This judgment is handed down by the Court remotely by circulation to the parties' advisers by email and release to the National Archive.

The date for hand-down is deemed to be 21 October 2022.

Neutral Citation Number: [2022] EWCA Crim 1379

Case No: 202200881

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT NEWCASTLE
His Honour Judge Evans
T20077039

Royal Courts of Justice Strand, London, WC2A 2LL

Date: 21/10/2022

Before :

LORD JUSTICE WILLIAM DAVIS
MR JUSTICE FRASER
and
MRS JUSTICE HILL

Between :

REX	**Respondent**
- and -	
PAUL RICHARD SURREY	**Applicant/Appellant**

Mr Fitzgerald KC and Ms Woodrow (instructed by Dr Laura Janes of **GT Stewart Solicitors**) for the **Appellant**
Mr Jarvis (instructed by **Crown Prosecution Service**) for the **Respondent**

Hearing date : 6 October 2022

Judgment

Mr Justice Fraser:

Introduction

1. This is an application for permission to appeal against sentence which has been referred to the Full Court by the Registrar. It is also an application for an extension of time of 14 years 11 months and an application to admit fresh evidence under s.23 Criminal Appeal Act 1968. For reasons of convenience we shall refer to the applicant/appellant simply as Surrey. No discourtesy is intended by the use of solely the applicant/appellant's family name.

2. The provisions of s.39 of the Children and Young Persons Act 1933 ("CYPA 1933") were engaged in this case because the applicant was under 18 years of age both at the time that he was convicted, and also when he was sentenced. An order was made on the date of sentence, 29 March 2007, under s.39 of CYPA 1933 in relation to proceedings in the Crown Court in the following terms: "The Court prohibits the publication of the name of the defendant who is the subject of this order." Those provisions are no longer engaged as the defendant is now over the age of 18, when such orders lapse. This interpretation of the operation of the prohibition was made clear in ***R v JC and RT and Others*** [2014] EWHC 1041 (QB) by the Divisional Court (PQBD, Cranston J and Holroyde J (as he then was)).

3. For completeness we record that s.39 of the CYPA 1933 was repealed when section 45 of the Youth Justice and Criminal Evidence Act 1999 came into force, which replaced it, the relevant date for that latter statutory provision coming into force being 13 April 2015. That makes no difference to the fact that reporting restrictions are no longer in force in this case and have not been for many years.

4. On 16 January 2007 in the Crown Court at Newcastle, Surrey pleaded guilty before Her Honour Judge Bolton to one count of wounding with intent to cause grievous bodily harm, contrary to section 18 of the Offences against the Person Act 1861 ("OAPA 1861"). Surrey was aged 17 both at the time of the offence, when he pleaded guilty and when he was sentenced. That sentencing hearing also took place in the Crown Court at Newcastle before His Honour Judge Evans, on 29 March 2007.

5. Section 91 of the Powers of Criminal Courts (Sentencing) Act 2000 was in force at that time and applied in Surrey's case. This provided that if the court was of the opinion that neither a community sentence nor a detention and training order was appropriate, then it could impose a sentence on him up to the statutory maximum for the offence, notwithstanding his age at the time. He had previously been sentenced in September 2005 to a detention and training order of 6 months in duration for a previous offence. It is therefore no surprise that the court concluded that such an order was not an appropriate for his section 18 offence.

6. Section 226 of the Criminal Justice Act 2003 ("CJA 2003") also applied because he had committed a specified serious offence and the court was of the opinion that there was a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences. The sentencing judge took the view that it was not necessary for him to impose a life sentence and that an extended sentence under section 228 would not be adequate to protect the public from

the risk posed by Surrey. In those circumstances, the sentencing judge was required to impose a sentence of detention for public protection.

7. The judge therefore sentenced Surrey to a sentence of detention for public protection under s.226 CJA 2003. Such a sentence is more usually known as an DPP and is for those under the age of 18. It is the equivalent sentence to one for adults called imprisonment for public protection which is often referred to as an IPP, such sentences being created by section 225 of the Criminal Justice Act 2003. These types of sentence were subsequently modified and then finally abolished by the Legal Aid, Sentencing and Punishment of Offenders Act 2012, although that was done with prospective effect from December 2012. Thus, it remains the lawful sentence which Surrey is required to serve, pending the outcome of this application and, if permission is given, the appeal.

8. The custodial element of the sentence passed upon Surrey was 2 years, less the period he had by then spent in custody on remand, which was 81 days. Surrey therefore had a little more than about 21 months or so further to serve in custody, before the custodial element of his DPP was served. Serving that period would not, however, mean that Surrey would be entitled to release at that point.

9. This is because such a sentence has a minimum custodial term specified by the court at the time of passing the sentence, which is the period that must be served before the prisoner is entitled to have their case considered by the Parole Board. It is the element of the sentence designed to achieve two of the three aims of sentencing, namely punishment and deterrence. The third aim, protection, is achieved by the nature of the sentence once the minimum custodial term has been served. The sentence can potentially lead to some confusion on the part of some people, in that the minimum custodial term could (incorrectly) be interpreted as a period of imprisonment in the same way that a fixed determinate term would be. Importantly, if a person has been sentenced to an IPP sentence, they can potentially remain in detention long after the minimum custodial term had been served. Their release is permitted only when the Parole Board decide that such risk as they present can be adequately managed in the community. Simply because the minimum custodial term has been served, it does not mean that they are entitled to release, or are indeed safe to be released. Once released, such a prisoner remains on licence and can be recalled to prison, either for breach of any conditions of that licence, or if other offences are committed. The sentence remains in force indefinitely, and an offender is therefore subject to licence conditions and potential recall for the remainder of their life.

10. Surrey has not been released for reasons which will become clear. He remains in custody, although not in prison. He is now in secure hospital.

