith's "Disclosure Note" records Dr Sivaprasad's comments on her own experience of the operation of the release regimes under sections 37 and 41 and section 45A, in the light of the discussion in *R. v Edwards* (at paragraphs 16 to 30). She pointed out that where an order has been made under section 45A, the offender's "involvement with mental health services will be voluntary" (paragraph 5 of the "Disclosure Note"), and that a licence condition requiring attendance at appointments with a psychiatrist and co-operation with recommended treatment can only be used if the offender consents to that treatment, and the offender "could withdraw such consent at any stage" (paragraph 8).

The probation officer's pre-appeal report

73. The probation officer's "pre-appeal report" acknowledged that under sections 37 and 41 the Probation Service has "no responsibility for the supervision … or risk management" of the offender. Describing the regime under section 45A, the probation officer said:

> "… [Under section 45A, the hospital direction and limitation direction] does not apply if past the release date (if the offender is still in hospital). If an indeterminate sentence prisoner then the limitation direction will remain in place for the duration of their detention in hospital, even if this is past the minimum term or tariff. In such a circumstance the release date would not be fixed but would be set by the Parole Board, who would be guided accordingly at each of the hearings they would have to review [the appellant's] progress made regarding his mental health. The primary information source for the Parole Board would be reports from mental health professionals.
>
> In the event of [the appellant's] mental health improving whilst he is in [the Reaside Clinic]/Hospital a decision can be made by the Parole Board for him to be transferred to prison where he can serve out his sentence accordingly. In the event of a deterioration whilst in custody he can similarly be returned to a hospital setting. Although Probation do not provide any of the mental health intervention, we work closely with those agencies … , along with the Police[,] all of whom have clear defining roles as they work in a collaborative manner to manage cases sentenced under [section 45A]."

and in his "Conclusion":

> "… [The] Probation Service would only be able to offer a regime under [section 45A]. … [Such] intervention would consist of community risk management, courtesy of close monitoring, and sharing of information through the MAPPA process to facilitate a robust multi-agency approach in terms of managing the risk posed to the community by [the appellant].

> When released, he would have licence conditions he would be expected to comply with, a breach of any of the conditions could potentially lead to [him] being recalled to custody. However, the Court is reminded that … such a regime is dependent on [his] progress under the supervision of the mental health professionals, and the advice/guidance available in the progress reports provided."

Dr Sivaprasad's evidence before us

74. In her evidence at the resumed hearing on 12 March 2020, Dr Sivaprasad amplified the content of the joint report. She said she would place "quite a lot of emphasis" on what the appellant had said to Dr Reed and Dr Holmes on 2 December 2017, in an almost contemporaneous account of the offence. She confirmed her view and Dr Kenney-Herbert's that the appellant was "experiencing an acute psychotic exacerbation against the background of his chronic psychotic illness … in the lead-up to, and during and after the incident …". The killing was, she said, "largely attributable … to his mental illness". In cross-examination by Mr Duck, she said the view that his "expression of anger" at the time of the offence was a "manifestation of his mental illness" had been "borne out when he was not on medication". In answer to a question from the court, she said that when, at the sentencing hearing, she had contemplated the appellant's release, on a "best case scenario", after five years, she had not appreciated the "full extent" of his problems – "not just psychotic illness but a whole host of other difficulties".

The main thrust of the appeal

75. The main thrust of the appeal, reinforced by the most recent psychiatric evidence, is that in the particular circumstances of this case the judge should not have rejected the making of a hospital order under section 37 and a restriction order under 41. That, it is submitted, was the right disposal in this case. The sentence passed by the judge was therefore wrong in principle.

