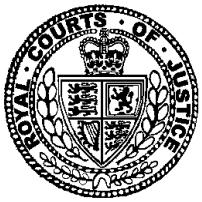

Neutral Citation Number: [2021] EWCA Crim 404

Case No: 202100101 A4

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
IN THE MATTER OF A REFERENCE BY THE ATTORNEY GENERAL
UNDER SECTION 36 OF THE CRIMINAL JUSTICE ACT 1988

ON APPEAL FROM THE CROWN COURT AT INNER LONDON
HER HONOUR JUDGE KARU

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/03/2021

Before :

LORD JUSTICE BEAN
MRS JUSTICE LAMBERT
and
MR JUSTICE CALVER

- -

Between :

THE QUEEN
and
GURJEET LALL

- -
- -

Duncan Atkinson QC for the **Attorney General**
Siobhan Grey QC for the **Respondent**

Hearing date: 12 March 2021

- -

Approved Judgment

Lord Justice Bean :

1. On 24 August 2019 Allan Isichei was stabbed to death in the street by Gurjeet Lall. Mr Lall was charged with murder and stood trial at the Crown Court at Inner London before Her Honour Judge Karu, Honorary Recorder of Southwark, and a jury. Mr Lall was acquitted of murder but convicted of manslaughter by reason of diminished responsibility. On 14 December 2020 the judge imposed a hospital order and a restriction, without limit of time, under sections 37 and 41 of the Mental Health Act 1983.

2. The Attorney General seeks leave to refer that sentence to this court as being unduly lenient. Mr Duncan Atkinson QC on behalf of the Attorney submits that the correct order should have been imprisonment for life with a limitation restriction under s 45A of the 1983 Act.

The facts

3. At the time of his death, Mr Isichei was aged 69. He had been married for 49 years, and had 3 children and 5 grandchildren. For 35 years, he and his wife had lived in St. Mary's Avenue South, Southall. Mr Lall ("the Offender") lived nearby, with his father.

4. At about 18:30 on Sunday 24 August 2019, Mr Isichei was walking home from the local public house. He was carrying his I-Pad tablet. The Offender was standing on the pavement in St. Mary's Avenue South. As Mr Isichei walked towards him, the Offender spat on the pavement. Mr. Isichei asked him why he had done so, and an argument began between the two men. Mr. Isichei started to walk away, but he turned back when the Offender again spat on the ground. Mr. Isichei placed his I-pad on a nearby car roof, and confronted the Offender.

5. The Offender pulled out a large kitchen knife from his right trouser pocket and stabbed Mr. Isichei in the stomach. Mr. Isichei put both his hands to the site of the wound and backed away. The Offender lunged towards him and stabbed him again.

6. A struggle for the knife ensued, during which both fell to the ground. Mr. Isichei fell on top of the Offender, bleeding profusely from his wounds. The two men remained struggling on the ground for several minutes, before both got to their feet. The Offender returned to his home address, and Mr Isichei started to stagger and crawl home. Realising that he was not going to make it, he sought help from a nearby address. Emergency aid was provided, but it was not possible to save Mr Isichei's life, and he was pronounced dead shortly before 8 pm.

7. The pathologist noted there were two principal wounds to the middle left and left side of the abdomen. The first was 18cm deep; the second, 11cm deep. Mr Isichei had cuts to his hands which were 'defensive' in nature. The cause of death was bleeding from the incised wounds to the abdomen.

8. The knife was recovered from the road; it had been dropped after Mr Isichei had disarmed the Offender. It had an 11cm long serrated blade.

9. Police who responded to the stabbing identified a blood trail which led from the scene to the Offender's address, less than 60 metres away. Entry was forced and inside police found the Offender sitting on the sofa clutching at facial injuries he had suffered when he and Mr Isichei had fallen to the ground. He claimed he could not move. He was asked what happened and said, "He attacked me". When asked if he could stand up, the Offender said, "He was pinning me down, he is a big guy and he was on my leg". At 19:50, the Offender was arrested for attempted murder. He made no reply to the caution. Six minutes later, when Allan Isichei was pronounced dead, the Offender was further arrested for murder. He was cautioned again and replied, "So he's dead then?" The Offender was treated by a paramedic and then conveyed to Ealing Hospital for further treatment for injuries he had sustained after the stabbing.

10. The Offender's medical notes from Ealing Hospital record multiple stab injuries including to the scalp, face and left eye and 3 'defensive' wounds. He reported blurred vision in left eye and pain in right hip. CT scans were conducted to his pelvis, hand and hip. Fractures were recorded of left orbital floor and left laminae papyracea, and to the right blade of his pelvis. In light of his eye injuries, the Offender was transferred to Moorfields Eye Hospital, where he was diagnosed with a suspected penetrating injury and multiple lacerations around his left eye.

11. The Offender's phone was recovered. On it were found numerous texts of a racially offensive nature, and messages referring to sexual and physical violence which he had sent mainly to himself. The psychiatrists considered that these texts tended to show that since April 2019 the Offender had become psychiatrically unwell.

