Neutral Citation Number: [2020] EWCA Crim 1615

Case No: 201203467 A1

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT EXETER
His Honour Judge Cottle
T20110338 and T201220122

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 2/12/2020

Before :

LORD JUSTICE DINGEMANS
and
HER HONOUR JUDGE WALDEN-SMITH

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Between :

Keith Nelson	**Appellant**
- and -	
Regina	**Respondent**

- -
- -

Philip Rule (instructed by **The Registrar of Criminal Appeals**) for the **Appellant**
Denis Barry (instructed by **The Crown Prosecution Service**) for the **Respondent**

Hearing date: 24 November 2020

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Approved Judgment

Lord Justice Dingemans:

Introduction

1. This appeal against sentence demonstrates some of the practical differences between, and advantages and disadvantages of, a "hybrid order" under section 45A of the Mental Health Act 1983 ("MHA") combining imprisonment with a hospital direction and limitation direction on the one hand, and a "hospital and restriction order" under section 37 MHA with section 41 MHA on the other hand. Guidance on the approach to section 45A hybrid orders and sections 37 and 41 hospital and restriction orders was given in *R v Vowles* [2015] EWCA Crim 45; [2015] 1 WLR 5131. This caused some misunderstanding which was then addressed in *R v Edwards and others* [2018] EWCA Crim 595; [2018] 4 WLR 64. Courts must, pursuant to section 125(1) of the Coroners and Justice Act 2009 and now section 59 of the Sentencing Act 2020, also follow the Sentencing Council's Guideline on "Sentencing offenders with mental disorders, developmental disorders or neurological impairment" ("the Guideline") which came into effect on 1 October 2020, unless it would be contrary to the interests of justice to do so.

The appellant

2. The appellant is now a 51 year old man. He was born in Liverpool and was one of five children whose mother struggled to cope with the children. The appellant witnessed abuse at home. He was taken into care when aged 3 years. He was returned to his mother when aged 7 years but was taken into care again. He had various foster placements. He suffered sexual assaults in the care homes when aged 9 years. After running away from a placement he was picked up from the streets and raped when aged 12 years (the appellant has waived his right to anonymity in respect of these sexual offences for the purposes of this judgment). The medical evidence suggests that he began to develop delusional thoughts from about this time demonstrating again the lasting damage done by sexual offending.

3. The appellant met his father for the first time when 14 years old but has had no real contact with him. The appellant's mother died in a housefire when the appellant was aged 15 years. The appellant began to take drugs including LSD and cannabis. The medical evidence shows that this adversely affected his mental state, proving again the damage done by drugs. The appellant attempted to commit suicide when he was aged 16 years. He spent many years living rough and in cars.

4. By 2011 the appellant had 12 previous convictions for 30 offences committed between 1982 and 2008. Relevant past convictions included a conviction for affray and a conviction for wounding with intent contrary to section 18 of the Offences against the Person Act 1861. This was a very serious offence which occurred when the appellant attacked a police officer using a claw hammer to hit the police officer on the head.

5. It is common ground that the appellant developed a delusional disorder that parasites were living in his body, eating him from the inside and laying eggs in his eyes. He suffered some auditory hallucinations. It is also common ground that the appellant had an anti-social personality disorder.

The circumstances of the offences

6. The racially aggravated offences of assault occasioning actual bodily harm and damage to property occurred on 21 September 2011. The victims were walking from their café to their car when the appellant came and racially abused them. The appellant smashed a scaffolding pole into their car and hit one of the victims through the window. The victims tried to drive off but crashed. The victims called the police and the appellant ran away.

7. On 3 October 2011 police saw the appellant and tried to detain him in relation to the incident on 21 September 2011. A taser was used but the appellant ran away. A young member of the public tripped up the appellant who then got up and punched the member of the public. This was the offence of assault by beating. The appellant was chased and caught by police.

