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IN THE COURT OF APPEAL
CRIMINAL DIVISION
CASE NO 202104096/A1
NCN: [2023] EWCA Crim 548

Royal Courts of Justice
Strand
London
WC2A 2LL

Thursday 11 May 2023

Before:
LORD JUSTICE DINGEMANS

MR JUSTICE FRASER

HIS HONOUR JUDGE FLEWITT KC
(Sitting as a Judge of the CACD)

REX

V
JOE WALKER

Computer Aided Transcript of Epiq Europe Ltd,
Lower Ground, 18-22 Furnival Street, London EC4A 1JS
Tel No: 020 7404 1400; Email: rcj@epiqglobal.co.uk (Official Shorthand Writers to the Court)

MR T STORRIE KC & MR P HOLDEN appeared on behalf of the Appellant
MR D TEMKIN KC & MR D TOAL appeared on behalf of the Crown.

J U D G M E N T

LORD JUSTICE DINGEMANS:

Introduction

1. This is the hearing of an appeal against sentence following a guilty plea to a count of manslaughter by reason of diminished responsibility. It is contended on behalf of the appellant that the judge was wrong to impose a sentence of life imprisonment, with a minimum term of 12 years with a Hospital and Limitation Direction, pursuant to section 45A of the Mental Health Act 1981, and that the judge should have imposed a Hospital Order with restrictions pursuant to sections 37 and 41 of the Mental Health Act.
2. The appeal, which has been brought with the leave of the full court, raises issues about whether the judge was entitled to make some of the findings about the retained responsibility of the appellant that he did and what sentence will provide the most protection for the public.

The factual circumstances of the offence

3. On 22 May 2020, which was shortly after the Coronavirus lockdown had commenced, the appellant stabbed and killed his father, Thomas Walker. The appellant had developed mental health problems shortly before the attack. Six weeks before his death, Thomas Walker had attended the local police station and told officers that the appellant was becoming increasingly paranoid about the Coronavirus pandemic and, when Thomas Walker had argued with the appellant about his beliefs, the appellant had punched him. On a different occasion the appellant had threatened Thomas Walker with a knife. The appellant attended the police station whilst Thomas Walker was making the report. He was visibly distressed and told officers that he intended to kill himself. As a result, the appellant was sectioned under the Mental Health Act.
4. During his time in the Royal Blackburn Hospital the appellant told staff that he had used

cocaine and cannabis. He was not diagnosed with psychosis and was released after 11 days with a prescription for antidepressants. It became common ground between the consultant forensic psychiatrists instructed on behalf of the prosecution and on behalf of the defence, that this medication would not have assisted the appellant, even if it had been taken in accordance with the instructions.

5. On release the appellant returned to live with Thomas Walker. Shortly before his death, Thomas Walker expressed concerns to his niece that the appellant was still unwell. He also told her that the appellant had been violent towards him and had stopped taking his medication. Whilst at work on 21 May 2020, Thomas Walker received a telephone call from the appellant, and witnesses described his efforts to calm the appellant. He returned home later that day. On 22 May 2020 the appellant telephoned his mother and told her that Thomas Walker was dead. Her partner telephoned the police, who attended the property and found the appellant in a distressed state. He had cuts to his arms that appeared to be self-inflicted. Police officers found Thomas Walker's body in the front room. He had been stabbed and beaten to death. The investigation revealed that the appellant had cleaned the scene after the attack and placed a knife into Thomas Walker's hand. It is apparent from the victim personal statements made by his sisters that Thomas Walker's death has had a devastating effect on the family.

The sentencing below

6. The appellant was initially found unfit to plead. However, he recovered sufficiently to be arraigned and pleaded not guilty to murder but guilty to manslaughter by reason of diminished responsibility. Dr Lucy Bacon, a consultant forensic psychiatrist instructed on behalf of the appellant, and Dr Stephen Barlow, a consultant forensic psychiatrist instructed on behalf of the prosecution, gave a joint opinion, in which they concluded that

the medical evidence supported the defence of diminished responsibility and as a result the plea was accepted.

