Neutral Citation Number: [2013] EWCA Crim 2332

Case No: 201203786 A3

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT BIRMINGHAM
HHJ WE DAVIS QC
T20087218

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Friday 13th December 2013

Before :

LORD JUSTICE AIKENS
MR JUSTICE SIMON
and
HIS HONOUR JUDGE MORRIS QC

- -

Between :

Regina	**Respondent**
- and -	
Jamie Daniel Fort	**Appellant**

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

Sally Hancox (instructed by **CPS**) for the **Respondent**
Rachel Brand QC (instructed by **GQS Solicitors**) for the **Appellant**

Judgment
As Approved by the Court

Lord Justice Aikens :

I. Synopsis

1. At about 3.20 am on 28 July 2008, the appellant Jamie Fort, who was then aged 18, called the emergency services from the house where he lived with his father, mother and sister in Castle Bromwich. The appellant said that he had killed his mother. That was so. He said over the telephone to the operator: "I can't honestly say why I've done it, please just get here and deal with it before I go mad". The appellant was subsequently arrested and charged with murder. Investigations were made into the state of the appellant's mental health and several reports were produced. The trial started on 10 August 2010 at Warwick Crown Court before HHJ Griffiths-Jones. In circumstances which we will elaborate below, the appellant was re-arraigned on 11 August and pleaded guilty to manslaughter by reason of diminished responsibility. Sentence was adjourned for further medical investigations and reports.

2. Over 18 months later and after a further 13 mental health reports had been produced by various specialists, the Recorder of Birmingham, HHJ Davis QC, passed sentence in the Crown Court at Birmingham on 22 February 2012, having heard oral evidence from Dr Rafiq Memon, consultant forensic psychiatrist. The judge sentenced the appellant to life "imprisonment", pursuant to section 225(2) of the Criminal Justice Act 2003 as amended. In fact, given that the appellant was under 21 at the time of conviction, the correct form of that sentence should have been custody for life. Pursuant to section 82A of the Powers of Criminal Courts (Sentencing) Act 2000 the judge set the minimum term to be served by the appellant at 4 years, less 1302 days spent on remand. The judge also certified the case as being suitable for appeal in respect of the sentence he had passed.

3. On 2 March 2012 the matter came back before the judge again. He then purported to make an order under section 45A(1) of the Mental Health Act 1983 (as amended) ("MHA") with the intention that the appellant be removed to and detained at the Reaside Clinic, rather than in a YOI or prison. We are satisfied, for reasons that we will explain, that both counsel were correct to accept before us that the order that HHJ Davis made under section 45A of the MHA 2983 was unlawful and must be rescinded.

4. On the same occasion the judge withdrew his certificate of leave to appeal. However, the single judge subsequently granted leave to appeal against sentence.

5. The issue on appeal to this court is whether the judge's sentence of custody for life was wrong in principle. It raises once again the complex relationship between custodial sentences and orders under the MHA in relation to an offender who suffers from a mental disorder. Ms Rachel Brand QC argued that HHJ Davis erred in principle and submitted that he should have made an order under section 37 of the MHA, coupled with a "restriction order" pursuant to section 41 of that Act.

6. At a directions hearing of the full court on 31 January 2013, it ordered that "medical reports addressing issues in the case" be obtained; one on behalf of the appellant and one on behalf of the Crown. At the hearing before us on 8 November 2013 we had the report dated 8 June 2013 of Dr Dinesh Maganty, consultant forensic psychiatrist at the Reaside Clinic, where the appellant is presently detained. Dr Maganty is

currently the appellant's responsible clinician and his report was produced on behalf of the appellant. We also had before us the report of Dr Philip Hopley, consultant forensic psychiatrist, which was produced on behalf of the Crown. We heard oral evidence from Dr Maganty, who is approved by the Secretary of State, pursuant to section 12 of the MHA, as having specialist experience in the diagnosis and treatment of mental disorders. Miss Sally Hancox, who appeared for the Crown, said that there was no objection from the Crown to the court receiving the evidence of Doctors Maganty and Hopley. Indeed, she did not advance any arguments contrary to those of Ms Brand.