12. Analysis of a blood sample taken from him detected alcohol concentration at 46 milligrams per 100 millilitres of blood. Back calculation estimated the most likely level of blood alcohol concentration at the time of the attack would have been just over 1½ times the legal limit for driving. There was no trace of the anti-psychotic medication which had been prescribed, suggesting he had not been taking it. Indeed, numerous boxes of clopixol and procyclide hydrochloride tablets were recovered from his address. These medications were both prescribed to the Offender, and revealed a significant period of non-compliance with medication prescribed for his mental health.

13. On 30 August 2019, the Offender was interviewed. He made no comment in answer to questions, but, in a prepared statement read out on his behalf, he blamed Mr. Isichei. He said he had spat on the ground, which was a habit, that Mr. Isichei was upset by it and became very aggressive. In the ensuing argument, Mr. Isichei had threatened him and would not leave. He spat again and Mr. Isichei came towards him. He said that Mr Isichei was the aggressor and he had acted only in self-defence.

Medical reports

14. The judge had a number of psychiatric reports available to her for the purpose of sentencing. Dr Martin Lock, a consultant forensic psychiatrist instructed on behalf of the prosecution, prepared a substantive report dated 25 June 2020 to which he provided an addendum dated 29 June 2020 and a further addendum dated 28 October 2020. Dr Frank Farnham, a consultant forensic psychiatrist instructed by the defence, provided three reports: 13 February 2020, 20 July 2020 and 30 November 2020. The judge also had available to her a report from Dr Helen Youngman focussing upon the

defendant's fitness to plead and a report from Dr Marc Jeanneret, the offender's treating psychiatrist, who also gave oral evidence at the sentencing hearing.

15. So far as relevant to the issues which we must consider, the psychiatrists were in broad agreement; to the extent that there were differences between them, those differences were relatively subtle.

16. All agreed that the offender suffered from paranoid schizophrenia. The illness had been formally diagnosed in 2008. In their joint expert note (prepared for the purposes of the murder trial) Dr Farnham and Dr Lock recorded that the Offender's condition was characterised by paranoid and persecutory delusions, poor compliance with medication, irritability and aggression. The psychosis was of an enduring nature. Dr Lock observed that, since his arrest, and in the absence of medication, the Offender had continued to experience psychotic symptoms. He had remained guarded to the extent that Dr Lock had been unable to ascertain the extent of the Offender's current symptoms, noting only that he "offers implausible explanations for what is known about his thinking and his behaviour." This behaviour included smiling, muttering to himself and rolling around the floor.

17. A further common thread in the expert evidence was that Mr Lall had no insight into his psychiatric illness and so no insight into the need for treatment with an antipsychotic medication. Dr Lock noted that the effect of the absence of insight was poor compliance with the prescribed medication regime due to the Offender's belief that he did not suffer from psychiatric ill health and did not therefore require treatment. Dr Farnham remarked that one of the hallmarks of the major mental illness from which Mr Lall suffered was lack of insight (together with paranoia and reduced contact with reality) and lack of capacity to engage on a voluntary basis with treatment. He reported that the Offender had told him in terms that he saw no reason to remain in a psychiatric hospital nor require any form of psychiatric or psychological treatment. The Offender had been equally insistent that he had not been "in any way" psychiatrically unwell in the lead up to or at the time of the offence. Dr Farnham's view was that the lack of insight which the Offender demonstrated, and the linked refusal to accept the need to take medication, were very common features in those suffering from paranoid schizophrenia.

18. All three experts agreed that the offender's illness was either the main driver or a very significant driver of the offence. Dr Farnham expressed the opinion that Mr Lall's degree of culpability and retained responsibility was "relatively low" and "towards the lower end of the spectrum of diminished responsibility", for the reason that absence of insight and paranoia were characteristics of the mental illness. He also noted that the onset of the Offender's antisocial behaviour and violence had coincided with the development of a major mental illness. His view was that the index offence had been "very significantly influenced" by mental illness in that Mr Lall was, at the time of the offence, suffering from hyper-vigilance coupled with an exaggerated sense of threat. Dr Farnham and Dr Jeanneret were in no doubt that the text messages sent by the Offender shortly before the killing indicated that he had at the time been in a psychotic state characterised by paranoia, anger and violent and disordered thought processes.

19. Both Dr Farnham and Dr Lock concluded that the Offender's non-compliance with medication was likely to have led to his mental state at the time of the killing. Dr

Lock considered that Mr Lall would have been "highly unlikely" to have committed the index offence if he had remained compliant with taking the prescribed medication and that the illness had a "major part to play in his behaviour at the time of the index offence". Dr Lock added the rider that other factors such as antisocial personality traits, illicit substance and alcohol misuse, anger and emotion control, general dissatisfaction with life and racist views should be considered. Our reading of his reports, however, do not lead us to the view that those other factors referred to by Dr Lock were intended to undermine his opinion that mental illness (and the linked poor compliance with the prescribed medication regime) was the main reason for the killing, or at least a very significant driver of it.