7. At the sentencing hearing, the prosecution submitted that the appellant retained a high level of responsibility. This was because there was a history of violence, the attack was sustained, and the appellant had attempted to clean the scene.

8. In addition to preparing a written report, Dr Bacon gave evidence stating that the appellant suffered from paranoid schizophrenia and was experiencing psychosis when he was sectioned. He was not diagnosed as psychotic whilst detained and the anti-depressants he received would not have improved his symptoms. For that reason, his decision to stop taking them had no impact on his psychosis.

9. The appellant's decision to clean the scene was described as being needing to be understood in terms of his psychosis and his understanding of the world. Both Dr Bacon and Dr Barlow had concluded that there was no link between the appellant's use of cocaine and cannabis and the onset of his psychosis. They said it was rare for people to develop psychosis through the use of illicit drugs and it was very rare for people to rapidly develop acute psychosis after a long history of drug use. In most cases the onset of schizophrenia and psychosis was separate from drug use. This conclusion was supported by the fact that the appellant remained psychotic even though he had been drug-free in prison during the Covid lockdown and when being treated in hospital.

10. Dr Bacon said that the appellant suffered from treatment resistant schizophrenia and despite receiving antipsychotic medication he still had psychotic symptoms. It was likely that he would spend many years in hospital. For that reason, she believed that he would benefit from a Hospital Order with restrictions, pursuant to sections 37 and 41 of the Mental Health Act. It was preferable to a section 45A direction, which tended to

focus on getting the appellant sufficiently well to return to the prison system. Moreover, the appellant was being treated with clozapine and many prisons refused to take prisoners being treated with clozapine because of the level of monitoring that they required. Finally, following release, he would be better managed under the section 37 and 41 regime, as he would be placed in suitable accommodation and supported by mental health professionals. Such provisions were not available under the section 45A regime.

11. The prosecution also contended at the sentencing hearing that the appellant's retained responsibility was high because of his past drug use and his failure to take medication. On behalf of the appellant, it was contended that the retained responsibility was low because of the psychotic illness and the fact that the past drug taking did not induce the psychosis and that the failure to take the medication was irrelevant because it had been prescribed on the basis of a misdiagnosis.

The sentencing hearing and remarks

12. When sentencing, the judge accepted that the appellant's personal responsibility was significantly impaired by the psychosis. However, the judge also found that the appellant had used cannabis and cocaine for many years, and it was well known that the drugs could exacerbate mental health conditions. The judge also concluded that the appellant committed a sustained assault on the deceased and cleaned the scene after the attack. He inflicted injuries on himself and placed a knife in the deceased's hands in an attempt to suggest he was acting in self-defence. For those reasons, the judge concluded that the appellant retained a high level of responsibility. The judge rejected Dr Bacon's opinion that a Hospital Order with restriction was appropriate, and the judge found that there was no good reason to depart from the usual course for imposing a sentence with a penal element. However, the judge did accept that it was appropriate for the appellant to

be detained in a hospital for treatment.

13. Having made all those findings, the judge concluded that the starting point under the Guidelines was 24 years' imprisonment. The offending was aggravated by the fact that the victim was the appellant's father, the use of a weapon, the prolonged nature of the attack and the evidence of previous assaults and the attempts to clean the scene. Those features justified increasing the starting point to 27 years' imprisonment. He reduced the sentence to 18 years' imprisonment to reflect the guilty plea. Having identified the notional determinate sentence, the judge concluded that the appellant posed an extremely high risk to the public. He had committed a brutal offence in a psychotic state and had been diagnosed with treatment resistant schizophrenia. A life sentence was therefore necessary. The judge set a minimum term of 12 years' imprisonment less time spent on remand, to reflect the fact that the appellant would have served two-thirds of a notional determinate sentence of 18 years. He imposed a section 45A direction.