7. At the conclusion of oral argument we reserved judgment.

II. The appellant's history and events up to and including the offence

8. The appellant's parents were married in 1986 and the appellant was born in 1990. His father worked with the Post Office and his mother, Mrs Patricia Fort, worked as a kitchen manager at King Edward VI Grammar School, Birmingham. The appellant's home life as a child was secure. The appellant told doctors subsequently that his relationship with his father had deteriorated in the 3 years before the offence, but his relationship with his mother was generally good. He attended primary, secondary and sixth form schools. He took 11 GCSEs at grades A to C and three A levels at Grades C, D and E. He was noted as being very quiet in his teenage years and he did not get on very well with people in his secondary school. He was bullied. There were no suspensions or expulsions from his school or any other disciplinary problems. He was interested in listening to music and playing on the computer. He did not socialise. He used to go to church with his family until the age of 15. The appellant told Dr Maganty that he stopped going to church then because he had thoughts of harming others which thoughts he could not prevent. The appellant said that going to church and praying did not stop them so he ceased going as he "did not see the point".

9. Prior to the present offence he had had no contact with the mental health services and he did not suffer from any other medical problems. He had no drug or alcohol problems. There was no history of self-harm. He had never been arrested and he had no criminal convictions, cautions or warnings. However, the appellant subsequently told doctors that for some years before the offence he had had intrusive thoughts which were of a violent and sometimes sexual nature, although he had always previously been able to suppress them.

10. The events leading up to the offence are as follows: the appellant finished his A level exams around 11 June 2008. He stayed at home for most of the time afterwards. The appellant said that had been less and less able to sleep properly and sometimes not at all.

11. On the day before the offence the appellant had been watching his computer, having slept well the previous night. In the evening of 27/28 July 2008 the appellant read a book and, having finished it, he went downstairs to see if anyone was watching the television. His mother was lying on the sofa. They had a short conversation, then, in the appellant's words "…that just happened". In the descriptions of the offence given by the appellant to doctors subsequently, he stated that he could not remember exactly what happened next but he saw himself and he saw what was going on but

could not stop himself and he had no feeling of what he was doing until he rang the emergency services.

12. In fact the appellant had taken a large kitchen knife and had stabbed his mother 35 times. The appellant's father and sister were asleep upstairs during the attack.

13. After the appellant's 999 call an ambulance and the police arrived quickly at the scene. Mrs Fort was taken to the Heartlands Hospital where she was declared dead at 4.13 am. Mrs Fort was aged 57 at her death. The pathologist who conducted the post-mortem on the afternoon of 28 July found that there were 18 wounds in Mrs Fort's head and 17 in her chest, back and abdomen. The wounds were severe and included an incised wound to the victim's liver and a penetration of the duodenum. The deceased died principally as a result of a catastrophic loss of blood on account of her multiple wounds.

14. The appellant was arrested on suspicion of murder. On 29 July 2008 he was interviewed by the police under caution with his solicitor present. He answered no comment to all questions. Questions to the appellant's family revealed that he was an intelligent young man but also reclusive and socially isolated. This led to investigation into the appellant's mental health.

III. Mental health and other reports during custody prior to the trial

15. The appellant was held in custody at HMYOI Glen Parva from 29 July 2008 until June 2009, when he was removed to the Reaside Clinic in Birmingham where he remained under psychiatric care until October 2009 when he was returned to Glen Parva. He remained in custody there until the trial in August 2010 and he was returned to Glen Parva after he had pleaded guilty to manslaughter by reason of diminished responsibility. The appellant remained in custody in Glen Parva until he was made the subject of an interim hospital order by Macur J pursuant to section 38 of the MHA in July 2011, when he returned to the Reaside Clinic until sentence was passed in February and March 2012.