20. The experts were of one view as to the appropriate mental health disposal: that Mr Lall should be made subject to a hospital order with restriction pursuant to ss 37 and 41 of the Mental Health Act 1983 in preference to a hybrid order under s 45A. They reached this view essentially because of the release regime. Under a s 37/41 order the Offender's eventual discharge from hospital (if it ever occurred) would follow an application to the First Tier Tribunal; if the Offender was continuing to refuse treatment it would be very unlikely that the Tribunal would grant the discharge. Dr Jeanneret noted that whilst the release regime under a s 45A order does not preclude the involvement of mental health services, the s 37/41 regime would guarantee that mental health services were the primary agency and that a Social Supervisor and Clinical Supervisor (likely to be a consultant psychiatrist) would be allocated. Those professionals would provide reports to the Ministry of Justice every three months and undertake regular reviews of the patient. Supervision by mental health services would have the advantage over supervision by probation services, under the s 45A regime, that subtle signs of relapse in the offender's psychosis could be picked up and acted upon quickly.

21. Dr Lock agreed with this analysis, adding only that, given the Offender's long history of poor insight into his psychiatric illness and the need for continuing treatment, while he might improve in hospital, he would then stop the medication if remitted to prison, necessitating his readmission to hospital; and this "yo-yo" pattern might be repeated over a lengthy period. Conditions set at the time of any conditional discharge from hospital should be sufficient to ensure compliance with treatment recommendations and complete abstinence.

22. Dr Jeanneret, in a report dated 1 December 2020, having noted that the index offence marked a significant escalation in Mr Lall's violence, wrote:

"Mr Lall was psychotic at the time, and was hyper vigilant with an exaggerated sense of threat due to his paranoia. What is more, the violent undertones of the text messages that he sent earlier that day suggests an undercurrent of disordered, psychotic, angry, and violent thoughts. These, coupled with his exaggerated sense of threat, would have served to drive the violent reaction that he had to the victim when he confronted Mr Lall about spitting in the street."

23. Dr Jeanneret, in his oral evidence at the sentencing hearing, emphasised that under the regime of a s 37/41 order, in the event of Mr Lall ever being discharged from hospital and relapsing owing to a failure to take his medication, it would be possible for him to be detained very rapidly indeed, usually within two hours.

The Mental Health Act 1983 sections 37, 41 and 45A

24. Section 37 of the Mental Health Act 1983 provides:

> "(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;… 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…
>
> (4) An order for the admission of an offender to a hospital (in this Act referred to as *"a hospital order"*) shall not be made under this section 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 for his admission to that hospital , and for his admission to it within the period of 28 days beginning with the date of the making of such an order; and the court may, pending his admission within that period, given such directions as it thinks fit for his conveyance to and detention in a place of safety…"

25. Section 41 provides:

> "(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."

26. Section 45A provides:

"(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 taken into account by the court under subsection (2) above has given evidence orally before the court.

> (5) A hospital direction and a limitation direction 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…"

The authorities

27. In *R v Vowles* [2015] EWCA Crim 45, this court (Lord Thomas of Cwmgiedd CJ presiding) provided guidance on the approach to be adopted at [51] to [54]:

> "51. It is important to emphasise that the judge must carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions. A judge must therefore consider, where the conditions in 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 to include (1) the extent to which the offender needs treatment for the mental disorder from which the offender suffers, (2) the extent to which the offending is attributable to the mental disorder, (3) the extent to which punishment is required, and (4) the protection of the public including the regime for deciding release and the regime after release. There must always be sound reasons for departing from the usual course of imposing a penal sentence and the judge must set these out.
>
> 52. … a judge when sentencing must now pay very careful attention to the different effect in each case of the conditions applicable to and after release. … This consideration may be one matter leading to the imposition of a hospital order under section 37/41.
>
> 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, [and] (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). ... (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)."

28. In *R v Edwards* [2018] EWCA Crim 595, this court considered the release provisions relating to those subject to an order under ss 37/41, like the Offender here, and those made subject to a s 45A order. Hallett LJ said at [12]:

> "A level of misunderstanding of the guidance offered in *Vowles* appears to have arisen as to the order in which a sentencing judge should approach the making of a s.37 or a s.45A order and the precedence allegedly given in *Vowles* to a s.45A order. In our view, section 45A could have been better drafted but the position is clear. Section 45A and the judgment in *Vowles* do not provide a 'default' setting of imprisonment, as some have assumed. The sentencing judge should first consider if a hospital order may be appropriate under section 37 (2) (a). If so, before making such an order, the court must consider all the powers at its disposal including a s.45A order. Consideration of a s.45A order must come before the making [of] a hospital order. This is because a disposal under section 45A includes a penal element, and the court must have 'sound reasons' for departing from the usual course of imposing a sentence with a penal element. Sound reasons may include the nature of the offence and the limited nature of any penal element (if imposed) and the fact that the offending was very substantially (albeit not wholly) attributable to the offender's illness. However, the graver the offence and the greater the risk to the public on release of the offender, the greater the emphasis the

> judge must place upon the protection of the public and the release regime."