The fresh evidence from the psychiatrists

14. The appellant sought permission to appeal against sentence and obtained further evidence from Dr Bacon. Dr Bacon remained satisfied that the appellant suffers from schizophrenia. He was suffering from schizophrenia at the time of the offence, which was undiagnosed and therefore untreated at the time. His use of illegal substances was not the cause of his illness and Dr Bacon stated that the appellant had been treated with clozapine but continues to hold fixed delusional beliefs. If he was returned to prison under the section 45A regime, there would be serious concerns about his access to appropriate treatment and the prison's ability to manage the risk that he poses. For that reason, Dr Bacon remained of the view that a section 37/41 order was the most appropriate sentence to manage the appellant's risk.

15. In reaching this conclusion, Dr Bacon noted that if the appellant became well enough to return to prison, many prisons would be unable to provide him with clozapine, which was a vital medication for treatment of his schizophrenia. Some prisons, especially prisons responsible for managing prisoners serving life sentences, struggle to provide the monitoring necessary for the long-term administration of clozapine. The appellant is highly likely to suffer an immediate relapse if he stopped receiving clozapine. Dr Bacon stated that the prison system is unlikely to be able to manage the risk posed by schizophrenia. The programmes offered in prison are unlikely to address mental health issues effectively and therefore failed to reduce the risk that he poses to public on release. He would not receive psycho education or insight-related intervention in prison. In contrast, the risk he poses can be ameliorated far more effectively by intervention in hospital pursuant to a Hospital Order with restrictions. Dr Bacon continued that when someone is returned to prison under the section 45A regime, there is no statutory framework for mental health treatment either when they are in prison or when they are released. Moreover, following release there is no framework to ensure compulsory treatment and the appellant would be unable to access forensic community centres, which are best suited to people with the appellant's needs. Probation officers are not trained to recognise relapse indicators which means that there is a real risk that any relapse would not be identified or managed appropriately which greatly increased the risk that he posed. If the appellant, by contrast, received a section 37/41 disposal he would follow a full hospital care pathway, would engage in a comprehensive treatment and rehabilitation package of care over several years. The focus would be on public protection and his release, if ever, would be carefully monitored and supervised.
16. Dr Barlow gave oral evidence before the Court today and also produced a written report.

Dr Barlow, in his further evidence, remained satisfied that the appellant suffers from a particularly severe and persistent form of schizophrenia. He was grossly psychotic when he was admitted to hospital before the assault, but his illness was not diagnosed and he therefore did not receive treatment. His decision to cease taking antidepressants had no bearing on his condition and was not a material factor in the offence. Moreover, whilst his drug use may have played some causal role in the development of his schizophrenia, he would have developed schizophrenia irrespective of his use of cannabis.

17. In terms of management, Dr Barlow advised that in cases of psychotically driven homicides the public is better protected by the release regime under sections 37 and 41 of the Mental Health Act than by the provisions under section 45A. This is because Mental Health professionals are far more involved in the process. In particular, under the section 37/41 regime, the release of a patient can be gradually tested using periods of graded and supervised leave in the community over a prolonged period of time before progressing to discharge. This allows for the risk posed by the patient to be properly and safely assessed prior to release. In contrast the supervision and monitoring regime governing release from prison is extremely limited and less closely supervised.
Dr Barlow said that in prison the mental health professionals who are responsible for management and supervision would have little involvement in the decision to release. In contrast, under the section 37/41 regime, the treating clinician has far greater involvement in the decision. In his oral evidence, Dr Barlow recognised that some prisons would take prisoners using clozapine and although a prisoner could not be started on clozapine in prison, a prisoner might be subjected to a prison regime when taking clozapine. The process of moving him to a community-based clinician would involve more discussions and direct involvement and would likely to be the case when identifying a service to

manage an offender scheduled for release from prison. Dr Barlow noted that the section 45A release provisions were overseen by the Parole Board. While the Parole Board can recommend that an offender is monitored by healthcare professionals, they cannot mandate clinical monitoring and clinicians are able to refuse to defer to the Parole Board, whereas such a situation cannot arise under the section 37/41 regime. The conditions that can be attached to a conditional discharge under section 37/41 regime are wide ranging and comprehensive. The clinicians provide structure and thorough reports to the Secretary of State one month following discharge and then regular updates, and this goes a long way to ensuring that risk factors are adequately monitored. Dr Barlow also confirmed in evidence that, although the appellant was suffering from treatment resistance schizophrenia and the treatment was gradually leading to some amelioration of symptoms, this was not a case where the hospital would say that he could not be treated so that he might then be discharged.

