Neutral Citation Number: [2019] EWCA Crim 621

Case No: 201801505

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM Oxford Crown Court (HHJ Mowat)
T20117198

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/04/2019

Before:

LADY JUSTICE THIRLWALL DBE
MRS JUSTICE ANDREWS DBE
and
HHJ DHIR QC
(Sitting as a Judge of the Court of Appeal Criminal Division)

- -

Between:

REGINA	**Respondent**
- and -	
MICHAEL PAUL RENDELL	**Appellant**

- -
- -

Mr Simon Ray (instructed by **CPS**) for the Respondent
Ms L Tapper (instructed by **Reeds Solicitors**) for the **Appellant**

Hearing date: 6th December 2018

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Judgment Approved

LADY JUSTICE THIRLWALL :

This is the judgment of the Court to which we have all contributed.

1. On 13th February 2012 at Oxford Crown Court Michael Rendell pleaded guilty to wounding with intent, contrary to section 18 of the Offences against the Person Act 1861. On 28th March 2012 he was sentenced to an indeterminate term of imprisonment, pursuant to section 225 of the Criminal Justice Act 2003, with a minimum term of three years to be served before consideration of parole. He completed the minimum term in 2015. This is his appeal against sentence which he brings out of time by leave of the single judge.

Facts

2. On 20th November 2011 the appellant was drinking in a bar in Oxford. Witnesses considered he was drunk. He later told the probation officer that he had snorted a gram of cocaine and had drunk seven pints of lager and four whiskies before the incident we now describe. Mr Stephen Walsh was in the bar, drinking with friends. The appellant tugged at his shirt from behind, apparently to gain his attention. Mr Walsh turned, saw the appellant, whom he did not recognise, and turned away from him. The appellant did the same thing again; this time asking whether Mr Walsh knew someone who had the same surname as the appellant. Mr Walsh said he did know him and that he also knew Janine and Hayley, two other cousins. Mr Walsh thought that was the end of the conversation and turned back to his friends. About 5 minutes later Mr Walsh and his friends decided to leave the bar. As he did so he was aware of a "punch or scuff" to the right-hand side of his face. The appellant had struck him. Mr Walsh punched the appellant in the face with his right fist. The appellant fell to the ground. Mr Walsh realised that he had a wound to the right-hand side of his neck. It was bleeding profusely. He was terrified. A friend tied a jacket around his neck to try and stem the flow of blood. A police officer attended and applied pressure to his neck until the ambulance arrived to take him to hospital.

3. The appellant had stabbed Mr Walsh to the neck with a broken glass which had cut through the external carotid artery, into his internal jugular vein and transected his right facial nerve and hypoglossal nerve. On arrival at hospital Mr Walsh was tachycardic, his blood pressure was low. The bleeding could not be stemmed and emergency surgery was required to tie off the blood vessels.

4. Remarkably Mr Walsh survived but his injuries had long term consequences: paralysis of the right side of his face, nerve damage and difficulty in eating.

5. The appellant was arrested and interviewed. He made no comment and subsequently pleaded guilty.

Sentencing hearing

6. At the date of sentence the appellant was 25. His criminal record began at the age of 18 with convictions for assault occasioning actual bodily harm and assaulting a constable. In 2006 he was convicted of aggravated vehicle taking and related offences. In 2007 there were two separate offences of assaulting a constable, disorderly behaviour in 2008 and being drunk and disorderly in 2009. Later in 2009 he assaulted a constable and used threatening, insulting or abusive words or behaviour. Violence to his partners became a common theme. Late in 2009 he was convicted of an offence of unlawful wounding and an offence of theft. In 2011, for two counts of assault occasioning actual bodily harm and an offence of battery, he was sentenced to 15 months' imprisonment. He was released on licence on 15th September 2011, two months before he committed the offence with which we are concerned. At that time he was living in supported accommodation.

7. There was before the judge a detailed pre-sentence report from the probation service and an assessment by Dr Lynda Meina, a consultant clinical and forensic psychologist. Both reports gave a comprehensive account of the appellant's history. His father was violent to him and his brother as they were growing up. Both subsequently became involved in violent behaviour. The appellant had had periods of employment after obtaining a diploma in sports science but drinking was a central feature of his life and his offences were all committed when he was drunk.