76. There is no dispute that the judge was right to find the appellant "dangerous", which, on the evidence, he clearly was. However, Mr Duck submitted, it was neither necessary nor appropriate here to pass an extended sentence of imprisonment, with a hospital limitation direction under section 45A. That sentence finds no support in the conclusions of the psychiatrists involved. The judge may have been unduly influenced by Dr Sivaprasad's evidence – though she was reluctant to speculate – that the appellant might be fit to be released from hospital in as little as five years' time. But in any event the psychiatrists were agreed. They believed the appellant would need continued care and treatment in hospital for the foreseeable future. And they were consistent in their shared view that a disposal under sections 37 and 41 was the right one. If such a sentence were substituted for that imposed by the judge, the regime operating on the appellant's release under would assure sufficient protection for the public.

77. Mr Duck submitted that the judge erred in placing the appellant's "retained responsibility" at the level of "medium to high". This was in conflict with the psychiatric evidence, and contrary to the prosecution position – both at the sentencing hearing and in the appeal – that the level of "retained responsibility" in this case was distinctly below that. The medical evidence on "retained responsibility" pointed clearly to the conclusion that the most important factor in the commission of the offence was the appellant's mental illness, that he

was suffering a psychotic episode – in fact, "floridly psychotic" – at the time, and that his "expression of anger" was to be regarded as a "manifestation of his illness".

78. Mr Duck based his submissions on the guidance in "Mentally disordered offenders – the restricted patient system" (December 2017), and the observations made by Dr Kenney-Herbert and Dr Sivaprasad in the joint report. He submitted that under the regime for and on release under sections 37 and 41 there would be effective safeguards to protect the public from any risk posed by the appellant.

79. Explaining the position taken in the respondent's notice, Mr Grieves-Smith acknowledged that it was the judge's role to make relevant findings of fact. He submitted, however, as is stated in the respondent's notice, that the judge did not "take full account of [the appellant's] mental illness". He confirmed that it was the respondent's view, in the light of the most recent evidence, that the level of "retained responsibility" was "low". In his submissions to us on the additional material produced during the adjournment, he accepted – as he put it in his skeleton argument – that "there is a proper basis for concluding that [orders under sections 37 and 41] would be appropriate and there is a sound reason for departing from the need to impose a sentence with a penal element".

The appellant's "retained responsibility"

80. We must remember the principles identified by Hallett L.J. in *R. v Edwards* (at paragraph 34). And we also remind ourselves of two things. First, we are not the sentencing court. Nor are we a "review court". We are performing an appellate role. The question for us is whether the sentence imposed by the judge was manifestly excessive or wrong in principle (see *R. v Edwards*, at paragraph 35). Secondly, in performing our appellate role we are not bound to endorse even a strong, definite and consistent medical consensus such as plainly exists in this case, any more than the judge himself was constrained in that way (see paragraph 51 of the judgment in *R. v Vowles*).

81. We say straight away that the judge was faced with an unenviable sentencing exercise. He went about it thoroughly. He took conspicuous care in seeking to apply the approach advised in the sentencing guidelines, with the benefit of as much help as he was given at the sentencing hearing. And it can also fairly be said that several matters seem not to have been as clearly and fully dealt with at that stage as they have been before us.

82. Nevertheless, we see considerable force in the submission made to us by counsel on either side, which draws strongly on the consensus of medical opinion, that the judge fell into significant error in fixing the appellant's "retained responsibility" at the level he did, namely "medium to high". It seems to us that on the evidence before him, and on all the evidence now before us, that conclusion was not sustainable. In our view, the only realistic conclusion was that the appellant's "retained responsibility" at the time of the offence was "low". This, we think, was clearly indicated by the medical evidence before the judge. And it is amply supported by the subsequent psychiatric reports. They serve to confirm the view that the factor of most significance in causing the appellant to commit the offence was his mental illness; that he was suffering a psychotic episode when he did so; and that his "anger" at the time was not extraneous to his mental illness, but a manifestation of it.