The Facts

11. The index offence which led to his being charged, and then pleading guilty, had occurred on 31 December 2006, at a New Year's Eve party. The complainant, a young person to whom we shall simply refer as the complainant, who was aged 16, attended a house party at an address in Vale Head, Whitley Bay. The party was being held at the home address of a friend of his. Amongst the attendees at the party were a group of five male youths from the Gateshead area, including Surrey, who was at that time aged 17.

They did not know the complainant. The complainant was wearing a number of prominent items of jewellery, including rings, and at one point during the party one of those present overheard Surrey saying words along the lines of "I think we should tax that kid's rings". These comments were understood by those who overheard them to be a suggestion that they should steal the complainant's jewellery. The complainant was informed of what had been said and the jewellery was temporarily hidden for safekeeping.

12. Later during the course of the evening the complainant, who had become upset at something that had gone on with a girl at the party, was sitting on the stairs. He was approached by Surrey who invited him into the main bedroom for a chat. They both sat on the bed and Surrey closed the door. Surrey asked the complainant what was wrong. Before the complainant could answer he felt a blow to the back of his head. He turned to his left and saw a knife in the applicant's hand. He ran from the bedroom downstairs shouting "I've been stabbed". As he looked back he could see Surrey who followed him downstairs shouting, "He fell over. I haven't done anything". The complainant ran outside into the front garden where friends tended to his injuries and contacted the emergency services. Police arrived at the location and found that the complainant had suffered a five inch laceration to the back of his head. He was taken by ambulance to hospital where he received 10 stitches to close the wound. He had been stabbed in the back of his head by Surrey, and had the knife penetrated 2 cm further than it had, it would have penetrated his spinal cord and caused significant and permanent injuries.

13. Police established that Surrey was responsible, and the knife that was used, which belonged to the mother of the person holding the party, was recovered from the front bedroom. It must have been taken from the kitchen by Surrey and was used to stab the complainant. Surrey was eventually arrested at 10:30 am on 1 January 2007 at his home address. He made no comment in interview. He was identified the following day by the complainant on a video identification parade.

14. Upon his plea of guilty, the court ordered preparation of a Pre-Sentence Report ("PSR"), which was provided dated 15 March 2007. This set out his childhood history, which was a very unhappy and dysfunctional one, and included reference to his low IQ, difficulties in seeing alternatives to conflict, and unsuccessful attempts to curb his aggression. He was living in a supportive environment with his father and grandparents, and his grandmother in particular were doing their best to support and encourage him, but he had substantial difficulties in accepting any authority from adults and was confrontational. The report concluded that he was at high risk of causing harm to members of the public through further violent offending, and was also at high risk of re-offending.

15. Surrey told the author of the report, Mr Bowman, in the two interviews that were held with him, that he had been drinking alcohol and smoking cannabis on the night in question and this had influenced his behaviour. He said that the incident arose as a result of the complainant giving him "dirty looks" after he had been kissing the complainant's ex-girlfriend. He admitted that he picked up the knife and approached the complainant with the intention of stabbing him because of the dirty looks he had given him. When they spoke in the bedroom the complainant had warned him to keep away from his ex-

girlfriend and referred to him as a "ginger nut". This made him angry and he stabbed him with an intent to cause him injury.

16. The court also had a medical report upon Surrey prepared by Dr Kennedy, a chartered clinical psychologist which was dated 23 March 2007. That report included further details about Surrey's troubled childhood. He had lived with his mother and her new partner, both of whom had subjected both him and his siblings to sustained abuse. He had been taken into care by the local authority on a number of occasions but returned to his mother. She was eventually convicted of sexual offences and was a Schedule 1 offender. Dr Kennedy had seen Surrey in October 2004 after he had been referred to the Northern Forensic Mental Health Service for Young People in June 2004. Dr Kennedy had concluded that he was not "overtly mentally unwell" and Surrey had been discharged on 29 October 2004. He was then re-referred in May 2005 but refused to engage, and was consequently discharged again on 3 June 2005.

17. Dr Kennedy's report was concerned to address the question of future risk and did not address whether the Applicant's conditions met the criteria for a Hospital Order under the Mental Health Act 1983 ("MHA"). No conclusion was offered as to whether Surrey suffered from a mental disorder within the meaning of the MHA, nor whether such a disorder was of a nature or degree which necessitated treatment in hospital.

18. Surrey had a high number of previous convictions, namely 28, commencing in 2003, and had been before the courts on 13 different occasions. His convictions included those from the juvenile courts, such as possessing an offensive weapon, possessing Class C drugs, common assault, battery, being drunk and disorderly, disorderly behaviour, criminal damage, breaches of supervision orders, breaches of previous detention and treatment orders that had been imposed, and theft.

19. The judge considered the circumstances of the offending, the contents of the PSR and the medical evidence of Dr Kennedy. He observed that despite the sentences that had been passed upon him for his previous offending, and despite Surrey having been supervised, his offending had persisted, and had escalated in frequency and seriousness. There was a developed pattern of anti-social behaviour on his part, and a pattern of perceived provocation with planned use of a weapon. He found him that there was a significant risk to the public of his committing further specified offences and causing serious harm, within the definition of s.226(1)(b) of the CJA 2003. This means that he satisfied the test of dangerousness within the Act. He therefore sentenced Surrey to a sentence of detention for public protection or DPP with a custodial term of 2 years less the time he had already served on remand.

20. The applicant was originally detained, due to his age at the time, in a series of Young Offender Institutions, and then he was transferred to an adult prison. During his imprisonment there have been a number of incidents of serious self-harm, suicide attempts, and also assaults on other inmates. In November 2010 he was transferred to Rampton Hospital for the first time where it was concluded that he suffered from personality disorders. Rampton Hospital is a secure hospital for the treatment of offenders who are mentally unwell. Following an assault on another patient in 2011 and a reluctance to engage in treatment, he was transferred back to prison in April 2012.

21. He acquired further convictions after the imposition of the DPP and whilst he has been in custody. On 22 July 2008 he was convicted of assault occasioning actual bodily harm contrary to s.47 OAPA 1861. On 21 April 2010 he was convicted of criminal damage, and on 25 April 2012 he was convicted of wounding/inflicting grievous bodily harm contrary to s.20 OAPA 1861. For each of these three offences he was sentenced to custodial sentences of 12 months, 20 months and 18 months respectively, each to be served concurrently to his DPP.