18. The parties had also helpfully agreed a joint note on issues raised and resolved by the psychiatric evidence. It was noted that the psychiatrists agreed that the appellant was suffering from schizophrenia at the time of the offending. He suffered from bizarre, intensely held delusions and was unaware of the nature of his illness at the time of the offence. His actions at the material time can only be judged against the background of his profound and severe psychosis. The appellant continues to suffer from schizophrenia, and the nature of his condition remains complex, severe and persistent. At the time of the offence the appellant was living in a different reality to anyone else. His noncompliance with the medication regime was a matter of irrelevance and his decision to clean up the scene was entirely consistent with him being unwell. The offending was located chiefly within the nature of his illness and the judge's conclusion

that the psychosis was caused by the appellant's drug use was unsafe. The cause of his psychosis was and remains complex in origins. The appellant, said the psychiatrists, should be subjected to a section 37/41 Order and a section 45A Order was unsuitable.

Admission of the psychiatric evidence

19. It was common ground between the parties that in the particular circumstances of this appeal it would be appropriate to admit the fresh evidence. The Court has power to receive fresh evidence on the hearing of an appeal pursuant to section 23 of the Criminal Appeal Act 1968. We agree that the fresh evidence from the psychiatrist should be admitted. It is common ground that the evidence appears to be capable of belief. The evidence might afford a ground for allowing the appeal if it is accepted, because it would show that the appellant would be better managed under a different sentence. The evidence would have been admissible before the judge. There is a reasonable explanation for not adducing this evidence, because it post-dated the judge's sentence and gave evidence about the appellant's current condition.

The respective cases on appeal

20. It was submitted on behalf of the appellant that the evidence clearly demonstrates that the offending was chiefly or wholly located in the appellant's illness. He retained minimum responsibility and there is undisputed clinical evidence that suggests that he should have received a section 37/41 Order. Moreover, the judge's conclusion was based on erroneous findings, specifically that the appellant's psychosis was caused by his drug use or failure to take prescription medication and his behaviour after the killing indicated high retained culpability.

21. It was submitted on behalf of the prosecution that, despite the agreement of the psychiatrist, the judge was entitled to impose a section 45A Order. The psychiatrists'

conclusions should not bind the court and the judge was entitled to reject the psychiatric evidence and conclude that the appellant retained sufficient responsibility to justify a section 45A Order. We are grateful to Mr Storrie KC and Mr Temkin KC and their respective legal teams for their helpful written and oral submissions.

22. It is apparent following the submissions and evidence before us today that the following matters are in issue. First, whether the judge was right to find that the appellant retained a high responsibility for the offending and, in particular, whether (a) the judge was entitled to find that the appellant's psychosis was caused by his drug use and (b) was entitled to take account of the fact, to the extent that he did, that the appellant's psychosis was caused by his failure to take medication; and secondly, whether the judge was right to impose a section 45A Order.

Relevant principles relating to Hybrid Orders and Hospital Restriction Orders

23. Guidance has been given by the Court of Appeal about the proper relationship between sentences of imprisonment, Hospital Orders under section 37 of the Mental Health Act, Restriction Orders under section 41 of the Mental Health Act and Hybrid Orders under section 45A of the Mental Health Act in R v Vowles [2015] EWCA Crim 45; [2015] 1 WLR 5131. That judgment gave rise to some misunderstanding, which was addressed in R v Edwards & Ors [2018] EWCA Crim 595; [2018] 4 WLR 64. Further, helpful guidance was provided in R v Cleland [2020] EWCA Crim 906; [2021] 1 Cr App R(S) 21, where a sentence of life detention for attempted murder was quashed and replaced by a Hospital and Restriction Order under sections 37/41 of the Mental Health Act. Some explanation about the practical differences between section 37 and 41 Orders and a section 45A Order was given in R v Nelson [2020] EWCA Crim 1615; [2020] 1 MHLR 219.