83. The judge was entirely justified in concluding that the appellant's mental disorder reduced his responsibility, as he put it, by "a significant margin". He was right to recognize that, because the appellant was, at the time, "suffering from paranoid schizophrenia and/or

schizo-affective disorder, and some other conditions", Dr Sivaprasad and Dr Kennedy regarded his "mental health condition" as the "most important factor" in causing the offence. And he was also right to acknowledge that the appellant's "abnormality of mental functioning was grave and longstanding".

84. However, the psychiatrists were not saying either that the appellant's mental illness was merely, as the judge went on to describe it, "… an important factor" in the commission of the offence or that it was "the sole cause". That was a false contrast. The burden of the psychiatric reports before the court at that stage, and still more firmly now, is that, as the judge had initially recognized, the appellant's long-standing mental illness was the "most" important factor, as Dr Kennedy had described it in his report of his report of 21 March 2019. Rather than rejecting that opinion, the judge appears first to have accepted it and then modified it, without, so far as we can see, any solid evidential basis for doing so.

85. The judge also seems to have discounted the significance of what the appellant said to Dr Reed and Dr Holmes on the day after the offence, when he told them of voices urging him to "kill" his mother, despite the fact that this was an account that both Dr Kennedy and Dr Sivaprasad evidently regarded as credible, against the background of "auditory hallucinations and paranoid delusions". They considered it "likely" that he was "experiencing voices at the time" if he said he was, and that they were "telling him to kill" (paragraph 182 of the joint report). The judge's observation that the appellant's "condition did not impair [his] ability to understand the nature and consequences of [his] actions" was also apparently contrary to Dr Kennedy's view in his report of 16 May 2018 that his "abnormality of mental functioning would have impaired his ability to form a rational judgment and exercise self-control", and that "his ability to understand the nature of his conduct impaired", because he was "clearly influenced by paranoid delusions". Here too the judge's conclusion seems unjustifiably at odds with the opinion of the psychiatrists.

86. After those remarks came what seems to have been the most significant of the judge's conclusions on "retained responsibility" – his statement that the offence was "caused by" the appellant's "anger" with his mother, echoing his earlier remark that "anger was the primary and driving reason why [he] killed her". To this he added that the appellant's "medical condition" made it likely that he would attack his mother "when stressed", and that once the attack "generated by anger" had begun he was "not able to exercise [his] self-control", which, he said, was "the significant impact of [the appellant's] condition". This observation was not based on anything the psychiatrists had said in the reports they had prepared by the time of the sentencing hearing. Nor is it supported in any of the subsequent reports. And it is, we think, undermined by the conclusion in the joint report that the appellant's "expression of anger … has been … a significant manifestation of his mental illness on multiple occasions and particularly around the time of commission [of] the … offence" (paragraph 205).

87. The final conclusion at this stage of the judge's sentencing remarks was that "part of the cause" of the offence, for which the appellant bore "some significant responsibility" was his "failure to go to receive his medical treatment". This seems hard to reconcile with the events leading up to the offence, in particular the appellant's discharge by mental health services in October 2017, at a time when it seems he was in need of more support and treatment – as Dr Kenney-Herbert had said in his report of 10 May 2018, and as is stated in the joint report, he was "showing signs of mental instability due to his schizophrenic illness and was reporting aggression towards his elderly mother" (paragraph 209).

88. Thus, on a central – and ultimately crucial – question in the sentencing exercise, the appellant's "retained responsibility", the judge's approach was, we think, in error. It went against the unequivocal and, on the face of it, cogent view of the psychiatrists, clearly set out in their reports, that the appellant was seriously mentally ill at the time of the killing, and that his mental illness was the principal cause of the offence. The factors identified by the judge as increasing the level of the appellant's "retained responsibility", including his "anger", were themselves the product of his mental illness. In the circumstances we cannot accept that his conclusion on the level of retained responsibility, which he put at "medium to high", had at the time of the sentencing hearing, or has now, a proper foundation in expert medical opinion, or in fact. In short, it was not justified. We can see no reason to reject the relevant conclusions of the psychiatrists, which are, in our view, compelling. The reality here, as Dr Kenney-Herbert and Dr Sivaprasad have said in the joint report, is that the appellant's offence was "largely attributable to his mental disorder i.e. paranoid schizophrenia/schizoaffective disorder" (paragraph 195).