29. At [14] she said:

> "It follows that, as important as the offender's personal circumstances may be, rehabilitation of offenders is but one of the purposes of sentencing. The punishment of offenders and the protection of the public are also at the heart of the sentencing process. In assessing the seriousness of the offence, s. 143 (1) of the Criminal Justice Act provides that the court must consider the offender's culpability in committing the offence and any harm caused, intended or foreseeable."

30. At [34] she said:

> "Finally, to assist those representing and sentencing offenders with mental health problems that may justify a hospital order, a finding of dangerousness and/or a s.45A order, we summarise the following principles we have extracted from the statutory framework and the case law. "
>
> i. The first step is to consider whether a hospital order may be appropriate.
>
> ii. If so, the judge should then consider all his sentencing options including a s.45A order.
>
> iii. In deciding on the most suitable disposal the judge should remind him or herself of the importance of the penal element in a sentence.
>
> iv. To decide whether a penal element to the sentence is necessary the judge should assess (as best he or she can) the offender's culpability and the harm caused by the offence. The fact that an offender would not have committed the offence but for their mental illness does not necessarily relieve them of all responsibility for their actions.
>
> v. A failure to take prescribed medication is not necessarily a culpable omission; it may be attributable in whole or in part to the offender's mental illness.
>
> vi. If the judge decides to impose a hospital order under s.37/41, he or she must explain why a penal element is not appropriate.
>
> vii. The regimes on release of an offender on licence from a s.45A order and for an offender subject to s.37/41 orders are different but the latter do not necessarily offer a greater protection to the public, as may have been assumed in *Ahmed*

> and/or or by the parties in the cases before us. Each case turns on its own facts."

Manslaughter definitive guideline: diminished responsibility

31. We were referred to the Definitive Guideline on manslaughter published by the Sentencing Council in 2018. The relevant section is the final one, dealing with manslaughter by reason of diminished responsibility. The Guideline sets out a series of steps which sentencers should follow.

32. Step one requires the judge to assess the degree of responsibility retained. It states:

> - "A conviction for manslaughter by reason of diminished responsibility necessarily means that the offender's ability to understand the nature of the conduct, form a rational judgment and/or exercise self-control was substantially impaired."
>
> - The court should determine what level of responsibility the offender retained:
>
> - High;
>
> - Medium; or
>
> - Lower
>
> - The court should consider the extent to which the offender's responsibility was diminished by the mental disorder at the time of the offence with reference to the medical evidence and all the relevant information available to the court.
>
> - The degree to which the offender's actions or omissions contributed to the seriousness of the mental disorder **at the time of the offence** may be a relevant consideration. For example:
>
> - where an offender exacerbates the mental disorder by voluntarily abusing drugs or alcohol or by voluntarily failing to seek or follow medical advice this may increase responsibility. In considering the extent to which the offender's behaviour was voluntary, the extent to which a mental disorder has an impact on the offender's ability to exercise self-control or to engage with medical services will be relevant.
>
> - The degree to which the mental disorder was undiagnosed and/or untreated may be a relevant consideration. For example:

> - where an offender has sought help but not received appropriate treatment this may reduce responsibility.
>
> Harm
>
> For all cases of manslaughter the harm caused will inevitably be of the utmost seriousness. The loss of life is taken into account in the sentencing levels at step two."

33. At step 2 the guideline sets out starting points and category ranges for the three levels of retained responsibility referred to at step 1. It is sufficient to refer to the lower level where the starting point is 7 years custody and the category range is from 3-12 years. The guideline continues by identifying aggravating and mitigating factors, while warning that "care should be taken to avoid double counting factors already taken into account in assessing the level of responsibility retained". The fact that the offence involved the use of a weapon is one such factor. Another is "a significant degree of planning or premeditation". Previous convictions are a statutory aggravating factor having regard to the nature of the previous conviction and its relevance to the current offence, and the time that has elapsed since the conviction.

34. Step 3 requires the court to consider dangerousness. There was no dispute in the present case that Mr Lall was and remains dangerous within the statutory definition.

35. Step 4 is headed "consideration of mental health disposals". It reads

> "Step 4 – Consideration of mental health disposals (Mental Health Act 1983)"
>
> **Where:**
>
> (i) the evidence of medical practitioners suggests that the offender is currently suffering from a mental disorder,
>
> (ii) treatment is available, and
>
> (iii) the court considers that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case, the court should consider **all sentencing options** including a section 45A direction and consider the importance of a penal element in the sentence taking into account the level of responsibility assessed at step one.
>
> **Section 45A hospital and limitation direction**
>
> a. Before a hospital order is made under section 37 (with or without a restriction order under section 41), consider whether the mental disorder can appropriately be dealt with by custody with a hospital and limitation direction under section 45A. In deciding whether a section 45A direction is appropriate the court should bear in mind that the limitation direction will

> cease to have effect at the automatic release date of a determinate sentence.
>
> b. If a penal element is appropriate and the mental disorder can appropriately be dealt with by a direction under section 45A, then the judge should make such a direction. (Not available for a person under the age of 21 at the time of conviction).
>
> **Section 37 hospital order and section 41 restriction order**
>
> c. If a section 45A direction is not appropriate the court must then consider (assuming the conditions in section 37(2)(a) are satisfied) whether the matters referred to in section 37(2)(b) would make a hospital order (with or without a restriction order under section 41) the most suitable disposal. The court should explain why a penal element is not appropriate."