22. Having displayed psychotic symptoms in December 2013, in June 2014 he was transferred back to Rampton Hospital where he was diagnosed - for the first time - with schizophrenia. However, in the absence of his engagement in therapeutic work he was transferred back to prison in January 2015. There he continued to self-harm and he only complied inconsistently with his medication. There was a significant decline in his ability to cope in June 2015, which coincided with the death of his grandmother that month. His mental state since then has deteriorated and in June 2018 he was transferred back to Rampton Hospital under ss. 47 and 49 Mental Health Act 1983. He remained there for the next three years, until November 2021 when he was transferred to a medium secure unit at Northgate Hospital in Morpeth. Here he remains. He is in receipt of both medication and treatment for his schizophrenia which continues, and he is under the care of a consultant psychiatrist, Dr McKinnon, who is the Responsible Clinician.

The fresh evidence

23. We considered the fresh evidence *de bene esse* in the first instance. This was substantially from consultant psychiatrists, although Dr Carthy is a Specialty Registrar. The fresh evidence was from Dr David Brabiner, in a psychiatric report dated 30 June 2014; Dr Withecomb, in two reports dated 11 November 2015 and 10 June 2020; Dr Barani Sambandan, in both a psychiatric report and letter of 18 June 2021 and 28 June 2021; Dr Callum Ross and Dr Elliot Carthy, who prepared a Joint Psychiatric report dated 28 January 2022; Dr Iain McKinnon, whose views were set out in the psychiatric report of Dr Ross and Dr Carthy, 28 January 2022; and also Dr McKinnon's evidence in a Joint Report with Dr Ross dated 27 September 2022. We also had the benefit of what is called in the index a "Gatekeeping Assessment" from Dr Julie Thorpe dated 10 June 2020. We also received oral evidence from Dr Ross and Dr McKinnon which we refer to in more detail at [40] onwards.

24. Surrey had been assessed in 2013 and underwent a further assessment by Dr Brabiner of Rampton Hospital, which led to his second admission to Rampton. Dr Brabiner at that point identified concerns that Surrey may be suffering from a previously unidentified psychotic illness. Dr Brabiner was the clinician who recommended his transfer back to hospital. On 3 June 2014 he was transferred to the Learning Disability Service at Rampton Hospital and his mental state stabilised following the reintroduction of medication. However, he continued to express delusional and paranoid beliefs and refused to engage in any therapeutic work in relation to his personality disorders, insisting that he did not need to be in hospital (although he had previously expressed a desire to return to hospital). He was therefore kept separate from other patients. In a report of 30 June 2014, Dr Brabiner diagnosed him for the first time as having schizophrenia. Dr Brabiner concluded that this mental illness warranted his

detention in hospital for the protection of others. Dr Brabiner was unable to form a conclusion as to the presence of a concurrent personality disorder at that stage, but further confirmed the presence of a learning disability. In terms of the chronology, following this diagnosis, Surrey remained in Rampton but was returned to the prison estate following a period when he would not engage with the treatment in Rampton.

25. This led to a further period when Surrey was in prison rather than hospital. This, again, saw his condition deteriorate. This led to a further referral to the hospital authorities, and he was admitted to Rampton again. The report of Dr Thorpe dated 10 June 2020 was initiated to consider whether he had to complete further therapies within Rampton before he could be moved to Northgate. That report concluded that further treatment in Rampton was required and that the position should be reviewed before any transfer took place.

26. The First Tier (Health, Education and Social Care Chamber (Mental Health)) Tribunal then issued a decision dated 6 October 2021 following a further hearing to consider his treatment. That hearing was held whilst Surrey was at Rampton, which is a secure hospital, and the decision was whether to approve his move to Northgate Hospital, which is medium secure. The Tribunal found that he was suffering from paranoid schizophrenia and mild learning disability, based on the unchallenged evidence of the professional witnesses, namely Dr Sambandan in a report dated 18 June 2021 and other medical professionals involved in his treatment. Dr Sambandan is a consultant forensic psychiatrist and was Surrey's Responsible Clinician at Rampton Hospital. That evidence was found to be consistent, mutually supportive and aligned with all that was known about Surrey through what the Tribunal described as "his well-documented history" and also oral evidence given by him to the Tribunal. The Tribunal found that he suffered from mental disorder as prescribed by the Mental Health Act.

27. The Tribunal concluded that the primary disorder from which he suffered was a severe, chronic, psychotic disorder that was prone to rapid relapse. In the past, including recent past, relapse had been linked to non-compliance with a sustained, consistent medical regime. Social stressors, such as a change in environment had also played a significant role in his relapse pattern. The learning disability was lifelong. He experienced impairments relating to communication, intellectual reasoning, and social skills and his disability was associated with abnormally aggressive behaviour and seriously irresponsible conduct. The nature of both disorders was mitigated by the structured secure environment and medical regime which was being provided in a clinical setting under a legal framework. Were he to be removed from such an environment he would quickly and significantly relapse. Behaviour, including his impulsive and violent behaviour relating to his learning disability would quickly re-emerge. We would observe that this analysis and these findings entirely matched his history over the preceding years; his periods of relative stability would invariably be within a clinical environment, and movement following such stability (or his refusal to engage, which would lead to his discharge) back to the prison estate were invariably accompanied by significant deterioration of his mental condition.

