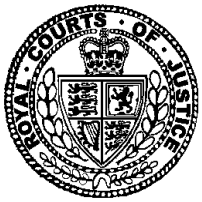

Neutral Citation Number: [2020] EWCA Crim 906

Case No: 2020 00351 A3

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT BRADFORD
HH Judge Durham Hall QC
T2013 7165

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/07/2020

Before:

LORD JUSTICE HOLROYDE
MR JUSTICE NICKLIN
and
MR JUSTICE MURRAY

- -

Between:

CAMERON JOHN CLELAND	**Appellant**
- and -	
THE QUEEN	**Respondent**

- -
- -

Mr Ed Fitzgerald QC and Ms Pippa Woodrow (instructed by **Scott-Moncrieff & Associates Ltd**) for the **Appellant**
Mr Louis Mably QC (instructed by **Appeals and Review Unit, Crown Prosecution Service**) for the **Respondent**

Hearing date: 9 July 2020

- -

Approved Judgment

Lord Justice Holroyde:

1. On 13 August 2013, in the Crown Court at Bradford, this appellant pleaded guilty to an offence of attempted murder. He was sentenced by HHJ Durham Hall QC to detention for life. The minimum term specified by the judge pursuant to section 82A of Powers of Criminal Courts (Sentencing) Act 2000 was 7 years. The appellant was also made subject to a restraining order of indefinite duration.

2. The appellant appealed against that sentence. His appeal was dismissed by the full court on 28 February 2014. A subsequent application for leave to appeal to the Supreme Court was refused on 8 July 2014.

3. The case now comes before this court upon a referral by the Criminal Cases Review Commission. By section 9(3) of the Criminal Appeal Act 1995, such a referral is treated for all purposes as an appeal against sentence. Leave is sought to admit fresh evidence that at the time of the offence the appellant suffered Autism Spectrum Disorder ("ASD"). On the basis of that evidence it is submitted that the appropriate sentence was, and is, a hospital order pursuant to section 37 of the Mental Health Act 1983 coupled with a restriction order pursuant to section 41 of that Act. For convenience, we shall use the shorthand "s37/s41 order" to refer to that combination of orders.

The facts:

4. The appellant was aged 16 when he committed the offence. His victim was aged just 12. In 2012 they lived near one another, attended the same school and would occasionally talk to one another. The appellant became infatuated with his victim. He sent many text messages expressing his interest in her. She indicated that she had no interest in him. Between about September 2012 and March 2013 there was no communication between them, and the victim thought the matter had ended.

5. Unbeknown to her, the appellant's infatuation had continued. He regularly used an on-line chat forum to contact Childline, saying that he really liked a girl aged 11 or 12 and was depressed because she had a boyfriend. In January 2013 he indicated to Childline that he wanted to rape her, because her life was too good and he wanted to balance things out. Later investigation was to show that he had used his computer to access material about rape and murder.

6. On 6 February 2013 the appellant was spoken to by the police. He claimed he had only said such things to gain attention. No further action was taken.

7. In March 2013 the appellant started sending further text messages to his victim. She refused his requests that they meet. The appellant repeatedly threatened to kill himself. Eventually she was pressurised into agreeing to meet him in a quiet lane near their respective homes on 21 April 2013.

8. The appellant arrived for that meeting wearing latex gloves. He pounced on his victim, knocked her to the ground and produced a penknife. She tried to fight back. The appellant said he was going to have to kill her. He threatened to rape her. He began stabbing at her throat and chest, but the knife appears to have been blunt and he caused only superficial wounds. He then tried instead to strangle her. By great good

fortune a dog walker came on the scene. She saw the appellant with his hands around his victim's throat. Realising that he had been seen, the appellant walked away. The victim was taken home and then to hospital. Fortunately, her physical injuries were minor.

9. The appellant was arrested later that day. He was in possession of the knife and bloodstained gloves. He admitted that he had tried to kill his victim. When interviewed under caution he made no comment.

The sentence imposed in the Crown Court:

10. At the sentencing hearing, the judge was assisted by the following:

    i) a pre-sentence report, which showed that the appellant was academically able and had a supportive family, but that concerns had been expressed about his behaviour and presentation, including his behaviour towards some other girls at school;

    ii) 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;

    iii) a report by a forensic psychologist, who assessed the appellant as having obsessional traits and being unable to see things from other persons' perspective, but considered it unlikely that he would currently meet the diagnostic criteria for an ASD; and

    iv) a victim personal statement from the victim's mother, which we assume described the psychological effects of this offence.