36. Step 5 requires the sentence in all cases to consider factors that may warrant an adjustment to the sentence:-

> "Step 5 – IN ALL CASES consider factors that may warrant an adjustment to the sentence"
>
> Cases of manslaughter by reason of diminished responsibility vary considerably on the facts of the offence and on the circumstances of the offender.
>
> The court should review whether the sentence as a whole meets the objectives of punishment, rehabilitation and protection of the public in a fair and proportionate way.
>
> Relevant factors will include the psychiatric evidence and the regime on release.
>
> An adjustment may require a departure from the sentence range identified at step two above."

Sentencing Guideline – offenders with mental disorders

37. The guideline on sentencing offenders with mental disorders was issued by the Sentencing Council in 2020. Ms Siobhan Grey QC for the Respondent drew attention to paragraphs 13-15, which state [emphasis added]:-

> "The sentencer, who will be in possession of all relevant information, is in the best position to make the assessment of culpability. Where relevant expert evidence is put forward, it must always be considered and will often be very valuable. However, it is the duty of the sentencer to make their own decision, and *the court is not bound to follow expert opinion if there are compelling reasons to set it aside.*
>
> The sentencer must state clearly their assessment of whether the offender's culpability was reduced and, if it was, the reasons for and extent of that reduction. *The*

sentencer must also state, where appropriate, their reasons for not following an expert opinion.

Courts may find the following questions a useful starting point. They are not exhaustive, and they are not a check list as the range of offenders, impairments and disorders is wide.

- At the time of the offence did the offender's impairment or disorder impair their ability:
    - to exercise appropriate judgement,
    - to make rational choices,
    - to understand the nature and consequences of their actions?
- At the time of the offence, did the offender's impairment or disorder cause them to behave in a disinhibited way?
- Are there other factors related to the offender's impairment or disorder which reduce culpability?
- **Medication**. *Where an offender was failing to take medication prescribed to them at the time of the offence, the court will need to consider the extent to which that failure was wilful or arose as a result of the offender's lack of insight into their impairment or disorder…..*
- **Insight**. *Courts need to be cautious before concluding that just because an offender has some insight into their impairment or disorder and/or insight into the importance of taking their medication, that insight automatically increases the culpability for the offence. Any insight, and its effect on culpability, is a matter of degree for the court to assess."*

Sentencing remarks

38. In passing sentence the judge said:

> "The reports contain full details of a mental history going back to 2008 when, at the age of 24, the defendant first came to the attention of the psychiatric services with incidents of violence and aggression, auditory hallucinations, cannabis and alcohol misuse, attempts at the provision of medication which, on occasion, he did take but more regularly did not, and the carrying weapons when his paranoia was at the fore. He has been admitted to a psychiatric hospital several times under section 2 or section 3 of the Mental Health Act, and has been on a community treatment order from 2010 to 2013. He remained under the community team until October 2018, after which he was discharged to his GP. It appears he last took medication in or about February 2018…
>
> According to the Sentencing Guidelines for Manslaughter by Diminished Responsibility, the court must follow a four-step approach. First, the court should determine what level of responsibility the offender retained; high, medium, or low.

[The judge quoted from the reports of Dr Farnham, Dr Lock and Dr Jeanneret, and continued:]

The harm in a case of manslaughter is inevitably of the upmost seriousness. In my judgment, having regard to medical evidence and all the relevant information available to the court, the level of responsibility is in the lower category.

At step two, the court must assess the sentence within the category range taking into account the aggravating and mitigating factors. The starting point for the lower category is seven years' imprisonment, with a range of three years to twelve years. Had the defendant been convicted of murder, the starting point would have been 25 years' imprisonment as a knife had been taken to the scene and been used.

Taking into account all the evidence in the trial; the defendant's previous convictions, including two for possession of an offensive weapon, the last one in January 2019 for which he was sentenced to four months' imprisonment; the offence involving the use of a weapon; it was committed under the influence of alcohol; and the deceit practised by obtaining prescriptions of the antipsychotic medication so as not arouse the GP's suspicions and then deliberately not taking it, the level of responsibility retained by the defendant, in my judgment, is at the upper end of the lower category and, subject to additional considerations which follow, would attract a term of 12 years' imprisonment.

At step three, the court is required to consider dangerousness and whether a life sentence or an extended sentence would be appropriate. Manslaughter is a serious specified offence for the purposes of sections 224 and 225(2) of the Criminal Justice Act 2003, and it is an offence listed in part one of schedule 15B for the purposes of consideration of dangerousness under section 226A.