89. In agreement therefore with the submission made to us by both counsel, we are driven to the conclusion that the appellant's level of "retained responsibility" for his offence could not properly have been set at a level above "low".

90. This is an important conclusion. It bears on the part of the sentencing exercise in which the judge had to consider the need for a "penal element", and, in turn, the decision on the appropriate disposal: whether it be under sections 37 and 41 or a sentence of imprisonment with an order under section 45A. Relevant here is that in the sentencing guidelines the starting point in a case where the level of "retained responsibility" is "medium" is 15 years' custody with a category range of 10 to 25 years, whereas in a case where it is "low", the starting point is seven years with a category range of three to 12. If, as we have concluded, the appellant's "retained responsibility" was "low", the appropriate sentence of imprisonment would likely be significantly shorter than that imposed by the judge.

The protection of the public

91. The judge was rightly anxious to ensure that any sentence he imposed would sufficiently protect the public. He was aware that, in the light of the assessment of the appellant as an in-patient at the Reaside Clinic for a period of six months, the psychiatrists were united in the opinion that the most appropriate disposal in this case was under sections 37 and 41. But on his view of the appellant's "culpability", he considered a "penal element" to be "important".

92. His conclusion that a disposal under sections 37 and 41 should be rejected in favour of one including an order under section 45A was strongly influenced by two factors that had carried significant weight in his conclusion on "retained responsibility": his findings that when the appellant killed his mother he was "angry with her, and as a result of [his] condition, he more readily lost control", and that the appellant had failed to take his medication, knowing this would place her at greater risk. He also referred to the prospect of the appellant being reintroduced into the community after as short a period as five years – which Dr Sivaprasad had suggested might be possible if his treatment went as well as it could.

93. Here too, in view of our conclusion on the appellant's "retained responsibility", we think the judge's conclusion cannot be sustained.

94. Given the need for the appellant's long-term and probably life-long need for treatment in a secure hospital, on which the psychiatrists remain agreed, we think there can be no doubt that in this case a hospital order was, and is, appropriate. We acknowledge that this conclusion may now be more solidly based in the psychiatrists' prognosis than it might have appeared from Dr Sivaprasad's evidence at the sentencing hearing. But it is, in our view, absolutely clear from the joint report.

95. It follows that all sentencing options, including a section 45A order as well as a disposal under sections 37 and 41, fell to be considered. In deciding on the most suitable disposal the judge had to consider the importance of a "penal element". And in deciding whether a "penal element" was necessary, he had to assess, as best he could, the appellant's culpability, as well as the harm caused by the offence.

96. In doing that, he relied on his assessment of the appellant's "retained responsibility", which, for the reasons we have given, we consider to have been unsound. There was nothing in the psychiatrists' reports, or in the oral evidence, to support the view that the two factors on which the judge particularly relied could properly be seen as increasing the appellant's culpability. As we have said, the psychiatrists have now made it plain that the appellant's "anger" was, in their view, a manifestation of his illness. And as this court said in *R. v Edwards* (at paragraph 34v), a failure to take prescribed medication is "not necessarily a culpable omission", but may be attributable, at least to some degree, to the offender's mental illness. Here, so far as we can see, there was no evidence that, in the circumstances as they were at the time of the offence, it was a "culpable omission".

97. On the basis of our conclusions on the appellant's "retained responsibility" and "culpability" and the consequences of those conclusions for the length of any custodial sentence, giving due weight to the psychiatrists' firm opinion on the nature of his enduring mental illness and his need for long-term treatment in hospital, and notwithstanding the gravity of his offence and the undisputed finding of "dangerousness", we are satisfied that a "penal element" in his sentence was not appropriate. In our view, the protection of the public from any risk he now presents, or will in the future present, can be effectively achieved by a disposal under sections 37 and 41. We accept the submissions to that effect made on either side.