24. There is also the Sentencing Council Guideline for the offence of manslaughter by reason of diminished responsibility. This identifies that under step 1 it is necessary to assess the degree of responsibility retained being high, medium or lower. The relevant notes states:

> "The court should consider the extent to which the offender's responsibility was diminished by the mental disorder at the time of the offence with reference to the medical evidence and all the relevant information available to the court. • The degree to which the offender's actions or omissions contributed to the seriousness of the mental disorder at the time of the offence may be a relevant consideration. For example: - where an offender exacerbates the mental disorder by voluntarily abusing drugs or alcohol or by voluntarily failing to seek or follow medical advice this may increase responsibility. In considering the extent to which the offender's behaviour was voluntary, the extent to which a mental disorder has an impact on the offender's ability to exercise self-control or to engage with medical services will be relevant. • The degree to which the mental disorder was undiagnosed and/or untreated may be a relevant consideration. For example: - where an offender has sought help but not received appropriate treatment this may reduce responsibility."

25. In addition, the Sentencing Council Guideline on the Sentencing of Offenders with Mental Disorders came into effect on 1 October 2020. It applies when sentencing offenders who, at the time of the offence or at the time of the sentencing have any mental disorder, neurological impairment or development disorder. The Guideline reflects guidance set out in R v Edwards and also summarises in appendix C the criteria and release provisions for sections 37 and 41, and 45A of the Mental Health Act, which it is relevant for the court to address when considering what order to impose.

26. When there is evidence of a mental disorder in a person convicted of an offence it is established that the first question for the court to consider is whether a Hospital Order is appropriate. Section 37 requires written or oral evidence from two doctors, at least one of whom must be approved under section 12 of the Mental Health Act. The court needs to be satisfied that the offender is suffering from a mental disorder of a nature or degree which makes it appropriate for the offender to be detained in hospital for medical treatment and that appropriate medical treatment is available.

27. The last requirement is important because there are mental disorders which are considered not to be currently treatable. A Hospital Order has effect for most purposes as a compulsory civil commitment under Part 2 of the Mental Health Act. The purposes of the Hospital Order are rehabilitation of the offender and protection of the public. It is not concerned with punishment.

28. Further matters for the court to consider are the release regimes which apply to the offender on release. A Restriction Order under section 41 of the Mental Health Act gives the Secretary of State for Justice a role in the release and recall of offenders who have been sentenced under Hospital Orders, as Dr Barlow reminded the Court in his evidence this morning. A Restriction Order under section 41 of the Mental Health Act should not be passed just to mark the seriousness of the offence, but only where it is required to protect the public from serious harm. There are monthly reports to the Secretary of State for Justice on those detained under sections 37 and 41 of the Mental Health Act and there are reviews by the Mental Health First-tier Tribunal. The Mental Health First-tier Tribunal can ensure that appropriate conditions are attached to any conditional release. These conditions can require abstinence from drugs and alcohol, and these are conditions which can be monitored. Any release into the community of a

person such as the appellant will take place with the community Mental Health Team, which will include a consultant psychiatrist, a senior social worker and, in most cases, a Mental Health Nurse.

29. Section 45A of the Mental Health Act permits in effect the combination of sentences of imprisonment with Hospital Orders, which is why they are referred to as "Hybrid Orders". Section 45A Orders are particularly appropriate in two situations. First, where notwithstanding the existence of the mental disorder, a penal element to the sentence is appropriate and the second was where the offender had a mental disorder but there were real doubts that he would comply with any treatment requirements in hospital, meaning that the offender would be looking after an offender who would be dangerous, who was not being treated. Evidence in other cases has shown one practical disadvantage of returning to prison an offender who has been treated for a delusional disorder in hospital and who is required to take antipsychotic medicine. This was that many such offenders ceased to take medication on return to prison. This was because, from their point of view, there was no obvious advantage in taking the medication. They were no longer in hospital and also because a side effect of taking the medication was that awareness of people and circumstances and surroundings were suppressed, which some prisoners considered made them very vulnerable to attack in a prison environment. Stopping taking medication causes the offender to relapse and require further treatment. This was a point identified in R v Rendell [2019] EWCA Crim 621; [2020] MHLR 60. Evidence given in other cases has also shown that illegal drugs were more likely to be available in prisons than hospitals, all of which could lead to a deterioration of a mental disorder of such an offender by a return to hospital. Any court considering whether to impose a section 45A Mental Health Act Hybrid Order would need to make a careful assessment of