8. When detained in prison on remand the appellant made unpleasant threats to prison officers. He reminded them that he had a conviction for attacking a police officer in 1997 with a claw hammer. During a consultation with a doctor the appellant racially abused the doctor. A prison officer present advised the doctor that she did not have to stay and listen to the appellant. The appellant later turned on the prison officer and threatened to kill the prison officer, stating that he knew where the prison officer met friends in a café. This was the offence of threats to kill.

9. On 1 December 2011, following an assessment for admission to Broadmoor high security hospital ("Broadmoor") by a psychiatrist, the appellant was admitted to Broadmoor. The appellant remained there until 7 September 2018 when he was transferred to Langdon medium secure hospital ("Langdon") where he remains at present.

Proceedings in the Crown Court

10. The appellant pleaded guilty in the Crown Court at Exeter to the offences on 17 February 2012, and he was sentenced on 10 May 2012. The judge had available a report on the appellant by Dr Sengupta, a consultant forensic psychiatrist who was then the appellant's responsible clinician at Broadmoor, dated 16 March 2012. The report concluded that the appellant suffered from a delusional disorder and an anti-social personality disorder. Dr Sengupta did not consider a section 37 MHA order with a section 41 restriction adequate to protect the public. He proposed a section 45A MHA order which he considered the most likely to achieve the best medical and psychological outcome. He confirmed that a bed was available at Broadmoor if such an order were to be imposed.

11. The judge also had a report from Dr Alcock, a consultant forensic psychiatrist, dated 4 May 2012. Dr Alcock concluded the appellant met the criteria for an anti-social personality disorder as his primary diagnosis. If a section 45A MHA order was imposed, he recommended that this be alongside a determinate term rather than a sentence of Imprisonment for Public Protection ("IPP").

12. The judge also had a report from Dr Brown, consultant forensic and addiction psychiatrist, dated 7 May 2012. Dr Brown concluded that the appellant suffered from a delusional disorder and a severe personality disorder. Dr Brown recommended the

Court consider imposing a hybrid order under section 45A of the MHA and considered the appellant to be a dangerous offender.

13. The judge heard evidence by video link from Dr Sengupta. Dr Sengupta described the appellant's delusional beliefs that he had insects living inside his bodily cavities, and diagnosed a delusional disorder and a personality disorder. Dr Sengupta supported a section 45A MHA order and IPP over a sections 37 and 41 MHA hospital and restrictions order so that the appellant's sentence would only come to an end once the parole board and the First-tier Tribunal (Mental Health) ("the Mental Health FTT") deemed him safe for release.

14. The judge also heard oral evidence from Dr Brown. Dr Brown stated that the appellant had two diagnoses, being a delusional disorder which was a mental illness, and a severe personality disorder. Dr Brown confirmed that the appellant was receiving treatment at Broadmoor. She agreed that an order under section 45A MHA was the appropriate disposal for the appellant.

Sentencing remarks

15. The judge found that the appellant was suffering from a mental disorder within the meaning of section 45A(2)(b) of the MHA. The judge did not undertake an assessment of the appellant's residual culpability for the offences in the light of the existence of the mental disorders. This was because the guidance in *R v Edwards* was not yet available. The judge found that the appellant satisfied the dangerousness provisions and that an IPP was appropriate. The judge also recorded that no issue had been taken by the parties concerning the imposition of a section 45A MHA order.

16. The appellant was sentenced to an IPP with a minimum term of 3 years with a hospital direction with a limitation direction under section 45A of the MHA 1983 for making threats to kill. He was sentenced to 2 years imprisonment concurrent with the IPP for racially aggravated assault occasioning actual bodily harm concurrent and 2 years imprisonment concurrent with the IPP for racially aggravated damage to property. No separate penalty was imposed for assault by beating.

The issues on the appeal

17. The appeal is brought with the leave of the full court granted on 16 January 2020. The full court granted leave for service of reports from the appellant's responsible clinician as well as leave for the respondent to obtain an updated report from a psychiatrist.