8. The appellant expressed concern that he could not control his own behaviour. He also spoke of his very high levels of anger. The probation officer was of the view that the appellant had a much heightened awareness of his own problems as a result of having committed this offence. He was expecting a lengthy prison sentence and expressed the view that he wanted to work towards improvement.

9. Drugs and alcohol featured in all the offending (he told Dr Meina that he had not been drinking before he stabbed Mr Walsh. This was obviously untrue). Probation records refer to a psychiatric report being obtained in 2005, but no mental illness was diagnosed. His medical records refer to several consultations with his GP and

referrals to mental health specialists in 2005 and 2006 but he was not diagnosed as being mentally ill. Probation records indicate that, following an attempt to take his own life in 2008, the appellant was referred to the community mental health team, but he did not keep any appointments and no assessment was completed. His medical records indicate that in 2010 he was referred to primary care psychology services and to the addiction services. He did not attend either.

10. His daughter was born on 27th September 2010, but he and his partner separated while he was in prison in 2011.

11. On his arrest for this offence the appellant was recalled to serve the remainder of the sentence of 15 months' imprisonment, which expired on 29th April 2012. As we have said, he pleaded guilty to the index offence on 13th February 2012. Curiously the probation officer said that there was no history of mental health issues (to her knowledge) and noted that the appellant was receiving some form of mental health intervention in custody, but had not been diagnosed with any specific illness. The probation officer was of the opinion that the appellant was dangerous within the meaning of the Criminal Justice Act 2003 and recommended an indeterminate sentence of imprisonment for public protection.

12. There was no psychiatric evidence before the court. None was sought. Dr Meina had interviewed the appellant and prepared a report dated 26th March 2012. She had been asked to assess the risk of future violence from the appellant. She carried out a comprehensive assessment of his cognitive functioning, administering a number of tests taken from the Wechsler Adult Intelligence Scale and other tests. She concluded that his general cognitive ability was in the bottom end of the borderline range of intellectual functioning, just above the extremely low end of the spectrum.

13. It is plain from the report that Dr Meina did not find it easy to assess the appellant's personality profile given the very high number of statistically significant findings she obtained from him. She noted both his very high levels of aggression and his ability to behave appropriately when in prison. Given the level of violence he had presented in the past she assessed him using a psychopathy checklist (PCL-E:2nd). She concluded that the appellant did not have a high level of psychopathy. This meant that the prognosis for intervention was better than if he were psychopathic.

14. Dr Meina applied the Anger Disorder Scale: shorter version which suggested severe anger pathology. She opined that the appellant's profile indicated that he would most probably meet the diagnostic criteria for one or more of the clinical disorders that are

often found alongside anger: anxiety, mood disorders or, potentially, dissociative disorder. He met the clinical level of anger to suggest an anger disorder. His score indicated severe anger pathology, such that he could be expected to have serious anger problems which influenced most or all areas of his life. His impaired cognitive function might make it difficult for him to demonstrate to the Parole Board, through standardised offending behaviour programmes, that he presented a reduced risk. The appellant's desire to change his behaviour was evident throughout both the probation and psychological reports.

15. Dr Meina observed that the appellant did not "present with any features of mental illness such as psychosis or bi polar disorder." She did not consider the question (because she was not asked to do so) whether the appellant was suffering from a mental disorder within the meaning of the Mental Health Act 1983.

16. In the light of those reports, the judge sentenced on the basis that the appellant did not have any form of mental illness, that his cognitive ability was low and, while he did not present as being a man with a high level of psychopathy, he had personality problems which were described as "severe anger pathology". The judge found that the appellant was dangerous. That finding was inevitable given the facts of the offence and the reports provided to the judge. On the information before the judge the sentence could not be criticised and no application for permission to appeal was made.