11. The judge noted that the medical evidence included a suggestion of an underlying illness, but showed that the appellant was not mentally ill and was not autistic. He found that the appellant had wanted to punish his victim, whom he blamed for his unhappiness. He had considered raping her but rejected that as inadequate, and over a period of time had planned to kill her and had rehearsed killing her. We interpose here that although it is unnecessary to go into the details of that planning and rehearsal, the accounts given by the appellant to a number of professionals contain deeply disturbing features. The judge went on to say that the appellant had armed himself and lured his victim to a quiet spot. He had threatened her with rape, thereby heightening her ordeal. She must have been terrified. She had only been saved by the arrival of the passer-by. The appellant had expressed regret that he had not succeeded in killing his victim and had shown neither empathy nor remorse. He had also said that he knew the consequence of killing her, if he were caught, would be life imprisonment, but that "it would have been worth it". The judge concluded that it was a case of "exceedingly high culpability and very real harm".

12. The judge noted that the psychiatrist had reported that when he told the appellant that the victim would almost certainly suffer lasting psychological harm, the appellant "seemed much more fulfilled" and said that made him feel better "as the offence had not been completely in vain".

13. The judge also noted that the appellant had told the psychologist that he considered that killing his victim was a perfectly justified way of dealing with the distress which he was suffering. He continued to resent her, and her family, and hoped she was still suffering trauma. The psychologist had concluded her report by saying:

> "I am not able to offer a prognosis of when his risk will reduce to a level that will mean it will be manageable in the community. … [G]iven the ingrained nature of some of the personality traits that have influenced [the appellant's] behaviour, it is my view that to be effective any intervention will probably take years …."

14. The judge concluded that an extended sentence was not sufficient to protect the public from the risk posed by the appellant, and that there was no alternative to detention for life. Taking into account the appellant's young age and previous good character, he imposed the minimum term of 7 years.

15. It follows from this brief summary that no medical disposal was put forward for the judge's consideration. Similarly, the unsuccessful appeal against sentence in 2014 was not based on any suggestion that a medical disposal was appropriate. Rather, it was a challenge to the imposition of a life sentence, on the ground that an extended sentence would have been sufficient to punish the appellant and to protect the public, and to the length of the minimum term.

The post-sentence diagnosis:

16. The appellant had great difficulty in coping with his custodial sentence. His presentation gave cause for concern about his mental health. In November 2014 he was transferred to a medium-secure hospital ward on a restricted basis, pursuant to sections 47 and 49 of the 1983 Act, for assessment of autism and potential psychopathy. Detailed assessment by a forensic adolescent psychiatrist, Dr Shah, and a clinical psychologist Dr Diggle, resulted in a conclusive diagnosis of autism. It is suggested that the reason why this diagnosis had not been made previously was that there had been inadequate assessment due to the unavailability of the full history.

17. The diagnosis was subsequently confirmed in reports by other experts. In July 2017 Dr Latham, a consultant forensic psychiatrist, concluded that there was very strong evidence that the appellant has an ASD. He might also have a separate personality disorder, but Dr Latham felt there was insufficient evidence to make that diagnosis. He concluded that there was a direct causal link between the ASD and the offence and that the ASD was a "highly significant contributory factor". He considered that the appellant's ASD required treatment in hospital, and should be dealt with via the mental health pathway release regime to best protect the public. In December 2017 Dr Stankard, a consultant forensic psychiatrist who has been the appellant's responsible clinician since April 2017, expressed the opinion that the ASD was "at the very least a significant contributor" to the offence. He set out the history of the appellant's treatment in custody and in hospital, noted that he was engaging positively and making progress, and stated that he continued to require treatment under sections 47 and 49 of the 1983 Act. On 2 February 2018 the First Tier (Health Education and Social Care) Tribunal found that detention and treatment in hospital was appropriate.

In the light of the appellant's progress, he was transferred to a low-secure ward in March 2019.

18. The grounds of appeal contend that evidence now shows that, at the time of the offence, the appellant was suffering from a previously-undiagnosed ASD, a mental disorder which at least significantly contributed to his commission of the offence, and that a s37/s41 order would best serve both the appellant's rehabilitation and the protection of the public. This court has been provided with a substantial body of medical evidence gathered since the appellant was sentenced. In particular, the appellant seeks to rely on fresh evidence in the form of reports and oral evidence by Dr Stankard and Dr Latham.

The fresh evidence on which the appellant seeks to rely:

19. In a joint statement dated 25 June 2020, and in the oral evidence which each of them gave to this court, Dr Stankard and Dr Latham confirm that the appellant is suffering from a mental disorder within the meaning of the Mental Health Act 1983, namely ASD; that his mental disorder is of a nature and degree which make it appropriate for him to be detained in hospital for treatment; and that the appropriate treatment is available for him.