18. As a result of the orders made by the full court we had as fresh evidence numerous past medical reports setting out the progress made by the appellant over the course of his treatment in hospital. We heard from Dr Linton, a consultant psychiatrist at Langdon who was the responsible clinician for the appellant until earlier in the year, who gave evidence via video link to the court. We also heard from Dr Cumming, a consultant forensic psychiatrist, clinical lead for Criminal Justice Liaison and Diversion Services for the South London & Maudsley NHS Foundation Trust, instructed by the respondent, who also gave evidence via video link to the court. Dr Cumming had worked in Her Majesty's Prison Belmarsh for 19 years and had practical experience of how prisoners with mental health disorders were dealt with in prison.

19. The appellant has now been detained and treated in hospital for over 9 years. The original tariff under the IPP was 3 years. Much more is now known about him as appears from the reports prepared on him over the years than was known at the time of sentence.

20. Mr Rule, on behalf of the appellant, submits that all of this new medical evidence shows that the section 45A hybrid order in his case will create problems both for the appellant and the public which it seeks to protect, and that the making of the hybrid order under section 45A with an IPP was wrong in principle and manifestly excessive. It is submitted that the appropriate order was a section 37 and 41 MHA hospital and restriction order.

21. Mr Barry, on behalf of the respondent, provided assistance to the court by making submissions about the practical effects of the orders and by arranging for the instruction of Dr Cumming to assist the court on the issue of the effects of the current sentence and the potential advantages and disadvantages of hospital and restriction orders under sections 37 and 41 of the MHA and hybrid orders under section 45A of the MHA. In the event and in the light of the fresh evidence available to this court but not available to the judge, Mr Barry did not make any positive submissions in support of the hybrid order under section 45A which was imposed in 2012.

22. We are very grateful to Mr Rule and Mr Barry for their very helpful written and oral submissions.

The new expert evidence

23. We received written reports from Dr David Somekh, a consultant forensic psychiatrist. Dr Somekh concluded that the offending behaviour and risk of causing serious harm exhibited by the appellant prior to sentence was "entirely attributable" to his mental disorder. He considered that treatment at Broadmoor was capable of addressing the relevant risk issues for the appellant. Dr Somekh recorded that the Mental Health FTT would not discharge a restricted patient simply because he had not responded to treatment. Dr Somekh stated that the appellant could be safely managed both in hospital and subsequently by mental health services in the community. Dr Somekh explained the practical advantages of the skilled supervision which is a statutory requirement of a conditional discharge by the Mental Health FTT, and the more flexible mechanism for return to hospital for further treatment if behaviour in the community gave rise to concern. On the other hand, once there had been a transfer to prison there would be no ongoing medical supervision.

24. Dr Jonathan Garabette, a consultant psychiatrist in forensic psychiatry and medical psychotherapy, who was for a time the appellant's responsible clinician at Broadmoor, set out his evidence in letters dated 9 February 2016 and 21 April 2016. His opinion was that the appellant "should be treated within the hospital system and that doing so is in the best interests of both [the appellant] with respect to his health and wellbeing, and the public with respect to reduction of future risk to others". The appellant's risk to others as well as his mental health needs were likely to be best met in a hospital setting as he appeared to respond well to a caring therapeutic environment. Dr Garabette's view was the appellant was likely to represent an increased risk to others if he were sent to a prison without an adequately therapeutic environment. Dr Garabette considered that on release the Appellant's "mental health needs and the protection of

the public would both be best served by on-going care under the Mental Health Act". Release would not be appropriate until a significant period of treatment had taken place in medium and low security hospitals. Dr Garabette said that it would be safer for the appellant's mental health, and public safety, if he remained in long term care in the hospital system. A termination of treatment and return to prison would have the likely consequence of relapse within the prison estate and a potential cycle of transfers.