28. The conclusion of the Tribunal was that he was suffering from mental disorders of a nature which made it appropriate for him to be liable to be detained in a hospital for medical treatment. In respect of the health, safety and protection of other people, the

Tribunal decided that if he were to leave hospital, he would be deprived of the significant level of specialist treatment he needed and was receiving and that such a course of action would "completely destabilise Mr Surrey's mental health". The history of transfers between prison and Rampton illustrated that due to his mental disorders he was unable to tolerate the stresses attached to a change in environment by returning him to prison. Transfers back to prison in the past had further demonstrated that he struggled to comply with his medication regime in the absence of the support provided in the secure hospital environment. The Tribunal decided that were he to leave hospital he would rapidly and severely deteriorate. He had a long and significant history of self-harm and suicide attempts both in the community (which we add here were when he was a teenager and before the imposition of the DPP) and also in prison. The prison, even with the specialisms available, were unable fully to contain this behaviour and the Tribunal concluded that it was very likely that this would quickly resurface were he to leave a clinical environment. His history confirmed that he posed a risk to others when unwell. The Tribunal decided that outside the ward environment he would again quickly become a risk to others.

29. Accordingly, the conclusion of the Tribunal was that the risks were such that it was necessary to warrant his continuing treatment in a secure hospital. Appropriate medical treatment was available to him at Rampton where he had psychiatric supervision and support from a specialist experienced team in a high secure hospital. He received clozapine medication which was supervised and monitored, and the plan was for him to be moved to a medium secure hospital environment at Northgate Hospital, which then occurred in November 2021. This was nearer to his family – his father and paternal grandparents – and facilitated family visits and increasing contact with them. This transfer was initially on the basis of what is called trial leave under s.17 MHA, and then a permanent transfer was made, that having been approved by the Ministry of Justice.

30. Dr Ross submitted a joint report to this Court together with Dr Carthy, who is a Specialty Registrar in Forensic Psychiatry. Their joint report is dated 28 January 2022 and it includes an extensive recitation of the history of his imprisonment, including previous admissions to Rampton, as well as what the report described as a "disastrous attempt to enter Mr Surrey into a therapeutic community at HMP Gartree" in 2012, which was done (as is usual) as a precursor to a prisoner being considered for release. However, given that the aim of the prison system is that a prisoner becomes medicine-free during such a process, the psychotropic medicine which he was taking was reduced and this caused a dramatic deterioration both in his condition and behaviour. In its conclusions the joint report states that Surrey suffers from mental disorders and treatment in hospital is required both for his treatment and the protection of others.

31. The mental disorders from which he is suffering are Paranoid Schizophrenia, Personality Disorder (emotionally unstable, dissocial and paranoid) together with a mild Learning Disability with his IQ being in the range of 50-70. This makes it appropriate for him to be detained in a hospital for the medical treatment he requires, which was available at Rampton Hospital.

32. The schizophrenic illness from which he suffers is characterised by those features which are overt, namely the positive features of the illness such as hearing voices and holding false beliefs. In Surrey's case, he endured beliefs in prison that officers were

going to slash his throat, he misinterpreted others' benign actions and interpreted them as threatening, he believed that his television had been interfered with, described hearing voices, and had an affect (which is an observable mood state) out of keeping with what would be reasonable. There were periods when he would laugh incongruously, his behaviour was erratic and unpredictable, and it included dangerous actions including swallowing cleaning fluid and other attempts at self-harm. There was also a very clear and temporal relationship with medications prescribed and withdrawn in terms of the psychotic symptoms from which he suffered.

33. The authors of this Joint Report were of the view that the horrific experiences he had endured as a child in his early childhood, and the trauma and significant neglect he experienced, had contributed to the evolution of his personality disorder.

34. One specific point of instruction addressed in the Joint Report was whether the requirements of section 37(2) of the MHA would, based on what was now known, have been met at the point of his sentencing in 2007. Their joint conclusion was that the diagnosis of mental illness was not something that a psychologist, as opposed to a psychiatrist, would have been expected to establish in the course of the psychological assessment performed by Dr Kennedy. They noted that there was evidence that by 2010 he was in the early period of the acute phase of his initial psychotic episode, and that the period preceding this, which is known as the prodrome phase, was likely to have begun several years before, at around the time of the index offence.

35. Dr McKinnon also provided some evidence which is contained in the Joint Report of Dr Ross and Dr Carthy dated 28 January 2022. This was to the effect that he broadly agreed with their clinical assessment and that Surrey was doing well following the transfer to Northgate from Rampton.

36. Dr Ross also prepared a joint report with Dr McKinnon, who as we have observed is the Responsible Clinician at Northgate Hospital and has therefore been the medical professional most closely involved with his treatment since his transfer to Northgate. This Joint Report is dated 27 September 2022, therefore very shortly before the hearing of the application and appeal before us on 6 October 2022. Dr McKinnon had already concurred with the views expressed in the Joint Report by Dr Ross and Dr Carthy to which we have referred above; and Dr Ross had continued to liaise with Dr McKinnon following Surrey's transfer to Northgate from Rampton. We summarise the conclusions of this, the most recent Joint Report, as follows.

37. Both Dr Ross and Dr McKinnon agreed that the diagnosis of learning disability was definitely present at the time of the index offence in 2007, and also that it was likely that the diagnosis of schizophrenia was present at the time and was prodromal. They agreed there were elements of paranoia in the offence in 2007, and that was significant. They also agreed that the most clearly demonstrable interventions that improved his mental state was the prescription of anti-psychotic medication, in his case this being clozapine. There were no areas of disagreement between them, and in isolation, or more likely in combination, these mental disorders were significant in his offending, and there was a causal link present. His diagnosis amounted to "mental disorder" in terms of section 1 of MHA.

38. They agreed with the list of factors identified in Dr Ross and Dr Carthy's Joint Report, and explained that it was "vitally important" that compliance with medication could be imposed as a condition upon release, if that was through the mental health regime, by a Mental Health Tribunal. The same conditions on taking medication are simply not possible if release of a person is sanctioned by the Parole Board. It is also far less likely that a probation officer, who would be responsible for supervising him upon release, would be able to spot early signs of any deterioration in his mental health compared to a multi-disciplinary clinical team who would be responsible for him if he were released by a Mental Health Tribunal.

39. We turn therefore to the oral evidence which we received on 6 October 2022 from Dr Ross and also Dr McKinnon, who remains (as at the date of both the hearing and this judgment) as the Responsible Clinician for Surrey's treatment under the MHA.