20. The key features of their written and oral evidence can be summarised as follows.

    i) ASD is a pervasive and persistent disorder: the appellant suffers from it now, and the nature of the disease is such that he suffered from it at the time of the offence and will continue to suffer throughout his life.

    ii) In the lead-up to the offence, the disorder affected his ability to manage relationships and his own emotional states, made him unable to cope with adverse experiences so that his distress level increased, and led to his irrational and paranoid thinking. The disorder was "the primary factor" (Dr Latham) in his commission of the offence and "substantially impaired" (Dr Stankard) his responsibility for committing it. If he had killed his victim, and been charged with her murder, the partial defence of diminished responsibility would have been available to him.

    iii) ASD was not however the sole cause of the offence: not every person who suffers from ASD becomes violent when distressed or engages in predatory behaviour. As Dr Latham put it, ASD explains how the appellant got into the situation and why it was so hard for him to deal with his problems, but it doesn't explain why events unfolded as they did. Other psychological factors, not part of his ASD, were therefore relevant to his offending. It is however difficult to separate out precisely those aspects of his personality which are attributable to ASD and those which are not. For example, those suffering from ASD may have an intellectual understanding of the fact that their behaviour will cause suffering to another, and want to cause suffering, but are unable to appreciate how the victim will feel. They do not really understand what they have done and may therefore appear to lack remorse. Although the appellant planned his offence, his ASD caused him to be in the emotional and mental state in which he made that plan.

iv) Since his transfer to hospital in 2014, the appellant has received appropriate treatment, which has followed a graded approach. He is currently managed in a low-secure ward with regular supervised community leave which has been approved by the Ministry of Justice. He has engaged well with his treatment, is managing to control his aggressive and inappropriate behaviour, and has been able to change his thinking about his victim. However, Dr Stankard has expressed the view that his case and risk formulation are very complex and that he -

> "will require extensive and continued psychological input to achieve future safe discharge to the community and ensure robust and effective future risk management".

v) The appellant's ASD is a lifelong condition and expert management will therefore be needed long after release. It is a feature of ASD that events which interfere with routine or stability, or anxiety, may exacerbate the condition. Monitoring for fluctuations in mood, depressive states and any associated mental state abnormality is therefore required. Without expert management there would be a serious concern about a risk of future violence.

vi) Treatment for the appellant's ASD, which is needed in order to help him manage his responses, should continue to be carried out by persons with specialist training and experience: they will be best be able to understand the appellant's condition and to monitor for fluctuations in his mental state and any future escalation in the risk he poses to others. With a more obvious mental illness such as schizophrenia, a deterioration in the sufferer's condition might be easier to detect; but the early warning signs of deterioration in someone suffering from ASD can be more subtle, and harder to spot.

vii) Because the offence can be clearly understood as arising from the appellant's disorder, his ASD is the target for intervention and treatment both now and after his release. Any future risk will always be associated with his ASD.

viii) Future risk can be reduced with treatment and continued mental health management so that he might eventually be released. The next stage in his treatment will be to move slowly and carefully from escorted to unescorted leave, a process which could take about two years. Further preparation would be needed after that before the appellant could be considered ready for discharge from hospital.

ix) If he were subject to a s37/s41 order, multi-agency public protection arrangements would be in place before he was discharged. Discharge from hospital would be pursuant to a decision of the First Tier Tribunal. In practice, a high threshold would be set for discharge: the approval of the Tribunal would be no easier to obtain than would be the approval of the Parole Board to release of the appellant on licence if he remains subject to his life sentence. Discharge from hospital would be subject to conditions requiring, for example, cooperation with medical appointments, residence at a specified address and disclosure of any new relationship. There might eventually be an absolute discharge, but that is very unlikely in this case. Unless and until he is

absolutely discharged, he could if necessary be recalled to hospital under a s37/s41 order.

x) A return to prison would not be clinically appropriate, either in facilitating the appellant's recovery or in ensuring the necessary expert assessment, monitoring and treatment on release, and so would not be in the public interest. Only the s37/s41 regime would guarantee that on release there is a mandated frequency of contact with mental health professionals, and would provide for the appellant's primary supervision to be by mental health professionals.

xi) If the appellant were to remain subject to a life sentence, and was released on licence, mental health care would be available for him and conditions of his licence could require him, for example, to engage in care as directed by a named psychiatrist. In the opinion of both doctors, however, that would not guarantee the level of involvement of a senior psychiatrist which would be provided under a s37/s41 order: licence conditions cannot compel a psychiatrist to be involved. Their opinion is that it is certainly possible for the appellant to receive appropriate care under the conditions of a life licence, but whether such care will in fact be provided is less certain than it would be under a s37/s41 order.

xii) In addition, whilst arrangements would be made for the appellant's accommodation if he were a prisoner released on licence, such accommodation would in practice be unlikely to be long-term and would therefore provide a less stable home environment than would be available under a s37/s41 order.