Dr Lock, at paragraph 17 of his report dated 20 October 2020, states, and I quote, "In my opinion, although Mr Lall's psychotic illness had a major part to play in his behaviour at the time of the index offence, other factors need to be considered including antisocial personality traits, his illicit substance and alcohol misuse, his anger and ability to control his emotions, his dissatisfaction with his life, and his racist views."

Dr Farnham, in his report dated 30 November, disagrees with Dr Lock in respect of the antisocial personality traits. In his opinion, he says, the defendant had no insight into his mental illness and it is likely that symptoms of untreated or partially treated psychosis have been implicated in most of his antisocial and violent behaviour. He said, and I quote, "Psychosis

represents the major risk factor for any future violent offending, rather than antisocial personality traits, or illicit drug use, or tendency towards racism."

Despite the disagreement over whether there are antisocial traits, both experts agree that the illness, if untreated, is severe enough to make him dangerous within the meaning of the Criminal Justice Act 2003, because the consequential increased paranoia and irritability will adversely affect his ability to act rationally and exercise self-control. Dr Lock says that, until he has undertaken therapy and made substantial progress, he will remain highly dangerous. Dr Jeanneret states the index offence demonstrates that, when psychotic, he is capable of very serious violence and that his offending has occurred in the context of non-compliance with medication.

I am satisfied, on all the evidence and the material I have been provided with, that there is a significant risk of serious harm to other persons occasioned by the commission of further offences by the defendant, and that he is dangerous as defined in the legislation.

What is not certain is how long he will be a risk to others. Plainly, a reduction in the obvious risk to the public posed by him is dependent upon his response to treatment for his mental condition. So far, he has expressed the view that he does not wish to take medication and that he would rather be returned to prison than remain in hospital if it means he would be forced to take medication. The defendant has not attended court for this sentence today. At present, antipsychotic treatment has not commenced. It is not known what the response to treatment will be -- although past history does suggest that he does take medication and, when he does, he remains stable -- or when or how complete his recovery will be.

Having regard to the psychiatric evidence, there remains a risk of a further psychotic episode particularly if the defendant fails to take his antipsychotic medication and/or uses illicit drugs again. It was, and still is, simply not possible to say if and when the risk of him causing serious harm to members of the public will be reduced to an appropriate level. In those circumstances, a sentence of life imprisonment or an extended sentence would be considered appropriate. The consultants, however, have unanimously recommended a section 37/41 order under the Mental Health Act 1983, as amended.

That brings me on to step four of the Sentencing Guidelines because the court is required to consider mental health disposals. I bear in mind the guidance given in the cases of *R v Vowles*, *Fisher*, and *Edwards*. I have also considered the Sentencing Offenders with Mental Disorders, Development

Disorders, or Neurological Impairments Guideline which came into force on 1 October 2020.

Where the evidence of medical practitioners suggests that the offender is currently suffering from a mental disorder, treatment is available, and the court considers that a hospital order, with or without a restriction order, may be an appropriate way of dealing with the case, the court should consider all sentencing options, including a section 45A direction, and consider the importance of a penal element in the sentence taking into account the level of responsibility assessed at step one.

In considering sentence, the court is concerned, on the one hand, with appropriate punishment and, on the other, with the protection of the public. They run hand in hand, especially in a case in which a defendant suffers from a mental disorder which significantly influenced the commission of the offence. It is of note that Dr Lock states that, in his opinion, it is highly unlikely that Mr Lall would have committed the index offence if he had remained compliant with taking the prescribed medication to treat his psychiatric illness. Drs Lock, Farnham, and Jeanneret also agree that non-compliance was attributable to the illness itself. They are unanimous in their respective opinions that, given his schizophrenia which was a significant factor in the offending, the most appropriate sentence is a hospital order with a restriction order under section 37, 41 of the Mental Health Act 1983, as amended.

Dr Farnham states his mental illness has not been treated particularly assertively in the past and, if it is, that is likely to reduce the severity of his psychotic symptoms and reduce the future risk of dangerousness. Dr Jeanneret, in evidence, agreed with this today. They agree, therefore, having regard to the nature of the offence, the defendant's antecedents, and the risk of him committing further offences if set at large, that it is necessary for the protection of the public from serious harm to impose the restriction order. They have considered a section 45A hybrid order, but principally, because of the regime on release -- i.e. the First Tier Tribunal rather than the Parole Board -- it is best placed to consider a conditional discharge. In their opinion, public protection is best achieved by a section 37/ 41 order.