16. During the period of over two years between the offence and the trial the appellant was seen by a number of specialists. The first was Dr NMJ Kennedy, consultant psychiatrist, who produced a report dated 5 February 2009. He concluded that at the time of the killing the appellant was suffering from a mental state which amounted to the condition known as "grossly dissociated state". Dr Philip Hopley, also a consultant psychiatrist, prepared a report for the CPS Coventry dated 19 February 2009. He concluded that the appellant was suffering from some form of mental disorder but its exact nature needed further assessment. He identified the possibilities as including "slowly evolving psychotic illness, a depressive disorder, which evolved into a psychotic process, abnormal personality development and a disorder on the autistic spectrum".

17. When the appellant was admitted to the Reaside Clinic, Birmingham, in June 2009 he scored 117 on an IQ test and an MRI scan on his brain was normal. At the Reaside Clinic the appellant was seen by Dr Rafiq Memon, who became responsible for the appellant's care there. Dr Memon prepared a report dated 12 November 2009 in which he concluded that the appellant suffered from epilepsy at the time of the offence. But in December 2009 Dr Hugh Rickards discounted this diagnosis. There

were further reports on the appellant by Dr P Vesey, a neuropsychologist, in July 2010, Dr Kanu Achinivu, a consultant in development neuropsychiatry, in October 2010 and Dr Kennedy in October 2010.

IV. The mental health issues at the time of the trial and the reports obtained between the trial and the sentencing hearing.

18. The appellant had always been prepared to plead guilty to manslaughter on the ground of diminished responsibility, but the prosecution had been unwilling to accept such a plea. The trial for murder started on 10 August 2010 and there were present the psychiatrist instructed by the prosecution, Dr Hopley, and the two psychiatrists instructed by the defence, Drs Kennedy and Rickards. They all had a meeting together on 11 August 2010 and as a result of it they drew up an Agreed Document which they all signed.

19. This document stated:

> 1. "Jamie Fort was suffering from an abnormality of mind, namely a Dissociative State, at the time of the killing. There is clear evidence of an underlying abnormal personality, probably a disorder on the Autistic Spectrum.
>
> 2. Jamie Fort's abnormal intrusive violent thoughts are not fantasy material. They are egodystonic, which means to say they cause him distress and are extremely unpleasant. Recurrent egodystonic intrusive violent thoughts would be a sufficient psychological trauma to trigger a Dissociative State.
>
> 3. Jamie Fort's abnormality of mind [Dissociative State] substantially impaired his mental responsibility for the killing.
>
> 4. An Autistic Spectrum Disorder underlying his Dissociative State has not been ruled out. Further assessment/investigation of this issue should be carried out prior to sentencing. We recommend either Doctor Stauffenburg [Norwich] or Doctor Kanu [Birmingham]. Both are Consultant Forensic Psychiatrists who specialise in Neuro-Developmental disorders including Autistic Spectrum Disorders."

20. These conclusions led the prosecution to accept the plea of manslaughter by reason of diminished responsibility, so the appellant was re-arraigned and that plea taken.

21. By the time that the appellant was sentenced by HHJ Davis on 22 February 2012 a further 13 reports and letters had been obtained from various consultant psychiatrists. The following is only a very short summary of their main conclusions and the progress in the appellant's case. In October 2010 Dr. Achinavu, a consultant neuropsychiatrist, ruled out a developmental disorder such as Asperger syndrome, or

an Autistic spectrum disorder, but expressed the view that the appellant has a schizoid personality disorder. He commented that treatment of such personality disorders was extremely difficult and drug treatment did not make a significant and lasting improvement; however, long term psychotherapy might be helpful if the appellant was willing to engage with it.

22. In October 2010, Drs. Kennedy and Hopley agreed with the diagnosis of 'schizoid personality disorder'. Dr. Kennedy suggested assessment by a forensic psychotherapist, and Dr Hopley raised the possibility of assessment for treatment at HMP Grendon Underwood, or within the independent psychiatric sector.