25. Dr Linton provided a written report dated 4 May 2020. Dr Linton provided an update as to the appellant's circumstances, progress and mental state. She confirmed his diagnosis of persistent delusional disorder and antisocial personality disorder and recorded that he had been continuously treated with antipsychotic medication and psychological therapies. He transferred to Langdon on 7 September 2018, after 7 years at Broadmoor. He has now had escorted community leave since August 2019 enabling him to undertake community voluntary work in gardening and conservation and for Animals in Distress. She noted his psychotic symptoms, and their influence on his behaviour.

26. Dr Linton referred to the decision of the Mental Health FTT held on 4 August 2015 at Broadmoor. The Mental Health FTT stated that:

> "Looking at the history it is clear that much of Mr Nelson's offending could have been prevented if he had been diverted much sooner to the mental health system from the criminal justice system, which has plainly failed to have any impact on reducing Mr Nelson's risk to others. Since starting his treatment, Mr Nelson has become a responsible patient who has not been a management problem. In our view, Mr Nelson is very appropriately placed in hospital and is getting the treatment he has long needed. He ought not to be transferred back to prison as he would not get the specialist treatment he needs to reduce his risks… All in all, Mr Nelson's risks to others can be more appropriately treated and managed if he remains in the hospital system."

27. Dr Linton considered that that the most effective management of the appellant would be achieved by a section 37 and 41 MHA hospital and restriction order.

28. In oral evidence Dr Linton stated that the appellant had first engaged when in Broadmoor, and that since 2012 he had not required any seclusion from the ward. Dr Linton confirmed that in her opinion the appellant's offending had been caused mainly by his mental disorders.

29. Dr Cumming produced a written report dated 18 June 2020. He agreed with the diagnosis of delusional disorder and antisocial personality disorder. Dr Cumming recorded that "9 years have passed and from being hostile, violent and aggressive, has emerged a much more peaceful and thoughtful man. This seems to have been achieved by treatment offered, in essence a combination of medication, psychological work and a therapeutic environment". Dr Cumming considered that, with the benefit of hindsight, the concerns at sentencing raised by Dr Sengupta had not been borne out, and that the appellant had been locked into a system from which it was difficult to get out. Dr Cumming concluded that the "the use of a hospital order (Section 37 of The

Mental Health Act 1983) with restrictions (Section 41 of The Mental Health Act 1983) is the right and proper power to manage him now".

30. In his evidence to the court Dr Cumming emphasised that the appellant was a very different person from the person who was offending in 2011 and that he was a "success story". If an individual were to be released under a section 37 and 41 MHA hospital and restriction order the offender would be given top priority of community mental health services and a framework for going forward.

Relevant principles relating to hybrid orders and hospital and restriction orders

31. Guidance has been given by the Court of Appeal about the proper relationship between: sentences of imprisonment; hospital orders under section 37 of the MHA; restriction orders under section 41 of the MHA; and hybrid orders under section 45A of the MHA. The guidance was given in *R v Vowles*. This was reported to have caused some misunderstanding which was addressed in *R v Edwards and other*. Further helpful guidance was provided in *R v Cleland* [2020] EWCA Crim 906 where a sentence of life detention for attempted murder was quashed and replaced by a hospital and restriction order under sections 37 and 41 of the MHA 1983.

32. In addition, as mentioned above, the Guideline came into effect on 1 October 2020. It applies when sentencing offenders who at the time of the offence or at the time of sentencing have any mental disorder, neurological impairment or developmental disorder. The Guideline reflects the guidance set out in *R v Edwards* and also usefully summarises in appendix C the criteria and release provisions for sections 37, 41 and 45A of the MHA, which it is relevant for the court to address when considering what order to impose.