Dr Jeanneret this morning, when asked questions by Mr Orchard, QC on behalf of the prosecution, did agree that it is possible for the Parole Board to impose a condition that the defendant is compelled to take his depot injection but, in essence, it is the whole supervision regime post release under section 37/41, as opposed to section 45A, that he believes is the

distinguishing factor. Quoting from Dr Jeanneret's report at paragraph 10.4.1:

"It is likely that, were Mr Lall to accept treatment for his paranoid schizophrenia and were it to be successful, his risk of violence would be very significantly reduced. There would be little difference in the day-to-day hospital management of Mr Lall under the section 37/41 or the section 45A regimes. The most palpable difference would be that he would be entitled to leave with MOJ approval under the former. This would only be applied for once the treating team had satisfied themselves that his risk to others had reduced significantly. This is likely to include him complying with medication and engaging with psychology work regarding his mental illness and the risk that he poses to others.

Under a section 45A regime, Mr Lall could be remitted back to prison once his mental state was deemed to have improved sufficiently. There is also the possibility that he would be remitted back were he found to be untreatable and his risk to himself or others on remittal was not deemed to be high. Just on this point, the yo-yoing that would be involved if the defendant was returned to prison and his mental state deteriorated and then returned to hospital cannot be said to be conducive to his mental health and treatment."

Dr Jeanneret says further:

"Under the section 37/41 regime, eventual discharge from hospital would be likely to be via the First Tier Tribunal. The defendant would have the right to apply to such tribunals and to ask them to consider his discharge, likely a conditional discharge, into the community. Were he to continue to refuse treatment, there is a very high possibility that the tribunal would not discharge him. In terms of the release regimes, managing Mr Lall's risk in the community would, in very large part, be based on managing his mental illness."

Dr Jeanneret confirmed that the regimes are different and that the section 37/41 regime would be the most sensible. The Mental Health Services would be the primary agency and would guarantee the allocation of a social supervisor and a clinical supervisor, likely a consultant psychiatrist. These professionals would have to provide reports to the Ministry of Justice every three months, with regular reviews of the patient. Supervision by the Mental Health Services would have the advantage, over supervision by the Probation Service under the section 45A release regime, in that subtle signs of relapse in Mr Lall's psychosis could be picked up by his social supervisor or his clinical supervisor.

The sentencing exercise in this case is not an easy one. I have given it very careful consideration. The most serious offence in the criminal calendar is to have taken someone's life by committing a criminal offence. Punishment is obviously merited. However, as in the present case, where the offender suffers from a mental disorder which contributed significantly to the offence, the court must look ahead to see if it possible that the risk of reoccurrence can be substantially reduced if not completely eradicated. If that can be achieved in the way suggested by those who are experts in the field, namely the consultant psychiatrists, then that is the appropriate sentence to pass commensurate with my public duty.

Having heard the medical evidence which has been given in court today by Dr Jeanneret and having regard to the reports prepared by Dr Lock and Dr Farnham, all of whom are approved by the Secretary of State under section 12(2) of the Mental Health Act 1983, I am satisfied that the defendant is suffering from a mental disorder, namely paranoid schizophrenia, that this order is of a nature which makes it appropriate for him to be detained in a hospital for medical treatment, and appropriate medical treatment is available for him at the John Howard Centre.

I am of the opinion that, because of all the circumstances of this case, including the nature of the offence of manslaughter by diminished responsibility, of which he has been convicted, his character and his past antecedents, which include a long-standing and complicated history of mental illness, and having consider all the other available ways in which I might deal with him, the most suitable method of dealing with his case is by making an order under section 37 of the Mental Health Act 1983.

I, therefore, make an order that he will be admitted to and detained at the John Howard Centre. I am satisfied that arrangements have been made for him to be detained within 28 days to this hospital where he has already been for many months.

I have also considered whether this order should be subject to special restrictions which are specified in section 41 of the Act. Having heard the evidence of Dr Jeanneret, I am satisfied that, because of the nature of the offence and, also, having regard to his past, including his history of mental illness, and to the risk that he will commit further offences if he is not detained, it is necessary to protect the public from serious harm and it is not possible to say for how long that will be.

> Accordingly, I order that he will be subject to the special restrictions set out in section 41 of the Mental Health Act 1983 without limit of time…"

39. There was then a short exchange between prosecution counsel and the judge which foreshadowed this application by the Attorney General:

> MR ORCHARD: I just want to make sure that your Ladyship is content that you have dealt with the paragraph in *Edwards*, that you have explained why a penal element is not appropriate.
>
> JUDGE KARU: Yes, I am satisfied.
>
> MR ORCHARD: Thank you.
>
> JUDGE KARU: I have been through the medical reports in full and it is plain that, although he had limited responsibility, the significant driver for his offence was his mental illness.

Submissions

40. Mr Atkinson QC, for the Attorney-General, submits that the judge should have started by considering a penal disposal, and explained in her sentencing remarks why that was inappropriate before moving on to a s 37/41 order. Since the offender was (correctly) found by the judge to be dangerous, he was liable to life imprisonment on conviction for manslaughter pursuant to what is now s 285 of the Sentencing Act 2020. Mr Atkinson submits that a life sentence was justified by reference in particular to these aggravating factors: (i) the gravity of the offence, and the use of a knife that had been carried as a weapon in its commission by an offender previously convicted for carrying a weapon on 30 January 2019; (ii) the fact that the Offender was under the influence of alcohol; and (iii) the Offender's deliberate action and the deceit practised by the Offender on medical professionals in securing the self-administration of his medication, allowing him deliberately to stop taking it, despite accepting he was aware of the possible effects of not doing so, and to conceal that fact by collecting the medications.