21. We are grateful to Dr Latham and Dr Stankard for their assistance. The appeal is brought on the basis that, if the evidence which they have given had been before the judge, he would not have imposed a life sentence but would or should instead have made a s37/s41 order. Before considering the submissions in a little more detail, it is necessary to set the legal framework.

The legal framework:

22. Because the appellant was under the age of 18 at the time of his conviction, the statutory purposes of sentencing set out in section 142 of the Criminal Justice Act 2003 did not apply to his case. The judge was required to have regard to the principal aim of the youth justice system, which by section 37 of the Crime and Disorder Act 1998 is to prevent offending by children and young persons, and to have regard to his welfare in accordance with the principle stated in section 44 of the Children and Young Persons Act 1933. He had to have regard to the then-current guideline published by the Sentencing Guidelines Council which set out overarching principles for sentencing children and young persons.

23. It is not in dispute that the judge had power, under section 226 of the Criminal Justice Act 2003, to impose a life sentence if he considered that the appellant posed a significant risk of serious harm to members of the public by the commission of further specified offences. Where such a sentence is imposed, section 28 of the Crime (Sentences) Act 1997 provides that the Secretary of State must order the offender's release on licence when he has served the minimum term and the Parole Board has directed his release, which it will only do if satisfied that it is no longer necessary for

the protection of the public that the offender should be confined. A prisoner released on licence is subject to conditions and to supervision by the Probation Service and may be recalled to prison to continue serving his life sentence.

24. As this case shows, the imposition of a custodial sentence does not mean that an offender who is in need of specialist treatment for a mental health disorder cannot receive it. Subject to certain conditions being satisfied, section 47 of the Mental Health Act 1983 provides for a prisoner to be transferred to, and detained in, hospital for treatment. Section 49 of the Act enables the court to order a restriction on discharge from hospital. Where the offender no longer requires treatment, the Secretary of State may order that he be remitted to prison, or may exercise any power of release which would have been exercisable on remission: see section 50. In practice, release in a case such as the present could only be ordered by the Secretary of State after the minimum term has expired and following a direction by the Parole Board. Dr Latham confirmed that release of the appellant on life licence could be managed, through a combination of the Parole Board and the First-Tier Tribunal, in such a way as to ensure that he would not have to be transferred back to prison and would remain in hospital until discharged.

25. The judge also had the power – though as we have said, no one asked him to consider exercising it – to make a hospital order under section 37 of the 1983 Act, which, so far as is material for present purposes, provides:

> "**37. Powers of courts to order hospital admission or guardianship.**
>
> (1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law … and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order …
>
> (2) The conditions referred to in subsection (1) above are that—
>
> (a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that either—
>
> (i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or
>
> (ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and
>
> (b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the

> character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.
>
> … "

26. A hospital order may be coupled with a restriction order under section 41 of the 1983 Act, the effect of which is that the offender cannot be discharged from hospital unless either the Secretary of State or the First Tier Tribunal find that he no longer poses a risk arising from his medical condition. Discharge may be subject to conditions and the offender will be under the supervision of a responsible clinician and liable to be recalled to hospital.

27. The approach to be taken when considering whether to exercise the power to make a s37/s41 order was the subject of detailed consideration in *R v Vowles* [2015] EWCA Crim 45, in particular at [51-54] of the judgment of the court given by Lord Thomas CJ. The court emphasised, at [51], that the judge must carefully consider all the evidence in the case and not feel circumscribed by the psychiatric opinions. The Lord Chief Justice continued –

> "A judge must therefore consider, where the conditions in section 37(2)(a) are met, what is the appropriate disposal. In considering that wider question the matters to which a judge will invariably have to have regard 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."