98. In coming to that conclusion, we have had in mind the illuminating comparison of the different regimes on release of an offender on licence from a section 45A order and for an offender subject to orders under sections 37 and 41 in *R. v Edwards* (at paragraphs 16 to 30) and also in *R. v Fisher* (at paragraphs 29 to 36), the guidance in "Mentally disordered offenders – the restricted patient system" (in particular, at paragraphs 5 to 9), the observations of Dr Kenney-Herbert and Dr Sivaprasad in the joint report (in paragraphs 121 to 153, 200 and 201), the "Disclosure Note", the probation officer's pre-appeal report, Dr Sivaprasad's evidence before us, and the submissions of counsel.

99. The main points are these. First, the regime under sections 37 and 41 does not necessarily provide greater protection to the public than that under section 45A, but on the facts of a particular case, it may (see *R. v Edwards*, at paragraph 30).

100. Secondly, the joint report, taken together with the previous medical evidence, gives no confidence that when the appellant's sentence expires the treatment of his mental illness will have been entirely successful, or the effective control of that illness outside a secure hospital entirely assured, that his release into the community could be contemplated. It may be that his return to the community will never become appropriate. There is, we think,

obvious good sense in his "[remaining] in a secure inpatient unit for the foreseeable future in order to receive the necessary treatment and rehabilitation …" (paragraph 130 of the joint report). And in this case at least, there is a distinct potential disadvantage to an order under section 45A by comparison with orders under section 37 and 41, in that if the appellant were to be returned to prison his mental health would be liable to deteriorate, with the risk that he would then refuse treatment (see paragraph 150 of the joint report).

101. Thirdly, if the appellant were made subject to orders under section 37 and 41 and if he were ever to be discharged from hospital, the arrangements that would then obtain would provide at least as much and probably more protection for the public than would the regime for an offender sentenced under section 45A. The potential disadvantages of a section 45A order are discussed in the joint report (in particular, at paragraphs 139 to 144 and 153). We have already referred to them (in paragraphs 69 and 70 above). If sentenced under section 45A, the appellant could not, after his release, be compelled to accept medical treatment. And the process for his recall could prove slower and more cumbersome than the process under sections 37 and 41, which, if need be, can be very swift.

102. Fourthly, therefore, in the circumstances of this case, we agree with the conclusion of Dr Kenney-Herbert and Dr Sivaprasad in the joint report: that orders under sections 37 and 41 would be "the most suitable method" of disposing of the case "having regard to all the circumstances … and to the other available methods of dealing with him" (paragraph 200); and that such a disposal and "the regime associated with it, pre and post discharge from hospital", will afford "optimal protection of the public over other available regimes …" (paragraph 201). As they have stressed, the restrictions that apply under section 41 "last indeterminately in hospital and in the community" (ibid.). These conclusions correspond to Dr Sivaprasad's and Dr Kennedy's at the time of the sentencing hearing: Dr Sivaprasad's in her report of 7 March 2019 (at paragraphs 223 and 224), and Dr Kennedy's in his of 21 March 2019 (at paragraphs 10 to 12).

The right disposal in this case

103. In the light of the principles set out in the authorities, and in particular the four considerations referred to in *R. v Vowles* (at paragraph 51), we conclude that the first ground of appeal is made good, and that the sentence passed by the judge must be quashed. In the circumstances of this case there was a sound reason for departing from the need to impose a sentence with a "penal element". In view of the low level of the appellant's "retained responsibility", the likelihood that for the rest of his life he will need psychiatric treatment and supervision that can most effectively be provided through orders under sections 37 and 41 of the Mental Health Act, and the likely advantages in this case of the regime for and on his release under such orders when compared to an order under section 45A, we consider that that is the right disposal here.