41. The judge concluded that that she was dealing with a dangerous Offender whose culpability was "at the upper end of the lower category" of culpability under the Sentencing Guideline for diminished responsibility. The Reference argues that "the aggravating factors rendered this a case within that middle category", although Mr Atkinson did not go that far in oral argument.

42. The judge was required to consider the comparative merits and difficulties posed by the release regimes under sections 37/41 and 45A. It is submitted by the Attorney General that this was a case where the s 37/41 regime did not offer significantly greater protection. Accordingly, such a disposal failed properly to punish the Offender for his very serious offence, without affording any significantly greater protection to the public.

43. Ms Grey QC, for the Offender, reminded us that the judge had the benefit of reports and oral evidence from three psychiatrists (two before the jury and one at the

sentencing hearing), all of whom considered that the main driver of the offending was Mr Lall's mental illness. They all took the view that the s 37/41 regime was the most appropriate for the protection of the public; there were no compelling reasons for the judge to have rejected this view; and the judge's sentence was therefore the right one and not unduly lenient.

Discussion and conclusion

44. The submissions of Mr Atkinson placed great emphasis on the judge's assessment of the level of culpability at Step 2 of the Diminished Responsibility Guideline, but skated rather rapidly over the Guideline for sentencing mentally disordered offenders. We consider that the defendant's complete lack of insight into his condition is a very important feature of this case. As Dr Lock opined, it is highly unlikely that he would have committed the offence if he had been taking his medication. He was not taking his medication, and was deceiving the doctors by continuing to receive a supply of it, *because* he believed that there was nothing wrong with him, and that therefore there was no reason for doctors to be prescribing him medication. It is not suggested that this belief was a pretence. In the case of a patient with insight into his condition such deceit would indeed be an aggravating factor, but not in the present case.

45. Similarly, the use of a knife taken to the scene is in many cases of homicide a gravely aggravating factor. In a case of murder, it increases the starting point for the minimum term from 15 to 25 years. In a case of manslaughter by reason of diminished responsibility, it may amount to an aggravating factor under Step 2 of the guideline in a case where it is evidence of planning and premeditation. But it is somewhat unrealistic, in our view, to treat it as evidence of planning or premeditation if the reason why the defendant was carrying a knife was that he was paranoid and had an exaggerated sense of threat or (as the Judge put it, "carrying weapons when his paranoia was at the fore"): in other words, that he believed (wrongly) that he was liable to be attacked by anyone at any moment.

46. The judge made a finding that the offender's level of retained responsibility was "in the lower category": then, a paragraph later, said that it was "at the upper end of the lower category and, subject to considerations which follow, would attract a term of 12 years imprisonment" at step 2 of the guideline. In a case where a non-Mental Health Act disposal, particularly a determinate sentence, is the likely outcome, such nuances of classification would be of considerable importance. But in the present case there can be no dispute that Mr Lall is highly dangerous and that an indeterminate sentence is essential. The only two sentences realistically in contention are imprisonment for life with a section 45A detention order and a section 37/41 order for an indefinite period. In these circumstances it seems to us that the notional determinate sentence under Step 2 of the diminished responsibility guideline is a somewhat academic issue.

47. As Hallett LJ said in *Edwards*, each case turns on its own facts, including the question of which regime offers greater protection to the public. The judge referred in her sentencing remarks to the need to consider all available options including a s 45A order and to consider the importance of a penal element in the sentence taking into account the level of responsibility assessed at Step 1. She did not spell out in so many words why she considered that a sentence with a penal element was inappropriate. However, that explanation can be discerned without difficulty from the findings she made, in particular: (a) it is highly unlikely that Mr Lall would have committed the

offence if he had remained in compliance with medication; (b) this non-compliance was attributable to the illness itself; (c) mental illness was therefore the significant driver for the offence; (d) the level of retained responsibility was "low" though "at the upper end of the lower category"; (e) the unanimous view of the three psychiatrists who had given evidence was that public protection could best be achieved in this case by a section 37/41 order, in particular because, in the event of Mr Lall ever being released, mental health specialists were more likely than probation officers to pick up subtle signs of relapse, and under the s 37/41 regime recall can take place as quickly as within two hours.

48. As the mentally disordered offenders Guideline states at paragraph 15, the duty of the sentencer is to make their own decision, and the court is not bound to follow expert opinion if there are compelling reasons to set it aside. Mr Atkinson has not identified any such compelling reasons why the judge should have set aside the consensus among the three psychiatrists. The judge was right to accept their recommendation that a section 37/41 order was the appropriate one to ensure so far as possible that, following the tragic death of Mr Isichei, the public can best be protected in future from harm caused by this Offender. We accordingly refuse the application for leave to refer the sentence.