28. At [52], the Lord Chief Justice said, with regard to the fourth of those features, that the sentencing judge must pay very careful attention to the different effect of the conditions applicable to and after release in each case. He continued:

> "53. The fact that two psychiatrists are of the opinion that a hospital order with restrictions under section 37/41 is the right disposal is therefore never a reason on its own to make such an order. The judge must first consider all the relevant circumstances, including the four issues we have set out in the preceding paragraphs and then consider the alternatives in the order in which we set them out in the next paragraph.
>
> 54. Therefore, in the light of the arguments addressed to us and the matters to which we have referred, a court should, in a case where (1) the evidence of medical practitioners suggests that the offender is suffering from a mental disorder, (2) that the offending is wholly or in significant part attributable to that

> disorder, (3) treatment is available, and it considers in the light of all the circumstances to which we have referred, that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case, consider the matters in the following order:
>
> (i) As the terms of section 45A(1) of the MHA require, before a hospital order is made under section 37/41, whether or not with a restriction order, a judge should consider whether the mental disorder can appropriately be dealt with by a hospital and limitation direction under section 45A.
>
> (ii) If it can, then the judge should make such a direction under section 45A(1). This consideration will not apply to a person under the age of 21 at the time of conviction as there is no power to make such an order in the case of such a person as we have set out at para 19 above.
>
> (iii) If such a direction is not appropriate the court must then consider, before going further, whether, if the medical evidence satisfies the condition in section 37(2)(a) (that the mental disorder is such that it would be appropriate for the offender to be detained in a hospital and treatment is available), the conditions set out in section 37(2)(b) would make that the most suitable method of disposal. It is essential that a judge gives detailed consideration to all the factors encompassed within 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 is no evidence he would be in any way dangerous, and (3) the offending is entirely due to that mental disorder, a hospital order under section 37/41 is likely to be the correct disposal.
>
> (iv) We have set out the general circumstances to which a court should have regard but, as the language of section 37(2)(b) makes clear, the court must also have regard to the question of whether other methods of dealing with him are available. This includes consideration of whether the powers under section 47 for transfer to prison for treatment would, taking into account all the other circumstances, be appropriate."

29. As is apparent from [54(ii)], a hybrid order under section 45A of the 1983 Act was not available in this case because of the appellant's age. It is no longer argued that an extended sentence should have been imposed. Thus, this appeal falls to be considered on the basis that the possible sentences are detention for life or a s37/s41 order.

Fresh evidence:

30. By section 23 of the Criminal Appeal Act 1968, this court may receive fresh evidence if it thinks it necessary or expedient in the interests of justice to do so. Subsection (2) lists matters to which the court should in particular have regard.

The powers of this court on appeal:

31. Section 11(3) of the Criminal Appeal Act 1968 provides:

> "(3) On an appeal against sentence the Court of Appeal, if they consider that the appellant should be sentenced differently for an offence for which he was dealt with by the court below may—
>
> (a) quash any sentence or order which is the subject of the appeal; and
>
> (b) in place of it pass such sentence or make such order as they think appropriate for the case and as the court below had power to pass or make when dealing with him for the offence;
>
> but the Court shall so exercise their powers under this subsection that, taking the case as a whole, the appellant is not more severely dealt with on appeal than he was dealt with by the court below."

The submissions:

32. In relation to the proposed fresh evidence, the appellant submits that the conditions in section 23 of the 1968 Act are met. The respondent does not argue to the contrary.

33. The core submission on behalf of the appellant is that, in the light of the fresh evidence, it can now be seen that the life sentence was based on an incorrect understanding and was wrong in principle. The judge, in the light of the evidence then available, proceeded on the basis that the appellant was not suffering from mental illness and was not autistic. There was no evidence on which he could make a s37/s41 order, and he therefore did not consider doing so. The appellant was in fact suffering from a mental disorder, then undiagnosed, which was capable of treatment and required treatment in hospital. A s37/s41 order was and remains the most appropriate disposal, both for the benefit of the appellant and for the protection of the public.

34. It is submitted that there is clear expert opinion that the appellant's ASD, though not the sole cause, contributed significantly to his offence. This link between the disorder and the offending supports the making of a s37/s41 order. It reduces the appellant's culpability so that it can no longer be assessed as "exceedingly high". The need for the sentence to contain a punitive element is therefore less than it appeared to be to the judge, and in any event a need for punishment should carry less weight in the case of a child or young person than in the case of an adult offender. The appellant's minimum term will expire next month, and so the loss of liberty which the judge considered appropriate will shortly have been served. Moreover, now that the diagnosis has been made and the link between the disorder and the offence can be

seen, it is apparent that the risk of reoffending can be reduced by treatment of the disorder, and the risk on release can be better managed in the community through clinical supervision.

35. As to the future, the appellant submits that the fresh evidence shows that the public would be better protected by a s37/s41 order than by release being subject to the approval of the Parole Board. Reliance is placed on the following passage in *R v Semanshia* [2015] EWCA Crim 2479 at [30]:

> "Under a section 37/41 order an offender can continue to receive treatment in a secure setting in a supported and secure environment, permitting his being tested and over time stepped down as regards level of security as he progresses, until a conditional discharge in the community (subject to conditions and to recall so as to reduce risks to the public) is in place. He would also be far more likely to receive the forensic psychiatric help he requires when eventually discharged into the community. Under section 47/49 he will at some stage be transferred back to a prison environment and discharged back into the community following a parole hearing. He might then be put in contact with local mental health services, but will not have the same level of scrutiny, supervision and support, nor be subject to conditions or recall, thus increasing risks to his well-being and public safety."