33. When there is evidence of a mental disorder in a person convicted of an offence it is established that the first question for the court to consider is whether a hospital order is appropriate. Section 37 requires written or oral evidence from two doctors, one of whom must be approved under section 12 of the MHA. The court needs to be satisfied that the offender is suffering from a mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment and appropriate medical treatment is available. This last requirement is important because there are mental disorders which are considered to be not currently treatable. A hospital order has effect for most purposes as a compulsory civil commitment under Part II of the MHA, see Blackstone's Criminal Practice 2021 at E22.2. The purposes of a hospital order are rehabilitation of the offender and protection of the public, it is not concerned with punishment.

34. Further matters for the court to consider are the release regimes which will apply to the offender on release. A restriction order under section 41 of the MHA gives the Secretary of State for Justice a role in the release and recall of offenders who have been sentenced under hospital orders. A restriction order under section 41 of the MHA should not be passed just to mark the seriousness of the offence, but only where it is required to protect the public from serious harm. The expert evidence before us showed that there are monthly reports to the Secretary of State for Justice on those detained under a section 37 and 41 MHA hospital and restriction order, and that there are reviews by the Mental Health FTT. The Mental Health FTT can ensure that appropriate conditions are attached to any conditional release. These conditions require abstinence

from drugs and alcohol and these are conditions which can be monitored. Any release into the community of a person such as the appellant will take place with the Community Mental Health Team which will include a consultant psychiatrist, a senior social worker and, in most cases, a mental health nurse. Dr Linton gave evidence that Langdon has established a forensic mental health team, which will supervise the release of offenders and provide even more specialist supervision and direction than a community mental health team.

35. Section 45A of the MHA permits, in effect, the combination of sentences of imprisonment with hospital and restrictions orders where the sentence is not fixed by law. The evidence before us showed that section 45A MHA orders were particularly appropriate in two situations: the first was where, notwithstanding the existence of the mental disorder, a penal element to the sentence was appropriate; and the second was where the offender had a mental disorder but there were real doubts that he would comply with any treatment requirements in hospital, meaning that the hospital would be looking after an offender (who might be dangerous) who was not being treated. Mr Barry properly pointed out that the expert evidence that we had was tailored to the particular circumstances of this case and that section 45A MHA hybrid orders might well be suitable in other circumstances. There is consideration in Archbold 2021 at 5A-1196 of situations where a section 45A MHA hybrid order had been found to be appropriate.

36. The evidence from Dr Linton and Dr Cumming showed one practical disadvantage of returning to prison an offender who had been treated for a delusional disorder in hospital and who required to take anti-psychotic medicine. This was that many such offenders ceased to take the medication on return to prison. This was because there was no obvious advantage to the offender in taking the medication, and also because a side effect of taking the medication was that awareness of people and surroundings was suppressed, which some prisoners considered made them more vulnerable in a prison environment. Stopping taking the medication causes the offender to relapse and require further treatment. This was a point identified in *R v Rendell* [2019] EWCA Crim 621; [2020] MHLR 60. Dr Cumming's evidence also showed that illegal drugs were more likely to be available in prisons than in hospital, all of which could lead to a deterioration of the mental disorder of such an offender followed by a return to hospital.

37. Any court considering whether to impose a section 45A MHA hybrid order will need to make a careful assessment of the culpability of the offender, notwithstanding the presence of the mental disorder, in accordance with the guidance given in *Vowles* and *Edwards*. Practical guidance about how to do that is set out in the Guideline.

38. If there is a determinate sentence to be served under a section 45A MHA hybrid order the prisoner will serve that before being released on licence. Any release on licence will be supervised by the probation officer, but it is apparent that the supervision will not be as regular as supervision by a community mental health team. If there is an indeterminate sentence to be served, such as an IPP or a sentence of life imprisonment, release will occur only once agreed by the parole board. Once the release has taken place the supervision will be by a probation officer. It is important to record that once released the effect of section 50 of the MHA "Further provisions as to prisoners under sentence" is that, by subsection (2) "a restriction direction in the case of a person serving a sentence of imprisonment shall cease to have effect, if it has not previously done so, on his release date". This means that the supervision of the released offender will be

carried out by the probation officer. Dr Cummings stated that the parole board did not impose conditions such as a requirement to take anti-psychotic medicine, and that a probation officer would not be able to intervene in the event of a subtle deterioration of mental state. Such an intervention would only take place in the event of the commission of further offences, by which time serious damage might have been caused to members of the public. Similar risks were identified in *R v Rendell* at paragraph 53.