Credit for plea

104. Our conclusion on the right disposal makes it unnecessary for us to reach a concluded view on the second ground of appeal – in which it is contended that if a sentence of imprisonment was appropriate, the term imposed by the judge was manifestly excessive. However, because we heard argument on one aspect of that second ground – the appropriate credit for the appellant's guilty plea, we shall deal briefly with that.

105. Where an offender suffering from a mental disorder has pleaded guilty, credit will normally be given for that plea. The correct approach was indicated in *R. v Markham*, where Sir Brian Leveson said (in paragraph 68):

> "68. … [Assuming] that there is a legitimate basis for any defendant's legal advisers to take the view that psychiatric evidence is necessary to investigate either fitness to plead, insanity or diminished responsibility, in circumstances where there is no issue as to the commission of the crime with the relevant intent, the first available opportunity might be as soon as that evidence is available. That would require the Crown to have been kept informed of the position so that any preparatory arrangements could be made with an eye to what could be the only possible issues that required to be tried. …".

106. The Sentencing Council's Definitive Guideline on the Reduction in Sentence for a Guilty Plea, issued in March 2017, says (in paragraph F1) that "[where] the sentencing court is satisfied that there were particular circumstances which significantly reduced the defendant's ability to understand what was alleged or otherwise made it unreasonable to expect the defendant to indicate a guilty plea sooner than was done, a reduction of one-third should still be made"; and that "[in] considering whether this exception applies, sentencers should distinguish between cases in which it is necessary to receive advice and/or have sight of evidence in order to understand whether the defendant is in fact and law guilty of the offence(s) charged, and cases in which a defendant merely delays guilty plea(s) in order to assess the strength of the prosecution evidence and the prospects of conviction or acquittal".

107. Mr Duck submitted that the judge gave inadequate credit for the appellant's guilty plea. There was no justification for limiting it to 20%. The appellant had no opportunity to plead until medical reports were prepared addressing the question of diminished responsibility. The prosecution had waited for a report before confirming that the plea was acceptable. At the pre-trial and preparation hearing, when the appellant pleaded not guilty to murder, it was made clear that reports had been sought. The appellant entered his plea of guilty to manslaughter as soon as was possible after the reports were available. He should therefore have received the credit appropriate for a plea of guilty entered at the first available opportunity, namely the full one-third reduction.

108. On the first day of the hearing before us, Mr Grieves-Smith conceded it was difficult to adhere to the contention in the respondent's notice that the judge had given appropriate credit for the appellant's plea because the appellant could, at an earlier stage, have abandoned the defence of self-defence he had put forward in interview and made it clear that the only issue at trial would be diminished responsibility. He accepted that until the psychiatric reports had been prepared, it was not possible to determine whether the appellant's assertion that he was acting in self-defence was an issue likely to be raised at trial or simply a manifestation of his mental illness.

109. We are inclined to agree. We accept that this could be seen as a case of the kind mentioned in paragraph F1 of the sentencing guideline, where it was open to the sentencing court to find that there were "particular circumstances which … made it unreasonable to expect the defendant to indicate a guilty plea sooner than was done" and, in its discretion, to make the full reduction of one third in the sentence imposed. It could be said, in our view, that it was "necessary" for the defence "to … have sight of [the psychiatric] evidence" to show whether the appellant could properly plead guilty to manslaughter by reason of diminished responsibility, and that he was not "merely [delaying] his guilty plea … to assess the

strength of the prosecution evidence and the prospects of conviction or acquittal". The circumstances here seem akin to those referred to by this court in *R. v Markham* (at paragraph 68). If this is right, we would accept that the appellant ought to have been given the maximum credit for his guilty plea.

Conclusion

110. For the reasons we have given, the appeal against sentence is allowed. We shall quash the sentence passed by the judge and substitute for it orders under sections 37 and 41 of the Mental Health Act.