Events post sentence

17. Much of the history is taken from the medical reports. The records from 2013 show that the appellant, then a serving prisoner, attended seven sessions with a clinical psychologist. The sessions focused on his violent thought patterns, feelings of low self-esteem and difficulties in managing emotions. In 2014 and 2015 he had contact with various mental health professionals. The appellant presented as suspicious and paranoid about other people trying to plot against him, and he reported hearing voices, specifically the voice of his uncle Michael. By March 2015, it appears that there was a broad consensus among the medical professionals involved in his treatment in prison that he suffered from an emotionally unstable and dissocial personality disorder. He was prescribed antipsychotic medication as well as antidepressants. In June 2015, a consultant psychiatrist, Dr Mark Lyall, produced a report in which he concluded that the appellant's significant personality pathology would require intensive psychological treatment. He recommended that the appellant be transferred to

hospital. Two other psychiatrists, Dr Ray and Dr Al-Taar, endorsed this recommendation.

18. The appellant's case was due to be considered by the Parole Board as he had reached the end of the minimum term but this did not take place and on 23rd September 2015 the appellant was removed to and detained in the Oxford Clinic, Littlemore Mental Health Centre, pursuant to a transfer direction made by the Secretary of State under section 47 and a restriction direction under section 49 of the Mental Health Act.

19. The appellant's responsible clinician at the Oxford Clinic is Dr Sukhjeet Lally, a consultant forensic psychiatrist. Dr Lally interviewed the appellant for the purpose of these proceedings on 6th October 2017 and prepared a report dated 17th October 2017. In summary, his opinion is that the appellant suffers from an emotionally unstable personality disorder and has done so throughout his adult life; his mental disorder makes it appropriate for him to be detained in hospital for medical treatment; and medical treatment is available for him.

Fresh Evidence

20. Another consultant forensic psychiatrist, Dr Robert Cornish, interviewed the appellant on 2nd March 2018 and prepared a report dated 8th March 2018 in which he expressed substantially the same opinion on those points as Dr Lally, although he preferred a diagnosis of a mixed personality disorder, with emotionally unstable and paranoid features.

21. In reliance on those reports, the notice of appeal was filed on 11th April 2018. On behalf of the appellant, Ms Tapper sought leave to adduce and rely upon fresh evidence in the form of the expert reports of Dr Lally and Dr Cornish. Pursuant to directions given by the single judge when granting leave, Dr Lally attended the hearing and Ms Tapper sought permission to call him to give oral evidence.

22. Mr Ray helpfully indicated that the respondent did not oppose the application to adduce fresh evidence, since if the psychiatric evidence had been available at the time of sentencing, the judge would have had the option of a mental health disposal available to her. He submitted, correctly in our view, that the imposition of a sentence of imprisonment for public protection was not wrong in principle but given that two psychiatrists have since agreed that the appellant fulfils (and fulfilled at the time of sentence) all the statutory criteria for detention under s.37 of the Mental Health Act, this court would have the power to substitute a Mental Health Act disposal if it

considered, in all the circumstances, that this would be the most suitable method of dealing with the appellant's case.

23. We read the reports of Dr Cornish and Dr Lally and heard the oral evidence of Dr Lally *de bene esse*.

24. Dr Cornish reports that the current general recommendation is that offenders with personality disorders are best treated in a prison setting or in the community, and not in hospital. However, he observes, the appellant did not respond to treatment in prison, and required a transfer to hospital, where the treatment he received has proved effective. Therefore, in hindsight, he concludes, "placing [the Appellant] in the hospital pathway at the point of sentence may well have been the most appropriate disposal".

25. Dr Cornish and Dr Lally describe in some detail the history that led to the appellant being transferred from prison to the Oxford Clinic to some of which we have already referred. During his time in prison he was reported as having worked hard to address his addiction issues which were acknowledged as a key factor in assessing his risk. Dr Cornish accepted that the appellant tried to complete offending based interventions within a prison-based setting, that he was reported to have shown good motivation, and that he was actively involved in completing a number of stand-alone courses. He also went to a prison Therapeutic Community specifically provided for offenders with below average intellectual functioning, which Dr Cornish explained is at the highest end of the hierarchy of interventions offered for offenders within a custodial setting. However, that proved to be unsuitable for the appellant because of his personality disorder.

26. Following his transfer to hospital, the appellant settled relatively quickly on the acute ward and engaged well with occupational therapy, his psychologist, and dual diagnosis work. He continued to make good progress into the early part of 2016 when he changed to work with a new psychologist, Dr Barker. He engaged well in psychological work, exploring issues around anger and the need to build emotional resilience. There have been occasional angry outbursts on the ward, but he has not been violent.