40. Dr Ross' oral evidence was entirely aligned with the earlier written evidence that he had submitted in his two Joint Reports, the first with Dr Carthy and the second with Dr McKinnon. He confirmed that both the nature and degree of the mental disorders from which Surrey was suffering were such that they warranted his continuing detention under the MHA, and that the detention was necessary both for the protection of the public, and also for his own health and safety. Dr Ross confirmed that it was recognised that those suffering from schizophrenia would, if left unsupervised, often or sometimes fail to take their medication. This can be for a variety of reasons including the adverse side-effects of the medication. This failure to comply with the prescribed medication is a feature of the condition which is well known.

41. Dr McKinnon fully agreed with Dr Ross and explained to the court that, in his opinion, the schizophrenia could have been identified at the time of the offending in 2007. However this would have been very difficult at that time as it was in the prodromal phase. The learning disability from which Surrey suffers could certainly have been identified then. Dr McKinnon considered that the schizophrenia could have been spotted earlier than it was, but it would have been necessary for someone to have the necessary expertise in order to do so. Surrey was now making reasonable progress and the intention was for him to be gradually tested in the community, eventually graduating to release, but this would be over a number of years and no release could be considered for quite some time. Following release, any indication that either he was not taking his medication, or that his mental state was deteriorating, would lead to his immediate return to secure hospital.

42. Both Dr Ross and Dr McKinnon in their oral evidence were agreed that Surrey needed treatment for his mental disorder, in particular the antipsychotic medicine which he was prescribed and was taking, namely clozapine, and that the treatment he was underdoing in Northgate helped his condition, and also prevented further deterioration in his mental state. They agreed that his offending was related to his mental disorders and that these contributed to his offending. There was a causal connection between his condition and his offending. Even if not, as Dr Ross put it, "fully blown" schizophrenia at the time in 2007, the condition was present then, in its prodromal state. Both Dr Ross and Dr McKinnon agreed that in terms of protection of the public, any eventual release into the community (should it be decided at some point in the future by a Tribunal that the conditions were at that stage to be satisfied) the mechanism for return was far more

comprehensive within the framework of release by a Mental Health Tribunal, than the Parole Board. In particular, the procedure of regular medical reviews and the ability to return Surrey to secure hospital should, for example, he fail to observe the medication regime that was prescribed, was something with which those medical professionals tasked with his supervision were well versed, rather than (say) a probation officer.

43. They were both of the view that the protection of the public would be increased by any release of Surrey taking place within what Mr Fitzgerald KC for Surrey described as the "mental health pathway", rather through the criminal justice system, namely parole. They both urged the imposition of a Hospital Order under section 37 MHA with a Restriction Order without restriction of time under section 41 MHA as the best way to achieve this.

44. We are satisfied that it is necessary in the interests of justice to receive all the fresh evidence contained in the reports put before us, and also the oral evidence of Dr Ross and Rr McKinnon. That evidence satisfies the criteria in section 23(2) of the Criminal Appeal Act 1968. Having admitted it, we accept the evidence as proving that Surrey was in fact suffering at all material times from a mental illness, something which was not brought to the attention of the sentencing judge in 2007, which is why he proceeded (perfectly properly, in the light of the evidence before him) on the basis that Surrey was not mentally ill. Indeed, given that Dr Kennedy's report before the sentencing judge did not offer any conclusion as to whether Surrey suffered from a mental disorder within the meaning of the MHA, nor whether such a disorder was of a nature or degree which necessitated treatment in hospital, the sentencing judge could not sensibly have proceeded at that time and on the information before him in any way other than he did. We further accept that the conditions set out in section 37(2)(a) of the 1983 Act are met.

The law and the parties' submissions

45. We have had the benefit of a detailed skeleton argument from Mr Fitzgerald KC and Ms Woodrow on behalf of Surrey, together with a Respondent's Notice from the Crown, who was represented before us by Mr Jarvis. The Crown did not actively oppose the appeal, but did not formally concede it, and Mr Jarvis attended the hearing. The position set out in the Respondent's Notice could be described as being one of sensible neutrality. We are very grateful for the Crown's detailed written submissions.

46. Section 37 MHA allows a sentencing court to order that an offender who might otherwise be sentenced pursuant to section 226 CJA, instead to be detained in hospital for treatment (a 'Hospital Order'). The circumstances in which a Hospital Order can be made are set out in Section 37(2) and are identical to the conditions required for transfer under Section 47(1), except that the assessment as to whether the order is appropriate is a matter for the court rather than the Secretary of State. Those conditions under s.47(1) are in circumstances where at least two clinicians agree that he is suffering from a mental disorder which is "of a nature and degree which makes it appropriate for him to be detained in a hospital for medical treatment, and that medical treatment is available." The Secretary of State, if such an order is made under s.47(1), or the court, if one is made under s.37, must also be of the opinion that it is expedient to do so having regard to the public interest and all the circumstances.

47. Under Section 37(2)(b) an order can only be made where: "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." A Hospital Order can be made subject to a Restriction Order under section 41 MHA, which effectively prevents an offender from being released from hospital unless and until either the Secretary of State or the First Tier Tribunal confirms that he no longer poses a risk arising from his medical condition. A Restriction Order cannot be made unless the court hears oral evidence from at least one of the two registered medical practitioners whose evidence is taken into account by the court under section 37(2)(a).

48. If such an order is made, any release will be subject to conditions and the patient will be supervised by a responsible clinician and liable to recall to hospital if those conditions are not complied with. Such conditions can include compliance with a regime to take prescribed medication.

49. Here, no application for permission to appeal was made by Surrey or on his behalf after his sentence in 2007. This means that an extension of time is required. A large number of authorities were lodged before us on all of the different legal issues which arise in this case, which we have considered, but we shall only refer to the most important ones that set out the main principles which fall to be considered in a case such as this one. Those are, in chronological order, as follows.