23. A report in January 2011(incorrectly dated 2010) requested by the defence from Dr. Judith Freedman of the Portman Clinic (consultant psychiatrist in psychotherapy) supported the dual diagnosis of 'schizoid personality disorder' and 'dissociative disorder'. It also highlighted the dangers of intense psychotherapeutic treatment and expressed the view that the appellant posed such a high risk that he should be placed in one of the high security hospitals i.e. Broadmoor, Ashworth, or Rampton. We note that Dr. Freedman is not approved under section 12 of the Mental Health Act 1983.

24. In February 2011 a letter from Dr. Memon expressed disagreement with Dr. Freedman's conclusion that a hospital order was required. He reiterated that his diagnosis was 'dissociative disorder'.

25. Between December 2010 and April 2011, the appellant, whilst at HMYOI Glen Parva, was under the care of the visiting consultant psychiatrist to that establishment, Dr. Halim. On 18 April 2011 Dr. Halim provided a letter, stating that he had been treating the appellant with anti-psychotic medication. He suggested that the appellant's intrusive thoughts of violence might be obsessive/compulsive in nature, and raised the possible diagnosis of epilepsy (ruled out during earlier investigations) and the possibility of an evolving schizophrenic illness. Dr Halim expressed the view that the appellant would not receive appropriate medical assessment and treatment in a prison setting, and recommended further assessment to decide whether a section 37 hospital order would be appropriate.

26. In an order of Macur J made in April 2011, Dr Halim was asked to provide a full report and Dr Memon was asked to provide an up-to-date addendum. Dr. Halim's full report of May 2011 gave his primary diagnosis as 'obsessive compulsive disorder' in relation to the intrusive thoughts of violence. However he also agreed with the diagnosis of 'schizoid personality disorder'. He referred again to the possibility of epilepsy and recommended admission to hospital. Dr. Memon's report in May 2011 also recommended admission to the Reaside Clinic under a section 38 interim hospital order, for further assessment. Dr. Hopley agreed in his report 3 June. After the appellant was re-admitted to the Reaside Clinic on 5 July 2011 under the care of Dr. Memon, he produced a further report in August 2011. He said that he was considering three conditions: obsessive compulsive disorder, dissociative convulsions, and epilepsy. He had referred the appellant for a further neuropsychiatric opinion from Dr. Bagary. We have not seen any such opinion. At Dr. Memon's request, further interim hospital orders were made from August 2011 until the appellant was sentenced.

27. Three final psychiatric reports were before HHJ Davis when he sentenced the appellant on 22 February 2012. They were from Dr Memon (December 2011), Dr Kennedy (January 2012) and Dr Hopley (February 2012). The appellant had also been seen by Dr Vivier, a consultant forensic psychotherapist, whose views were related to those in Dr Memon's report.

28. The final psychiatric reports agreed that:

> "**(1)** The appellant was suffering from a 'schizoid personality disorder.'
>
> **(2)** He had had a long-standing history of intrusive thoughts of violence, which he recognised as abnormal and found it distressing to discuss.
>
> **(3)** He continued to experience episodes of 'dissociation.'
>
> **(4)** The 'schizoid personality disorder' and 'dissociative disorder' constituted mental disorders within the meaning of the Mental Health Act 1983.
>
> **(5)** He had killed his mother during an episode of 'dissociation', and continued to present a risk of serious violence to others in the context of further periods of 'dissociation'."

29. In addition, Dr Memon and Dr Kennedy stated that it might be many years before any progress could be achieved by psychological and psychotherapeutic treatment.

30. In his oral evidence at the sentencing hearing Dr Memon confirmed, first, that the appellant suffered from a schizoid personality disorder that could persist for many years and could not be treated with medication but might be alleviated by maturity or psychotherapy. Secondly, he confirmed that the appellant suffered from longstanding intrusive thoughts of violence, which were "abnormal" thoughts were morbid (ie indicative of disease) but the diagnosis for them was unknown. The appellant found it very distressing to talk about them. Lastly, the appellant had experienced "dissociative episodes" but the factor that precipitated these episodes had not been identified. It was during such an episode that the appellant killed his mother, losing his normal self-control, with the result that he acted on longstanding violent thoughts, making them manifest as opposed to them being just in his mind. There had been two documented further episodes since then. The range of possible violence associated with the episodes of "disassociation" was very wide, from none to homicide.