36. The appellant submits that a s37/s41 order would make it possible for the appellant to be subject after release to strict conditions and compulsory medical treatment, whereas a life sentence would not. It is submitted that, as in *R v Fuller* [2016] EWCA Crim 1867, the interests of the appellant are aligned with the public interest, and both will best be served by release being managed under the s37/s41 regime. Reliance is placed on the view of the court in *Fuller* at [49] that:

> "… the appellant's release into the community can only be contemplated if he is properly monitored by a multi-disciplinary 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."

37. It is further submitted that a transfer of the appellant back from hospital to prison is likely to have a significant detrimental effect on the appellant's rehabilitation. The appellant has no other convictions, and in the early stages of his sentence he struggled severely with custody. If transferred, he would for the first time enter the adult prison estate, a prospect which he is said to fear. Moreover, it is submitted, those managing him in prison would be less expert in managing his disorder.

38. The respondent acknowledges that the fresh evidence is capable of meeting the conditions in section 37 of the 1983 Act for the making of a hospital order, and

suggests that the principal question for the court is whether the condition in section 37(2)(b) is satisfied. In that regard, the respondent submits that the evidence clearly shows a need for continuing treatment in order to address the risk which the appellant continues to pose of acts of violence towards members of the public, especially women. It is submitted that the treatment which the appellant is receiving helps him to understand and live with his condition, but does not cure his ASD. The evidence also shows that the appellant's paranoid thinking is accentuated if he comes under stress. Moreover, features of the offence relevant to the judge's assessment of culpability, such as its calculated and predatory nature and the appellant's desire to inflict pain, were not related to, or explained by, the appellant's ASD.

39. As to the element of punishment, the respondent submits that the appellant retained a high level of responsibility for his offence and that detention for life was justified, notwithstanding his young age. The appeal against that sentence was dismissed.

40. It is submitted that a life sentence does not prevent the proper treatment of the appellant's condition, as his treatment in hospital over several years shows; and it is accepted by the doctors that the Parole Board would be able to consider release on licence without a need for the appellant to be transferred from hospital to prison before release. As to protection of the public after release, the respondent submits that, under a life sentence, the Parole Board can take account of wider questions of risk than can the First Tier Tribunal, which would focus on risk arising from the appellant's ASD. Release on licence would be subject to conditions and to monitoring and supervision, and mental health intervention could continue. The court is entitled to assume that public authorities will comply with their duty and implement such conditions. Moreover, the life sentence retains the ability to recall the appellant to prison at any time, if it is necessary because of a failure on his part to comply with conditions or an escalation in the risk he presents. A s37/s41order would make it possible (even if unlikely) that at some stage in the future, the appellant might be absolutely discharged and therefore not subject to the possibility of compulsory recall for further treatment.

41. Submissions were made as to the relevance of the fact that the appellant's minimum term will shortly expire. For the appellant, it is submitted that the answer to the third question posed in *Vowles* at [51] (see [27] above) is that there is now no need for punishment. Reliance is placed in this regard on *R v Erskine* [2009] EWCA Crim 183, [2010] 1 WLR 183, *R v Ahmed (Saber Mohammed)* [2016] EWCA Crim 670 and *Fuller*. For the respondent, it is submitted that this is an offence which is deserving of punishment, but the fact that the appellant has served a long period of his sentence is something which the court can take into account.

42. We are grateful to all counsel for their very helpful submissions, and to all who have been involved in the preparation and presentation of this appeal.

Discussion and conclusions:

43. We begin by considering the application to adduce fresh evidence. In *R v Beatty* [2006] EWCA Crim 2359, the court drew an important distinction between a prisoner serving a life sentence who develops a mental illness or disorder post-sentence and is transferred to hospital under sections 47 and 49 of the 1983 Act, and one whose

condition at the time of sentence was such that the judge should have made a s37/s41 order. Scott Baker LJ, giving the judgment of the court, said at [62]:

> "… the court will always scrutinise with great care cases in which an appellant seeks to rely on psychiatric evidence directed to his mental state at the date of sentence that was not advanced at the time. Each case is likely to be decided on its own specific facts."