50. In ***R v Beatty*** [2006] EWCA Crim 2359 (per Scott Baker LJ, Jack and Mitting JJ) the Court of Appeal considered an appeal referred to it by the Criminal Cases Review Commission against a discretionary life sentence imposed upon an appellant in 1991 for rape, kidnapping and making threats to kill. The appellant had been transferred to Broadmoor 3 years after sentence. It is unnecessary to recite the facts, but the medical evidence available to the sentencing judge at the time had made it clear that the conditions for making a Hospital Order were not, at that time, met. Accordingly, the judge passed a discretionary life sentence.

51. At [60]-[62] the Court of Appeal held that it has the power to quash a sentence of detention and impose a Hospital Order where fresh medical evidence demonstrates that the criteria under section 37 and section 41 MHA would in fact have been satisfied at the time of sentence, had that evidence been before the sentencing judge. The power arises under sections 9 and 11 of the Criminal Appeal Act 1968. In those circumstances the original sentences imposed were held to be 'wrong in principle' (albeit with no criticism of the sentencing judge who could proceed only on the evidence then before the court).

52. In ***R v Vowles*** [2015] EWCA Crim 45 (per Lord Thomas LCJ, Macur LJ and Globe J) the Court of Appeal heard six appeals together that had been conjoined. In each of them there had been psychiatric medical evidence before the court at the time of sentence, but in each of them the sentencing judges had imposed an indeterminate sentence (namely either an IPP or a life sentence) rather than a Hospital Order. In each case the offender appealed to the court against sentence on the grounds that a hospital and restriction order should have been imposed by the court below. The court gave

authoritative guidance on the approach to be taken when deciding whether such orders should be substituted on the basis of fresh evidence. Of the six conjoined cases before the court, all of those in which the court was satisfied that the public would be better protected by the imposition of a hospital order resulted in the quashing of the original sentence of imprisonment.

53. The principles which should guide a court in determining whether to make a Hospital Order under the 1983 Act either at the time of sentence, or on appeal in substitution for a custodial sentence, were set out by the Court of Appeal at [51] to [54]. They are as follows.

1. The requirements as to the recommendations of two registered medical practitioners in Section 37(2)(a) must be met, but this alone is not sufficient.

2. Where the conditions in Section 37(2)(a) are met judges must then have regard to "all relevant circumstances" including the following four issues when deciding whether the condition in Section 37(2)(b) is (or would have been) met:

a) The extent to which the offender needed the treatment for the mental disorder which he was suffering;

b) the extent to which the offending was attributable to that disorder;

c) the extent to which punishment was required; and

d) the protection of the public, including the various regimes in determining release and post-release. In relation to this consideration, the court emphasised at [52] that judges "must now pay very careful attention to the different effect in each case of the conditions applicable to and after release."

54. In relation to the fourth important consideration at (d) in the list which we have set out at [53] above, the Court emphasised at [52] in ***Vowles*** that judges:

"must now pay very careful attention to the different effect in each case of the conditions applicable to and after release. As is shown by the case of *R v Teasdale* [2012] MHLR 387 to which we have referred at para 48(iv), this consideration may be one matter leading to the imposition of a hospital order under s.37/41."

(emphasis added)

55. The Court at [54] gave further guidance as to the order in which judges must consider the issues arising in cases such as this one where it appears that a hospital order may be appropriate. Firstly, the court must consider whether a hybrid 'limitation order' under section 45A MHA may be appropriate. Given that Surrey was aged only 17 at the date of sentence, the only disposal open to the court below other than a sentence of imprisonment was the imposition of a hospital order under sections 37 and 41 MHA and a so-called hybrid order was not available. That consideration does not therefore arise in this case.

56. Secondly, the Court should also consider the following matters. Firstly, whether the conditions under Section 37(2)(a) are satisfied (that the appellant suffers from a mental disorder which is such that it would be appropriate for the offender to be detained in a hospital and treatment is available). Secondly, whether the conditions in 37(2)(b) are met such that a Hospital Order is the most suitable method of disposal. The Court stated that it was essential that the judge gives detailed consideration to all the factors encompassed within section 37(2)(b). For example, in a case where the court is considering a life sentence under the Criminal Justice Act 2003 as amended in 2012 (following the guidance given in ***R v Burinskas (Attorney General's Reference (No 27 of 2013)***) [2014] 1 WLR 4209), if (1) the mental disorder is treatable, (2) once treated there was no evidence he would be in any way dangerous, and (3) the offending is entirely due to that mental disorder, a hospital order under sections 37 and 41 was likely to be the correct disposal.

57. The Court also made clear that when assessing suitability of disposal under section 37(2)(b) MHA, regard must be had to the possibility of 'other methods of dealing with' an offender, including whether the powers of transfer to hospital for treatment under section 47 would be appropriate.

58. This approach was endorsed in the subsequent case of ***R v Edwards*** [2018] EWCA Crim 595 in which the Court of Appeal again summarised the relevant considerations at [34] of that judgment, making clear that there is no presumption in favour of imprisonment and that each case will ultimately turn on its own facts.

59. The correct approach for an appellate court considering an appeal seeking a Hospital Order was most recently confirmed by this Court in ***R v Cleland*** [2020] EWCA Crim 906. In that case, the appellant had pleaded guilty to a charge of attempted murder and been sentenced in 2013 to life imprisonment with a minimum term of 7 years. He had been 16 at the time and the victim, with whom he was infatuated, was 12. He appealed in 2014 and his appeal was dismissed by the Full Court, and his application to the Supreme Court for permission to appeal had been dismissed on 8 July 2014. The Criminal Cases Review Commission had then, in 2020, referred his case again to the Full Court, such a referral being treated as an appeal against sentence. The court (Holroyde LJ, Nicklin and Murray JJ) heard that at his sentencing below, amongst other evidence, the court had before it a report by a consultant forensic psychiatrist, who suggested that the appellant might have an emerging psychopathic disorder, but found no evidence that he was mentally ill and made no recommendation of a medical disposal.