culpability notwithstanding the presence of the mental disorder in accordance with guidance given in Vowles and Edwards.

30. If there is a determinate sentence to be served under section 45 Hybrid Order, the prisoner will serve that before being released on licence. Any release on licence will be supervised by the probation officer. It is apparent that the supervision will not be as regular as supervision by a Community Mental Health Team. If there is an indeterminate sentence to be served, such as a sentence of life imprisonment which was imposed on this appellant, release would only occur once agreed by the Parole Board. Once a release has taken place, supervision will be by a probation officer, and it is important to record that once released the effect of section 50 of the Mental Health Act is "further provisions as to prisoners under sentence" is that, by subsection (2) "a restriction direction, in the case of a person serving a sentence of imprisonment, shall cease to have effect if it has not previously done so on his release date". This means that the supervision of the released offender will be carried out only by the probation officer. Evidence from previous cases showed that the Parole Board did not impose conditions such as the requirement to take antipsychotic medicine and that a probation officer was unlikely to be able to intervene in the event of a subtle deterioration of mental state. Such an intervention would only take place in the event of commission of further offences by which time serious damage might have been caused to members of the public. Similar risks were identified in Rendell at paragraph 53.

Retained responsibility

31. We turn to consider the judge's finding that the appellant had retained high responsibility for this offence. As is apparent particular complaint is made on behalf of the appellant about the judge's findings that the appellant's psychosis was caused by his drug use and

the use made by the judge of the fact that the appellant's psychosis was caused by his failure to take medication.

The finding in relation to the cause of the psychosis

32. As to the finding in relation to the cause of the psychosis, we understand the judge's view that the appellant's abuse of drugs caused his mental disorder. The link between drug use and the development of mental disorders is well-established, as is the wreckage of lives in society caused by drug taking. There was however, in this case, expert evidence from consultant forensic psychiatrists instructed by both sides to the effect that the appellant's drug taking did not cause his particular psychosis. It seems that the principal reasons given for these opinions were the delay between the drug taking and the onset of psychosis, and the persistence of psychosis notwithstanding the absence of drug taking, both when he was in lockdown in prison and since he has been in hospital.

33. Relevant expert evidence must be considered but it is the duty of the judge to make their own decision. The judge is not bound to follow the expert evidence if there are compelling reasons to ignore it. However, in our judgment, the judge had to give some form of coherent reasoned rebuttal to those expert opinions in order to make the finding that he did, compare Flannery & Or v Halifax Estate Agencies Ltd [2000] 1 WLR 377. As was made clear in Flannery, a case decided by the Court of Appeal Civil Division but whose principles are applicable here, where reasons and analysis are advanced, a judge might have to enter into the issues canvassed and explain why the judge has rejected an expert opinion. In this case no such reasoned rebuttal was given and, although the prosecution rightly pointed out that the judge was the decision maker, no reasons to justify his findings were suggested to us. We do not consider that the judge was, on the evidence in this case, entitled to make the finding that the appellant's drug use caused his

particular psychosis.

The failure to take medication

34. We turn to the judge's finding that the appellant's psychosis was caused by his failure to take medication. Again, we understand why the judge might have formed a provisional view that the appellant's failure to take medication had led to the development of his psychosis. Indeed, it is a specific factor highlighted in the relevant Guidelines to be considered. There was, however, again, agreed expert evidence to the effect that the appellant's failure to take his medication had no effect on the development of his psychosis. The evidence from the experts to that effect was not surprising given that it appears that the medication was an antidepressant, and, at that stage, the appellant's psychosis had not been diagnosed. The judge gave no reasons for rejecting the evidence from the medical experts and we can see no reasons which would have justified rejecting that evidence. The judge was, on the evidence, not justified in finding a link between the failure to take the medication and the onset of the psychosis.