44. In the more recent case of *R v Rogers* [2016] EWCA Crim 801, [2017] 1 WLR 481 Lord Thomas CJ made clear that where an appellant seeks to argue, on the basis of evidence acquired post-sentence, that a hospital order should be made, the provisions of section 23 of the Criminal Appeal Act 1968 must be followed. As is clear from *Erskine*, the decision whether to admit fresh evidence in a particular case will be fact-specific.

45. In this case, we can deal with the matter shortly. The evidence of Dr Latham and Dr Stankard is clearly capable of belief. It may afford a ground for allowing the appeal. 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.

46. Before addressing the condition in section 37(2)(b), we consider next the powers of this court on an appeal against sentence. In *R v Bennett* [1968] 1 WLR 988, the court drew attention to a significant change in the legislation in this regard. The Criminal Appeal Act 1907 formerly provided that if the Court of Criminal Appeal on an appeal against sentence "think that a different sentence should have been passed" it may quash the sentence and in place of it pass such sentence "as they think ought to have been passed". In contrast, later provisions (now contained in section 11(3) of the 1968 Act) enable the court to consider whether the appellant "should be sentenced differently". The court observed that that wording enabled the court on appeal to make a hospital order even though there had been no evidence before the court below on which such an order could have been made. In that case, the sentencing judge had been concerned about the mental health of the appellant, and a report from the prison medical officer had recommended psychiatric treatment of the appellant; but there had been no evidence capable of satisfying the statutory conditions for a hospital order. On appeal, expert evidence satisfying those conditions was before the court.

47. In *Beatty*, the sentencing judge was unable to make such a hospital order because there was no evidence that the appellant's condition was treatable, and so imposed a life sentence. Fresh evidence admitted on appeal showed that the appellant was treatable and had been treatable at the time of sentence. The appeal was allowed, the life sentence quashed, and a hospital order substituted. Scott Baker LJ said at [51] that section 11(3) of the 1968 Act was

> "sufficiently wide to permit the court to re-sentence the appellant on information placed before it which was not put before the sentencing judge."

He went on to say that the Court of Appeal may therefore

> "substitute a sentence on the basis of psychiatric and other evidence coming to light after the sentence was passed."

48. The terms in which those observations were expressed show 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.

49. The appellant invites us to take such a course in this case. We have considered whether to do so would be a departure from the principle that it is not the function of this court, on an appeal against sentence, to conduct a sentencing hearing: as Lord Burnett CJ said in *R v Chin-Charles* [2019] EWCA Crim 1140, [2019] 1 WLR 5921 at [8]:

> "The task of the Court of Appeal is not to review the reasons of the sentencing judge as the Administrative Court would a public law decision. Its task is to determine whether the sentence imposed was manifestly excessive or wrong in principle."

We are satisfied that it would not. 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.

50. We therefore turn to consider the matters mentioned in *Vowles* at [51-54]. We accept the appellant's submission that they are factors which are relevant to be considered, rather than inflexible criteria or pre-conditions of the court's imposing a particular form of sentence. In a case of this nature, the decision as to the most suitable method of disposal will necessarily be fact-specific.

51. First, the appellant clearly continues to need treatment for his ASD. His disorder will endure throughout his life.

52. Secondly, we accept that the appellant's offending was in significant part, though certainly not wholly, attributable to his ASD. We accept the appellant's submission that the fresh evidence shows that the level of culpability was not as high as the judge thought it was. We are however satisfied that the appellant did retain a significant level of responsibility for his actions, and there are serious features of his crime for which he was culpable. His ASD no doubt provided the explanation for his thinking that murder was a logical solution to his own problems, but it did not in our view reduce the seriousness of the careful planning and preparation which he put into the

offence, or of his conduct in abandoning the knife which did not serve his purpose and resorting instead to attempting to kill by manual strangulation.

53. Thirdly, we have given careful thought to the extent to which punishment is required. It follows, from what we have said in relation to the second factor, that a premeditated crime as serious as this called for punishment, even in the case of a young offender of previous good character who was suffering from a mental disorder. There is however an issue of principle as to the extent to which it is appropriate to take into account the passage of time during which the appellant has been serving his life sentence, albeit that he has been in hospital for most of that time.

54. As we have said at [41] above, the appellant relies on three cases in relation to this issue. In *Erskine*, at [96], the court said:

> "… we are in effect reflecting on the appropriate sentence for manslaughter on grounds of diminished responsibility over 20 years after conviction, and 20 years or so after the appellant was removed from prison into a maximum security hospital where he has remained ever since. We cannot ignore these realities."

In *Ahmed (Saber Mohammed,)* at [28], the court considered the question of the extent to which the offending was attributable to the appellant's illness and concluded by saying:

> "We should add (dealing with the third question in *Vowles*) that he has already served the minimum term imposed upon him, the punitive element of his sentence."