27. The appellant moved from the acute ward to a medium secure rehabilitation ward in April 2016. On 12th April 2016 he commenced escorted community leave with the use of a tracking device. His escorted leave was gradually increased to periods of up to 4 hours.

28. On 6th March 2017, when he was still in the medium secure unit, the appellant began periods of unescorted leave in the local area, again using a tracking device, starting with shorter periods and gradually building up to periods of 8-10 hours a day. He must say where he is going and obtain agreement from the mental health team, but once he is out in the community, he is on his own. In June 2017 he began a relationship with his current partner. His good progress continued over the next few months. When he was examined by Dr Cornish in March 2018, he had been having periods of 10 hours' leave since August 2017. He was completing a college course as a barber and had been working in a voluntary capacity in a barber's shop one day a week. He had also been going to a local gym three or four times a week and coaching boxing there. He attends a local church. Dr Cornish reported him as being positive about the treatment he had received in hospital from Dr Lally, but especially from Dr Barker, who he said had "done more for me than anyone else in my life".

29. The appellant has now moved to an open unit. This is the final stage of progress towards conditional discharge into the community. Dr Lally explained that the appellant is and would be subject to multi-agency public protection arrangements (MAPPA) irrespective of whether he was in prison or in hospital. MAPPA is the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. MAPPA were informed when he commenced escorted leave, but they did not request a meeting to discuss his case, as they would do if they had any concerns. The Oxford Clinic operates on the basis of full information exchange with MAPPA, and this would include keeping MAPPA informed of the appellant's move to an open unit or changes in the conditions under which the appellant was allowed to leave the unit. There have been no concerns expressed by MAPPA, and no meetings have been requested by them to date.

30. The appellant is subject to random alcohol and drug testing. He is breathalysed twice a week and tested for drugs at least once a fortnight. This testing is carried out at the hospital. He has not failed a test. He told Dr Cornish that he had not used drugs or alcohol since he committed the index offence, and that is consistent with the prison and hospital records. He remains on antipsychotic and antidepressant medication. Dr Lally said in answer to questions from Mr Ray that he is very open about his symptoms, and that nowadays the voices subside very quickly and outbursts of anger have become less frequent.

31. Having read the psychiatric reports and heard from Dr Lally we are satisfied that the statutory criteria for the admission of the evidence set out in section 23(2) of the 1968 Act are met and it is in the interests of justice to receive the fresh evidence.

Statutory Framework

32. The following provisions of the Mental Health Act 1983 are relevant to this case.

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

…
(2) The conditions referred to in subsection (1) above are that-
(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that either-
(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or
(ii) …
and
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

33. Section 41 reads:

Power of higher courts to restrict discharge from hospital
41.-(1) Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section, […] and an order under this section shall be known as "a restriction order".
(2) A restriction order shall not be made in the case of any person unless at least one of the registered medical practitioners whose evidence is taken into account by the court under section 37(2)(a) above has given evidence orally before the court.
(3) The special restrictions applicable to a patient in respect of whom a restriction order is in force are as follows-
(a) none of the provisions of Part II of this Act relating to the duration, renewal and expiration of authority for the detention of patients shall apply, and the patient shall continue to be liable to be detained by virtue of the relevant hospital order until he is duly discharged under the said Part II or absolutely discharged

under section 42, 73, 74 or 75 below

…

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

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

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

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

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

…

34. Section 47 provides for the removal to hospital of a person serving a sentence of imprisonment on the direction of the Secretary of State. Before doing so the Secretary of State must be satisfied from reports from two medical practitioners that the prisoner is suffering from a mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment, effectively the same test as for an order under section 37. A transfer direction has the same effect as a hospital order under section 37 (see section 47(3)).

35. Section 49 mirrors section 41: where the Secretary of State makes a transfer direction under section 47 he may also direct that the person be subject to the special restrictions set out in section 41. Such a direction has the same effect as an order made under section 41 and is known as a "restriction direction" (see 49(2)).