31. Mr Christopher Hotten QC, who appeared for the prosecution at the trial, cross-examined Dr Memon, who confirmed that there was no medication to treat the dissociative episodes (page 9H of transcript); nor could psychotherapy treat them (page 10B). However, the longstanding violent thoughts, which were evidence of a mental disorder as yet unclear, could both be better treated and better managed in hospital, as opposed to in a YOI or prison (page 11B). Dr Memon stated that "with current medical knowledge and medical skills" he could not predict when the

appellant might have a dissociative thought or, if he did, what the level of the consequent violence might be (page 12G). Dr Memon accepted that, in principle, if the psychotherapy treatment of the appellant's schizoid personality disorder was successful such that all other things being equal, he did not need to be in hospital anymore, then there would be no reason to keep him in hospital.

32. There was then the following exchange between Mr Hotten and Dr Memon at page 13E to 14B of the transcript:

> "Q: Obviously it's a theoretical possibility, because of all these various combinations, but it's not only theoretical: it is a possibility, admittedly some considerable time in the future, is it not?
>
> A: Yes. I'm just looking at my opinion again. On page 7, paragraph 17 I say: "It is presently difficult to know if or when he may ever be safely discharged from hospital back to the community", and that's my position. Were he to improve mentally from the psychotherapist's point of view, in terms of the schizoid personality disorder point of view, not have any further episodes of dissociation, if his morbid thoughts resolved then the situation would be very different. To be discharged from a section 37/41, that could only happen either through a mental health tribunal or via the Ministry of Justice, the Secretary of State, so I would not be able to discharge him myself.
>
> Q: No, I follow that, but the tribunal would obviously…the first port of call, assuming he was still there, would be you, the responsible clinician.
>
> A: Yes, and it's difficult for me to visualise that far ahead to know what I might say, because this is such an unusual case I don't have any case to compare it with."

V. The judge's sentencing remarks.

33. The judge summed up the medical evidence as follows: (1) the reason why the appellant had killed his mother was "because he was suffering from a significant mental disorder" and the "responsibility he had for his actions was very limited". (2) The opinion of Dr Memon in his reports and oral evidence was that there were the three aspects to the appellant's mental disorder. We have already set those out above. (3) There had subsequently been at least one violent episode with "dissasociative thoughts" in prison, but that had not led to any criminal proceedings. (4) All the psychiatrists, Dr Memon, Dr Kennedy and Dr Hopley agreed that the appellant would be best managed in a hospital environment rather than a prison environment. (5) The psychiatrists concluded that the appellant was "very dangerous" and that he presented " a very severe risk of significant violence to other people when affected by one of these dissociative episodes" so that he needed to be detained, but the view was that this detention "was better managed in hospital rather than in prison". Therefore

they proposed that the appellant be made the subject of an order under section 37 of the MHA 1983.

34. The judge recognised the force of that view, but stated that he had to consider the legislative framework under which the appellant would be detained in hospital. The judge said that he was satisfied that the two preconditions for making an order under section 37 of the MHA 1983 were fulfilled in this case. He also accepted that if a section 37 order were made there would also have to be a restriction order pursuant to section 41 of that Act in this case.

35. However, the judge then expressed his concern, which he said was based on Dr Memon's evidence to him. This was that there could come a point, perhaps far in the future, where the mental disorder from which the appellant was suffering was no longer such that it would be appropriate for him to be detained for medical treatment under the MHA sections 37 and 41. The judge continued:

> "…if there comes a point at which Mr Fort is no longer suffering from a mental disorder which makes it appropriate for him to be detained for medical treatment, which is available, then the Secretary of State, on the advice of the Tribunal, will be obliged to discharge him. The likelihood is, looking at the regulations that it would have to be a conditional discharge but discharge it would be.
>
> I have to try and balance the short, medium even quite long-term benefits that would result from a hospital order, with the possible risks to the public in the much longer term because if I pass sentence involving the imposition of the hospital order, even with restriction, there may well come a time on the facts if this case when –the applicant [Jamie Fort] will be discharged even though he, as a matter of fact, still presents a danger to the public. That is my analysis. …On that analysis I regret that, albeit that to some extent I agree with Miss Brand in her suggestion that it is 'utterly wrong' to send this man to prison, that my duty to protect the public is only achieved by imposing a sentence that means his release is on the direction of the Parole Board which has in mind, and only in mind, the protection of the public and so for those reasons, which I hope I have explained satisfactorily, at least to the lawyers in the case, I come to the conclusion, with regret and with hesitation, that the proper sentence in this case is one of life imprisonment."

36. The judge then set the minimum term at 4 years.

37. When the matter came back before the judge on 2 March 2012, his attention had been drawn by Ms Brand to section 45A of the MHA 1983, which had been inserted into that Act by section 46 of the Crimes (Sentencing) Act 1997. The judge stated:

> "And for all the reasons I gave then, I am satisfied that it's appropriate to impose a sentence of imprisonment, indeed, life imprisonment, but for the reasons I gave then, I am perfectly

> satisfied that Mr Fort is suffering from a mental disorder, which at least at the moment is appropriate for him to be detained for medical treatment and the appropriate medical treatment is available – all of that was proved last Friday – and I therefore propose, having imposed the sentence of imprisonment that I did, to give two directions. First, that he be removed to and detained in the Reaside Clinic, and second, a direction that he be subject to the special restrictions set out in s.41 of the Mental Health Act, and I give those directions on the basis of the evidence I heard last Friday, together with that today.
>
> Pending his admission to the Reaside Clinic, Mr Fort must be taken to and detained in a pace of safety, namely Birmingham Prison, and upon the Reaside Clinic notifying the prison authorities that the place is available at some point within the next 28 days, I direct that the prison authorities or their agents transport him to the Reaside Clinic."

38. The judge also reiterated his earlier conclusion that the minimum term to be served under s.82A of the Crimes (Sentencing) Act 1997 was to be 4 years less time spent on remand. He withdrew the certificate which he had granted on 22 February that the case was fit for appeal.

VI. The medical evidence produced for the appeal and Dr Maganty's oral evidence on appeal.

39. Dr Maganty produced a report dated 8 June 2013. It followed a mental state examination and interview on 8 June. The report reviewed in full and careful detail the history of the opinions of the specialists who have examined and treated the appellant at various times. Dr Maganty reported that the appellant had "disengaged" with the clinical team looking after him. By April 2013 he had required a period of seclusion and restraint, but the position had ameliorated when the appellant had moved to the medium secure intensive care unit, Sycamore. He had started on anti-psychotic medication and there had been a favourable response involving the cessation of the appellant's thought insertion. There had also been an improvement in his participation with therapy activities and psychological sessions and also his emotional reactivity.

40. Dr Maganty noted the various diagnoses that had been made by other clinicians. He stated that "based on the above" a diagnosis of schizophrenia had been made in this case and the appellant had successfully begun treatment with anti-psychotic medication. However, Dr Maganty stated that it was impossible to predict whether the appellant's mental disorder would ever improve to the extent that psychiatrists treating him might be able to recommend to the Restricted Patients Panel that he be considered for conditional discharge. Nonetheless, it was "very much possible and probable" that the appellant's mental disorder would improve over time, although it would be likely to take "several more years".