In *Fuller* the appellant at the time of sentencing was a "deeply troubled young man", but the judge's sentencing options had been limited by the evidence which was available, and he imposed – "with evident reluctance" - a sentence of detention for public protection. This court admitted fresh evidence as to the appellant's mental health at the time of sentence and was in no doubt that the judge, had he known of the appellant's mental disorder at the time of sentence, would have made a hospital order. At [44] the court said that counsel had mentioned the issues of welfare and rehabilitation in the course of her submissions in relation to the issue of punishment, but did not need to develop them

> "…since the appellant is now 5 years post-tariff and the issue of punishment is therefore an academic one."

55. We think it clear from the decisions in those cases that in circumstances such as these, the court in deciding whether the offender should now be sentenced differently is entitled to take into account the extent to which punishment has already been imposed. Whether the issue of punishment has become "an academic one" will depend on the facts and circumstances of the case: were it otherwise, the outcome of the appeal might be determined by what may be an accident of timing as to when in the course of an offender's sentence his appeal is heard.

56. We bear in mind that the judge specified a minimum term of 7 years, and that this court in 2014 upheld that decision. Almost the whole of that 7-year term has now passed, and the appellant has therefore effectively served that part of his sentence which was considered appropriate by way of punishment. We conclude that, in deciding whether the life sentence should be quashed and the appellant sentenced differently, the need for punishment now carries little weight in the particular circumstances of this case.

57. The fourth factor - the protection of the public – is very important. The key considerations, in our view, are these.

58. First, treatment for the appellant's disorder is available. His disorder is not however "treatable" in the sense that there is a cure which will bring it to an end. Rather, the appellant can by specialist treatment and supervision be assisted to manage his disorder and to control his aggressive behaviour. It is clear from the fresh evidence which we have accepted that the pervasive and persistent nature of the disorder means that there will be a risk in the future of aggressive behaviour, in particular towards women. That risk will be increased should the appellant for any reason feel under stress or pressure. This is not, therefore, a case in which it could be said that once treated, the appellant will not in any way be dangerous.

59. Secondly, as we have indicated, the imposition of a life sentence was not and is not a bar to the appellant's receiving appropriate medical treatment in hospital. Whichever form of sentence may be imposed, we anticipate that there will be no question of the appellant's being released until his treatment has reached a stage at which those responsible for the decision can be satisfied that the risk which he poses to others can safely be managed in the community. The focus must therefore be on which of the two possible regimes provides the greater protection for the public when the appellant is released from prison or discharged from hospital.

60. Thirdly, we accept that a transfer from hospital to adult prison might in itself have an adverse effect on the appellant's treatment which would at best delay his release and would at worst increase the risk to others when he is released. We note however that such a transfer is not inevitable, even if the appellant remains subject to his life sentence.

61. Fourthly, we think it clear that, whichever regime is in place, the appellant will in practice remain in hospital for a considerable period. The evidence of Dr Stankard satisfies us that a properly cautious approach has been taken thus far, and will continue to be taken, towards the stage at which the appellant may eventually be regarded as suitable for discharge from hospital.

62. Fifthly, once that stage is reached, we accept that in practice the s37/s41 regime would result in better monitoring of the appellant and would increase the prospect of an early identification of any signs of a potential increase in risk. On the other hand, we take into account that those involved in the monitoring and supervision of the appellant under a s37/s41 regime would assess him purely from a mental health perspective and would not be concerned with issues which would be of concern to those supervising the appellant if he were released on life licence.

63. We find these competing considerations to be quite finely balanced. However, the principal risk against which it is necessary to guard is, in our view, the risk of further violent behaviour linked, to a greater or lesser degree, to the appellant's ASD: not a risk of some other form of criminal or harmful behaviour, unconnected to that disorder. We bear in mind also that the appellant's future treatment is not expected to be based on medication, and therefore does not depend on his ability and willingness to comply with a medication regime when living in the community. It follows, in our view, that the interests of the public will best be served by the appellant's continuing to receive expert treatment and monitoring which will reduce the risk arising from the appellant's ASD. Treatment and monitoring can be provided under either form of disposal, but we are persuaded by the evidence of Dr Latham and Dr Stankard that in the circumstances of this case, a s37/s41 order offers the greater prospect of managing the appellant's return to the community, and life in the community, in the way which will be most likely to reduce the relevant risk.

64. For those reasons we allow this appeal. We quash the sentence of detention for life and substitute for it an order pursuant to section 37 of the Mental Health Act 1983 requiring the appellant to be detained in the hospital in which he is presently detained, and an order pursuant to section 41 of that Act restricting the circumstances in which he may be discharged.