36. It is convenient to set out here two further provisions of the Act, s45A and 45B. Originally implemented in April 2005, they have been in force in their current form since 3rd November 2008. They read as follows:

Power of higher courts to direct hospital admission

45A.-(1) This section applies where, in the case of a person convicted before the Crown Court of an offence the sentence for which is not fixed by law-

(a) the conditions mentioned in subsection (2) below are fulfilled; and

(b) […], the court considers making a hospital order in respect of him before deciding to impose a sentence of imprisonment ("the relevant sentence") in respect of the offence.

(2) The conditions referred to in subsection (1) above are that the court is satisfied, on the written or oral evidence of two registered medical practitioners –

(a) that the offender is suffering from mental disorder;
(b) that the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
(c) that appropriate medical treatment is available for him.
(3) The court may give both of the following directions, namely-
(a) a direction that, instead of being removed to and detained in a prison, the offender be removed to and detained in such hospital as may be specified in the direction (in this Act referred to as a "hospital direction"; and
(b) a direction that the offender be subject to the special restrictions set out in section 41 above (in this Act referred to as a "limitation direction").
(4) A hospital direction and a limitation direction shall not be given in relation to an offender unless at least one of the medical practitioners whose evidence is take n into account by the court under subsection (2) above has given evidence orally before the court.
(5) A hospital direction and a limitation directions shall not be given in relation to an offender unless the court is satisfied on the written or oral evidence of the approved clinician who would have overall responsibility for his case, or of some other person representing the managers of the hospital that arrangements have been made-
(a) for his admission to that hospital; and
(b) for his admission to it within the period of 28 days beginning with the day of the giving of such directions;
and the court may, pending his admission within that period, give such directions as it thinks fit for his conveyance to and detention in a place of safety.
…
(8) Section 38(1) and (5) and section 39 above shall have effect as if any reference to the making of a hospital order included a reference to the giving of a hospital direction and a limitation direction.
(9) A hospital direction and a limitation direction given in relation to an offender shall have effect not only as regards the relevant sentence but also (so far as applicable) as regards any other sentence of imprisonment imposed on the same or a previous occasion.

45B…
With respect to any person-
(a) a hospital direction shall have effect as a transfer direction; and
(b) a limitation direction shall have effect as a restriction direction.
…

37. As this court observed in **R v Ahmed [2016] EWCA** Crim 670, whilst the effect of a restriction direction (under section 49 or section 45B) is the same as a restriction order under section 41, a restriction direction ceases to have effect on the person's release date. This is the effect of Sections 50(2) and (3) of the Act.

38. It follows that for all practical purposes the appellant is now in the same position as he would have been had the judge passed an indeterminate sentence of imprisonment for public protection linked with an order under Section 45A of the Mental Health Act

(save that the treatment would probably have begun earlier). As matters stand the restriction which currently permits his recall to hospital will fall away on his release.

39. The questions for the sentencing court are set out in **R v Vowles [2015] EWCA** Crim 45. At paragraph 51 Lord Thomas CJ said;

> "it is important to emphasise that the judge must carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions. A judge must therefore consider, where the conditions in s37 (2)(a) are met, what is the appropriate disposal. In considering that wider question the matters to which a judge will invariably have to have regard include (1) the extent to which the offender needs treatment for the mental disorder from which the offender suffers (2) the extent to which the offending is attributable to the mental disorder (3) the extent to which punishment is required and (4) the protection of the public including the regime for deciding release and the regime after release. There must always be sound reasons for departing from the usual course of imposing a penal sentence and the judge must set these out".

40. At paragraph 53 the court reminded sentencing judges of the provisions of section 45A MHA and at paragraph 54 directed them to approach matters in the order we now follow.

The extent to which the offender needs treatment for the mental disorder from which he suffers

41. There is no dispute that the appellant needs treatment for the mental disorder from which he suffers. That is why the Secretary of State transferred him to hospital pursuant to section 47 of the Mental Health Act. Treatment has led to a significant improvement in his ability to control the behaviour arising out of his personality disorder. He is subject to a restriction direction and on return from periods away from the hospital he is rigorously tested for drugs and alcohol. Dr Lally envisages this continuing for some time.