60. Following the approach laid down in ***R v Bennett*** [1968] 1 WLR 988 and ***R v Beatty***, this court made clear that: "following the admission of fresh evidence as to the offender's mental health at the time of sentence, the court has the power to substitute the sentence which it considers is (and, as the evidence now shows, always was) appropriate."

61. The court made clear there is no inconsistency between this approach and the observations of the court in other cases such as ***R v Chin-Charles*** [2019] EWCA Crim 1140 at [8]. The court observed that rather, as it was expressed:

"having admitted the fresh evidence in accordance with the provisions of section 23, this court is asked to consider what that evidence shows to have been the true state of the appellant's mental health at the time of sentence. If the fresh evidence shows that it was otherwise than the judge believed it to be, the court has power to quash the original sentence if it considers that the appellant "should be sentenced differently", and to impose such sentence as it considers appropriate."

(emphasis added)

62. At [27] to [29] the Court considered the dicta of the Lord Chief Justice in ***R v Vowles*** [2015] EWCA Crim 45. The Court in ***Cleland*** heard submissions as to the relevance of the fact that the appellant's minimum term was shortly to expire. For the appellant, it was submitted that the answer to the third question posed in ***Vowles*** at [51] (referred to above) is that there was now no need for punishment given the minimum term was very close to expiring. Concerning the medical evidence regarding the appellant's mental health, the court found:

"[45] It would have been admissible in the court below. There is a reasonable explanation for the failure to adduce the evidence in the court below, in that at that stage no detailed assessment had been made giving rise to a diagnosis of ASD. We are satisfied that it is necessary in the interests of justice to receive the evidence contained in the reports and oral evidence of Dr Stankard and Dr Latham. Having admitted it, we accept the evidence as proving that the appellant was in fact suffering at all material times from a mental illness, whereas the judge proceeded (perfectly properly, in the light of the evidence before him) on the basis that the appellant was not mentally ill. We further accept that the conditions set out in section 37(2)(a) of the 1983 Act are met."

63. The court stated that it was appropriate to consider, in cases such as that one, whether the need for punishment fell away, or were of lesser consideration, given the appellant had served almost the whole of the minimum term specified in any event. The court took into account all the different competing considerations, which it found to be "finely balanced" but concluded that in all the circumstances a section 37/section 41 order offered the greater prospect of managing both that appellant's return to the community, and life in the community, in the way which would be most likely to reduce the relevant risk. Accordingly, the life sentence was quashed and a Hospital Order under section 37/section 41 was imposed.

64. In the instant case, the period of time ordered to be served by Surrey as the custodial element of the DPP was served long ago. Indeed, that period is somewhat modest by comparison with the total time that he has spent in custody since he was sentenced over 15 years ago. That element of a DPP (or IPP for offenders over the age of 18) represents the component part of the sentence aimed at punishment of the offender; the remainder of the sentence is designed to protect the public from serious harm caused by commission of further specified offences. It is clear that in this case, the punishment required for the offence in question has been served.

65. Finally, it is important to observe that Surrey was aged 17 at the time both of his offending in the very early hours of New Year's Day 2007 and sentencing later that

year. He was therefore a child when he was sentenced. Any court when sentencing an offender below the age of 18 at the time of the offence must have regard both to the statutory purpose of the youth justice system under section 37 of the Crime and Disorder Act 1998 (CDA), and the 'welfare principle' under section 44 of the Children and Young Persons Act 1933 (CYPA). Section 44 CYPA requires that all courts concerned with those who deal with children and young people must have regard to the welfare of that child or young person and "shall in a proper case take steps for removing him from undesirable surroundings, and for securing that proper provision is made for his education and training". This is what is meant by the welfare principle. Courts concerned with young offenders must apply this principle as a primary consideration.

66. The need to have regard to the welfare principle and aims of the youth justice system at every stage of consideration when sentencing those who offend as children is also made clear in guidance issued by the Sentencing Council. The definitive guideline on youth justice, namely "Overarching Principles – Sentencing Youths" dated November 2009 and was not in place when Surrey was sentenced. However, the guideline codified the principles of sentencing young persons that were well recognised before 2009 (we record that it has been replaced since by similar guidance published in 2017). The application of the principles in ***Vowles*** to an appeal of this nature concerning a child were considered in ***Cleland*** and only in one other case, namely ***R v Fuller*** [2016] EWCA Crim 1867.

67. In the case of ***Fuller***, the appellant had been 15 years old at the time of sentence and was convicted of two counts of attempted rape and one count of sexual assault contrary to section 3 of the Sexual Offences Act 2003. He, as with Surrey, was sentenced in 2009 to a DPP with a custodial term of 3 years. The court (Sharp LJ, Morris J and the Recorder of Maidstone) at [41] expressly considered ***Vowles***. No separate or different consideration of the principles arises because an appellant was sentenced when they were below the age of 18. At [49], in a passage which is redolent of our approach to, and conclusions in this case, the court in ***Fuller*** observed the following:

"[49] As his treating doctors have made clear, the appellant's release into the community can only be contemplated if he is properly monitored by a multidisciplinary mental health team, who are aware of his mental health condition; and who will be best placed to identify any non-compliance with any medication regime for example, or deterioration in his condition which could elevate his level of risk, and require his return to hospital for further treatment. In short, a hospital order with restrictions is most suitable for the appellant and ultimately, for the protection of the public."

68. In conclusion therefore, our answers to the questions posed in ***Vowles*** are as follows:

1. The requirements as to the recommendations of two registered medical practitioners in Section 37(2)(a) are clearly met in this case. Both Dr Ross and Dr McKinnon gave oral evidence before us which we accept. That is a necessary pre-condition to continue to consider the other factors set out in ***Vowles***, but this alone is not sufficient.

2. We therefore address all the relevant circumstances of the offending. These include the four issues set out in ***Vowles*** when deciding whether the condition in Section 37(2)(b) would have been met at the time.