39. Dr Cumming gave evidence that those released under section 37 and 41 MHA hospital and restriction orders were likely to reoffend in 4 per cent of cases. By way of comparison Dr Cumming said that 28 per cent of those released under life licences would reoffend, although there was no exploration in the evidence of what was meant by life licences.

The proper order to make in the light of the further evidence

40. As noted above the further expert evidence has been admitted by order of the full court and it was common ground between the parties that all the expert evidence was properly admitted as fresh evidence under the Criminal Appeal Act 1968. It was also common ground that the question for us under section 11(3) of the Act was whether we "consider that the appellant should be sentenced differently for an offence for which he was dealt with by the court below …" on the basis that, in the light of the further evidence, it was apparent that the hospital and restriction order under sections 37 and 41 of the MHA was the only proper order to be made in this case.

41. In order to address this point we have considered the questions set out in *R v Vowles* at paragraph 51. The first question is the extent to which the offender requires treatment for the mental disorder from which he suffers. All the expert evidence before the judge and before us shows that the appellant required treatment and that it was necessary and appropriate to make a hospital order under section 37 of the MHA. The evidence shows that the appellant is likely to require treatment, at the least in taking anti-psychotic medication, throughout his life.

42. The second question is the extent to which the offending is attributable to the mental disorder. Section two of the Guideline provides helpful factors to be considered. In this case, all the expert evidence showed that the offending was mainly due to the mental disorder from which the appellant suffered, and that his residual culpability was limited.

43. The third question is the extent to which punishment is required. In this case although there was real harm to the victims of both offences, there is less need for punishment because the culpability was so much adversely affected by the appellant's mental disorder. It might be added, that the appellant has already been detained in hospital for 9 years.

44. The fourth question to be addressed is which regime for deciding release will provide the most protection for the public. In this respect there are two real concerns about the appellant's current sentence which have been expressed in the evidence which we have heard. The first concern is that once the appellant gets to a position to be considered for release from hospital he will be sent to prison. Such an environment is likely to lead to a relapse of his delusional disorder because he will not take his anti-psychotic medicine, meaning that he will be returned to hospital, before being getting better and

being returned again to prison. This means that he will "yo-yo" between hospital and prison for the foreseeable future. The second concern is that when finally released from prison the appellant will not be supervised by a team of mental health experts reporting to the hospital and Secretary of State for Justice but instead by a probation officer. A probation officer will not be trained to spot the subtle signs of mental health deterioration, and if they are identified the probation officer will not have the powers to intervene to arrest any such deterioration. This is a matter of particular importance because it is now apparent that the appellant will always suffer from some form of mental disorder, but with treatment and effective management and supervision he should progress to live as risk free as is reasonably achievable in society.

45. In our judgment it is clear that on a consideration of all the relevant questions, and on the evidence now available to the court which was not available to the judge, the proper order which needs to be made in the appellant's case to protect the public, and to assist in the recovery of the appellant, is a section 37 and 41 MHA hospital and restriction order.

Conclusion

46. For the detailed reasons set out above we allow the appeal against sentence. We quash the hybrid order under section 45A of the MHA being the IPP, hospital and limitation direction imposed in respect of the threats to kill and the concurrent sentences of 2 years imprisonment for the racially aggravated assault and criminal damage, and we impose a section 37 MHA hospital order with a section 41 MHA restriction order on all three counts. The order that there be no separate penalty for the assault by beating remains.