42. We are satisfied that the conditions in section 37(2)(a) are and were met at the time of sentence. We turn to section 37(2)(b): having regard to all the circumstances and to the available methods of dealing with the appellant, are we satisfied that an order under section 37 is the most suitable method of disposing of the case? We have in mind the questions posed in **Vowles.**

To what extent is his offending attributable to his illness?

43. Although the court there refers to illness this must mean a mental disorder within the meaning of the Mental Health Act. The question of the extent to which the offending is attributable to the mental disorder has exercised the court in this case. It is central to the assessment of the appellant's culpability. It is plain that drink and drugs, which he had consumed out of choice, affected the appellant's behaviour. In answer to a question from the court about the extent to which the appellant's consumption of drugs and alcohol, as opposed to his personality disorder, played a part in his commission of the index offence, Dr Lally said the chances of it happening were greatly increased by the lack of inhibition due to consumption of drugs and alcohol. However, the appellant's use of drugs and alcohol at the time of the index offence was an inherent part of his inability to cope with stress factors or with difficult thoughts and emotions. He has gained insight through work on this. Whilst he could offend violently without taking drugs and alcohol, the level of any violence would probably be much less. Dr Lally added in answer to a further question that the appellant's cognitive functioning, although low, is still within the normal range and was not so much a factor in his offending as the lack of emotional control.

44. We are satisfied that notwithstanding his limitations, the appellant had some understanding that he became particularly aggressive when under the influence of drink and drugs. However we accept the evidence of Dr Lally that part of the reason the appellant abused alcohol and took illegal drugs is the personality disorder for which treatment continues and is successful. We assess his culpability for this offence as moderate.

The regime for deciding release

45. The regime for release on life licence is different from the regime for release on a hospital order/restriction order. The focus for the parole board is broad; it considers the likelihood of reoffending and the risk to the public resulting from it. Under the section 37/41 regime the focus is entirely on the appellant's mental health although, as Dr Lally explained, the risk to the public and the risk of deterioration of the appellant's mental health are closely linked, the former being greater if there is a deterioration in the latter.

46. Dr Lally told the court that the appellant's case would be considered by the First-tier Tribunal on 19th December 2018, but that he and his colleagues would not be recommending his release then, because he needs to have a longer period of

unescorted leave. He said that the appellant was aware of this and had accepted it. However, it is possible that six months later the recommendation might be made for his conditional release. If the sentence of imprisonment for public protection remains in place, and if the FtT were to endorse the recommendation for conditional release the case would go to the Parole Board.

47. Dr Lally was very familiar with the workings of the Parole Board, having sat on the Board for 12 years. In Dr Lally's experience, in around 90% of cases where the First-tier Tribunal considered that an offender was no longer a risk due to his mental health condition, the Parole Board agreed that the criteria for that offender's release on licence were met. The delay between the FtT decision and that of the Parole Board was likely to be about six months.

48. Both Dr Cornish and Dr Lally were of the view that a return to prison pending consideration of the case by the Parole Board could lead to a loss of therapeutic gains and relapse in the appellant's mental health condition. Mr Ray made it plain, on behalf of the respondent, that he was not suggesting that the appropriate disposal for the appellant should involve his return to prison if parole were not granted. Section 74 of the Mental Health Act permits the Secretary of State to direct that a person may remain in hospital if a direction for discharge is not made, notwithstanding a recommendation to that effect. It follows that the appellant would not be returned to prison pending consideration of the recommendation of the FtT. Dr Lally was confident that would be the case.

49. The delay between the recommendation of the FtT and the decision of the parole board would not of itself be harmful but it would delay rehabilitation. Mr Ray submitted that the delay would be justified on the basis that the Parole Board would be a further safeguard for the public.

Regime post release

50. The question of the regime after release received close scrutiny from this court in **R v Edwards and others [2018] EWCA** Crim 595. The court was concerned to establish whether the opinions expressed by most of the psychiatrists in the serious cases before them that the regime post release was more effective in protecting the public under section 37/41 than post section 45A were correct. No evidence was before the court to contradict the views of the experts. In **Ahmed** this court

concluded on the facts of that case that the regime under section 37/41 was the most effective way of protecting the public in that case. The contrary was not argued.