69. Turning therefore to those four issues, Surrey needed treatment for the mental disorder which he was suffering, both at the time of the offending, and undoubtedly he does so now. The accounts of the offending itself demonstrate that his condition was a significant cause or contributing factor to the stabbing of the complainant. We have set out above at [15] Surrey's account at the time to the author of the PSR. His interpretation of the way that the complainant was acting towards him demonstrates the reaction of someone who is experiencing paranoia, something explained in the medical evidence before us. Both Dr Ross and Dr McKinnon are clear that there is a significant causal link between his condition and the index offence. His offending at the time was, in our judgment, clearly attributable to his mental disorder, which at the time was untreated. There can be no criticism of the sentencing judge in 2007 for failing to consider the imposition of a hospital order at that point as a sentencing option, because there was simply no material before him that referred to any diagnosis of Surrey's mental illness. Both Dr Ross and Dr McKinnon are clear that the mental illness would have been present in 2007, albeit undiagnosed at the time.

70. In some cases the next element for consideration will merit more detailed analysis than it does here, namely the extent to which punishment is required for the particular offending in question. Here, the position is more straightforward because the custodial term of both a DPP and an IPP represents the punishment element and this is expressly stated at the time of passing such a sentence. In the case of Surrey, this was set at a custodial term of 2 years in 2007. He has clearly served that period in custody, and exceeded it by some margin. In the particular circumstances of this case, therefore, this particular question is clearly answered in Surrey's favour because the requirement for punishment for the stabbing of the complainant has been satisfied some time ago.

71. We turn therefore to the protection of the public, including consideration of the various regimes both in determining his release, and the monitoring of him post-release. We give this specific point very careful attention, for obvious reasons. Not only is this emphasised at [52] in ***Vowles***, but also the rationale of both DPP and IPP sentences is to protect the public. That is why the structure of such a sentences is of indeterminate length. In our judgment, the different mechanisms both of release and post-release supervision under either the Parole Board (for a sentence of imprisonment) or the Mental Health Tribunal (for a hospital order) are substantially different in the case of Surrey in terms of this important question.

72. In particular, the powers available under the MHA for the clinical team to recall Surrey to hospital either if his mental health appears to be deteriorating, or if he fails to maintain his prescribed medication, are both important powers that are not available to the probation service, who would be responsible for his supervision were he to be released on parole. As recognised in the passage in ***Vowles*** we have recited at [54] above, this can be one significant factor which leads to the imposition of a hospital order under section 37/section 41 MHA. In our judgment, it alone represents the significant factor which justifies the imposition of such a hospital order in this case. We

also impose this without limit of time, which means that this protection of the public will continue for his lifetime.

Extension of time required

73. This therefore brings us to the question of delay in applying for permission to appeal, and the lengthy extension of time required. The delay in this case has been considerable, and therefore the extension of time is very long, as we have observed. There are, however, very good reasons for that, as set out in the detailed witness statement of Dr Janes, Surrey's solicitor. The principles to be applied in an extension of time case are well known. In ***R v Hughes*** [2009] EWCA Crim 841 at [20] it was said that an extension of time would "be granted only where there is good reason to give it, and ordinarily where the defendant will otherwise suffer significant injustice". In ***R v Thorsby*** [2015] EWCA Crim 1 it was stated "the principled approach to extensions of time is that the court will grant an extension if it is in the interests of justice to do so". It was also said in that case that "the public interest embraces also, and in our view critically, the justice of the case and the liberty of the individual….." and "the court will examine the merits of the underlying grounds before the decision is made whether to grant an extension of time." It also noted that the passage of time may put the court in difficulty in resolving whether an error has occurred, and if so to what extent.

74. In all the circumstances of this case we are clear that it is in the interests of justice to grant the extension of time that is sought. We have examined the merits of the underlying grounds and as we have explained above, these are strong. The extension required is very lengthy, but it is clear from considering the history of Surrey's imprisonment and more recent treatment in Rampton (three admissions in total), and now Northgate, that the passage of time, far from causing additional difficulty in considering the subject matter of the appeal, has in fact improved and enhanced the material before the court, in particular the fresh evidence. That was clearly not available before, something which the prosecution sensibly accepted in their constructive approach both to the applications and the appeal.

75. Further, Surrey did not seek to appeal in 2007. Were we to refuse to extend time, his only avenue would be an application to the Criminal Cases Review Commission, and were that body to refer his case to the Full Court as a potential miscarriage of justice, it would be considered on its merits. Failing to extend time would therefore, on the particular facts of this case, simply increase administrative delay and expense and ultimately serve no purpose. It is therefore in the interests of justice to grant the extension of time that is required and we do so.

Conclusion

76. Due to the nature of the case, we gave our decision at the conclusion of the hearing on 6 October 2022. These are our reserved and detailed reasons for that decision. We granted leave to appeal, admitted the fresh evidence and granted an extension of time in the required period for the application for permission to appeal to be made. We allowed the appeal. We quashed the sentence passed in the Crown Court in Newcastle on 29 March 2007 of a sentence of detention for public protection under section 226 CJA 2003 (the DPP), and in its place imposed a Hospital Order under s.37 of the Mental Health Act 1983 with a Restriction Order under s.41 of the same Act, unlimited in time.

We also extended the Representation Order to cover the work done by Surrey's solicitors from the date of lodging of his appeal.

77. We would add only this, in terms of the practical effect of our decision on this appeal. Once the custodial term of a DPP or an IPP has been served, the purpose of the continuation of detention as part of the sentence is protection of the public. Once such a prisoner is released, when this is considered safe by the Parole Board, that prisoner on licence can only be returned to custody when they breach their licence conditions or commit a further offence. When a prisoner who is under a section 37/section 41 Hospital Order is released, which occurs when the Mental Health Tribunal considers this to be safe, that person can be returned to a secure hospital for breaches of the medical conditions imposed upon that release, such as a failure to take their prescribed medication. This applies to Surrey. It can therefore be seen that the protection of the public is increased, rather than diminished, by the outcome of this appeal.