The finding on retained responsibility

35. In circumstances where two findings made by the judge which were relied on by the judge to find that the appellant retained a high level of responsibility, it becomes necessary to revisit that finding. The judge did refer to the appellant's sustained assault on the deceased, and the fact that appellant had cleaned the scene and had placed a knife in the hands of the deceased. The evidence from Dr Bacon was that these actions needed to be considered in the context of the mental disorder. This is consistent with the evidence that at the time of the killing the appellant was suffering from a profound and severe psychosis. The judge himself accepted that the personal responsibility was significantly impaired by the appellant's psychosis, it was just that the judge found that

the appellant was responsible for that psychosis. Looking carefully at all the evidence it does seem that the offending and the actions after the offending, were driven by the appellant's psychosis. He had been sectioned in the period of time before the killing, but he had been released and his mental disorder had not been properly diagnosed when he was released. We do not consider that the judge was justified in finding that there was a high level of responsibility on the part of the appellant. In this case the appellant's residual responsibility was low.

Whether to uphold the section 45A Order

36. In order to address this point, we have considered the question set out in R v Vowles at paragraph 51. The first question is the extent to which the offender requires treatment for the mental disorder from which he suffers. All the expert evidence before the judge and before us shows that the appellant required treatment, and it was necessary and appropriate to make a Hospital Order. The second question is the extent to which the offending is attributable to the mental disorder. The evidence before us shows that the offending was attributable to his psychosis. The appellant had a lower degree of retained responsibilities for all the reasons that we have given above. The third question is the extent to which punishment is required. In this case, there was devastating harm to the deceased and his family, but the need for punishment is reduced because the culpability was so adversely affected by the appellant's mental disorder. It is plain, however, that although the aim of a Hospital Order is not to punish, it seems very likely from the expert psychiatric evidence that the appellant will be detained in hospital for very many years to come and given his diagnosis of treatment resistant schizophrenia, there is a real possibility that he will never be released.

37. The fourth question to be addressed is which regime for deciding release (if that ever

occurs) will provide the most protection for the public. In this respect, there are real concerns about the appellant's treatment in a prison regime which have been identified in the evidence. The first concern is that once the appellant gets to a position to be considered for release from hospital, he will be sent to prison. It seems that many prisons will not be able to cope with the appellant taking clozapine. Such an environment may lead to a relapse because he will not, or might not, take his medicine, meaning he would be returned to hospital before getting better and being returned to prison. The second concern, and principal concern, is that when finally released, if he is ever to be released, the appellant would not be supervised by a team of mental health experts reporting to the hospital and the Secretary of State for Justice but instead by a probation officer. Such a probation officer will not be trained to spot the subtle signs of mental health deterioration and, if they are identified, the probation officer will not have the powers to intervene to arrest any such deterioration.

38. In our judgment, it is clear that on a consideration of all the relevant questions and on the evidence available to the Court, the proper order which needs to be made in the appellant's case, to protect the public and to assist in the recovery of the appellant, is section 37 and 41 Mental Health Act Hospital and Restriction Order.

Conclusion

39. For the detailed reasons given above, we allow the appeal against sentence to the extent that we set aside the sentence of life imprisonment with a minimum term of 12 years with a section 45A direction, and we impose a Hospital Order with restrictions on the appellant pursuant to sections 37 and 41 of the Mental Health Act. As already indicated, this may mean that the appellant is never released from hospital. To that extent the appeal succeeds.

40. We conclude by thanking Thomas Walker's family for their attendance today and dignified attention to these proceedings.

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

Lower Ground, 18-22 Furnival Street, London EC4A 1JS

Tel No: 020 7404 1400

Email: rcj@epiqglobal.co.uk