51. At the invitation of the court in **Edwards** the prosecution called a senior probation manager on short notice to describe the system of release from prison. He was unable to assist since he had no experience of the kind of supervision and risk management that would apply to a serious case. The court therefore sought further information from the Ministry of Justice. This came in the form of a letter from the Head of Practice Development and Public Protection. Its relevant contents are set out at paragraphs 19-29 of the judgment. We do not repeat them here. Mr Ray relied on one or two paragraphs in cross-examination as we shall record.

52. The question of whether the section 37/41 regime or section 45A (or the section 47/49) regime best protects the public is a matter of fact in each case. The information in Mr Denman's letter to the Court of Appeal in the case of **Edwards** gives a helpful general framework to which we add the detailed evidence as to what would happen in this case were the arrangements post release governed by licence or a hospital order.

53. If the existing sentence were upheld, and the Parole Board decided to release the appellant on life licence, there would be probation involvement at the outset. The appellant would have a named probation officer. This would be a new person, inevitably, rather than a member of the health care team with whom he already had a relationship. The appointment of a named officer would be the only practical difference in the supervision given to the appellant and it was Dr Lally's view that this would not improve the management of risk.

54. Dr Lally expressed the view that the conditions imposed on the appellant by a FtT would be as robust as any conditions imposed by the Parole Board on the appellant's release on licence, if not more so. If he were released on a life licence there would be some probation involvement early on, but in practical terms the hospital would provide all the other services, including six monthly reviews and treatment. Co-operation with the Mental Health Team at the treating hospital, and compliance with treatment would be a condition imposed under both regimes. Dr Lally explained that the Probation Service has no resources to carry out tests for drug or alcohol abuse, and therefore in practice, abstinence conditions are not imposed by the Parole Board. However, the FtT can and will impose abstinence conditions because the mental health services teams are both able and willing to carry out the testing themselves. Dr

Lally said that he and his team would ask the FtT to make routine testing a condition of discharge. This would start at a relatively high level and then be reduced over time.

55. When Mr Ray suggested that the Probation Service would be better placed to spot any warning signs of reliance on drugs and/or alcohol than the hospital, and that the mental health route would be more reactive than proactive, Dr Lally disagreed. Testing, which was not available to the Probation Service, was one of the ways to identify warning signs. As to being proactive, he said that whilst probation provide some group treatment by referring offenders to outside agencies, his team had more services available, such as the community psychology service, and access to specialist work on substance abuse.

56. As to the way in which a single breach of the conditions imposed under the two regimes would be dealt with, if he were given a conditional release from hospital, the initial response to a breach was likely to be an increase in vigilance and supervision. If he were released on licence, the consequences would depend on how probation viewed the breach. He would not be recalled to prison unless it could be proved that the risk to the public had increased, and in Dr Lally's experience (which was limited to offenders who were recalled) the offender would have several warnings and there would usually be a deterioration in behaviour and/or presentation before he was recalled.

57. Unlike the sentencing judge, we have the advantage not only of full medical reports but of evidence of the results of the treatment to date and a prognosis as to the future. There is good evidence of the appellant's changed behaviour and his motivation and ability to maintain improvement. The appellant's alcohol abuse was at the heart of his offending. Since he began his sentence he has not consumed alcohol, still less misused it. The hospital order regime provides the best way of securing the continued monitoring of that, for the reasons we have given above. It follows that we are satisfied, on the facts of this case that the sentence which will most effectively protect the public would be orders under section 37 and 41 of the Mental Health Act 1983.

58. We remind ourselves that there must always be sound reasons for departing from the usual course of imposing a penal sentence (see **Vowles** at [45]). This was a serious offence where culpability was moderate. To the reasoning set out above we would add that the appellant has served the punitive element of the sentence and has been detained for twice the minimum term, the equivalent of a 12-year sentence. In the

unusual circumstances of this case, which we have described in some detail we are satisfied that the appropriate sentence here are orders under section 37 and 41 of the Mental Health Act 1983.

59. Accordingly, this appeal is allowed. We quash the indeterminate sentence of imprisonment and substitute for it orders under section 37 and 41 of the MHA respectively.