41. Dr Maganty was asked by the appellant's solicitors to consider specific questions based upon the possible orders that might be made by this court. In the course of answering one of these, on the test to be applied for remitting the appellant to prison

in circumstances where he was sentenced to custody for life, but was subject to a section 47/49 Mental Health Act order, Dr Maganty stated (at page 58-9 of his report):

> "There is a direct relationship between Mr Fort's mental disorder and his risk to others. Mr Fort's violence on every occasion has been directly linked to this mental disorder, i.e. his thought insertion involving violent thoughts being inserted into his mind together with in some instances passivity (his actions being controlled by an external force). These symptoms have consistently been worsened by stress, such as examinations prior to the index offence, moving prisons in a custodial setting, withdrawal of CD's in a custodial setting and subsequently in a hospital setting (which he uses to distract himself from his thoughts). The two key features which would need to be addressed prior to any conditional discharge would be treatment and assurance that these episodes of passivity and thought insertion do not occur for a sustained period of time and he is able to face the stresses of changing situation and changing life events. This testing would require a number of years.
>
> …
>
> With regards to transfer back to prison under Section 47/49, there are significant difficulties. Stress directly precipitates psychotic episodes (thought insertion and passivity leading to violence in his case. Returning him back to prison in itself is very stressful and it is not possible to control the exposure to stress in such a setting. Furthermore, much more extensive work would need to be done to prepare him for this. It is also important to note that Mr Fort's break down into a psychotic episode, as has occurred in a custodial setting, poses a risk to others in such a setting, including prison officers, fellow inmates and healthcare staff, as he has done in the past. Furthermore, he would also pose a serious and significant risk to himself in such a setting. Therefore the threshold for his return back to prison which is detrimental to his health would be much higher. In my opinion, it is very unlikely that Mr Fort would be returned back to prison in the foreseeable future and even should he be returned back to prison this is likely to break down very quickly with his return back to hospital, potentially with serious injuries to others or serious harm to him."

Dr Maganty also stated that such a re-transfer to prison was likely to undo a large part of the therapeutic work undertaken with Mr Fort.

42. In answer to the question: if the appellant were the subject of an order under sections 37 and 41 of the MHA, were there any circumstances where it might be said by the Restricted Patients Panel that the appellant "must be conditionally discharged at a time when he continued to present a danger to the public", Dr Maganty stated:

> "Mr Fort has presented a danger to the public/others when he has suffered with inserted thoughts which have been of a violent nature with or without other passivity phenomena, such as his actions being controlled by others. These are the core features of his mental disorder. Therefore there is a direct causative link between his mental disorder and his violence. Until these core features are resolved and there is clear assurance that there would not be immediate recurrence or near term recurrence of this symptomatology together with a clear and robust plan in place to manage these risks in a community setting it is not possible for him to be conditionally discharged into a community setting.
>
> As there is a direct link between his mental disorder and his violence, management of the risk that he poses to others and reduction in these risks to an extent that would satisfy a Mental Health Review Tribunal that such a risk is not significant would be an essential part of any consideration of such a panel. In my opinion, therefore I do not foresee a situation where Mr Fort would be discharged by a Mental Health Review Tribunal into a community setting whilst he poses a risk to the public."

Dr Maganty concluded that he could not foresee a situation where a Restricted Patients Panel would order that the appellant must be conditionally discharged at a time when he would continue to represent a danger to the public (page 61).

43. Dr Maganty also made two further important points in his opinion. First, a custodial sentence would, in his view, be detrimental to the appellant's mental health leading to a relapse and thereby posing a serious risk to himself and others in a custodial setting. Secondly, he re-iterated that in the appellant's case, "his violence has always been directly linked to his mental disorder" and that neither prior to this offence nor subsequently was there evidence that he had been violent towards others "whilst not suffering with his mental disorder" (page 64).

44. Dr Hopley had prepared a report dated 22 May 2013 on behalf of the Crown. The report was prepared after an interview with the appellant and after Dr Hopley had discussed the appellant's recent progress with Dr Maganty. However, Dr Hopley had, obviously, not seen Dr Maganty's most recent report; nor had he had access to the appellant's medical records. The same questions posed to Dr Maganty were considered by Dr Hopley. His conclusions were, in summary: (1) that the diagnosis of "Dissociative Disorder" remained valid. (2) Although there was little to suggest that the appellant's dissociative episodes had changed over recent years, despite pharmacological and psychological treatments, the recent responses indicated that any psychotic illness may be amenable to treatment. (3) If the diagnosis were changed to one of a psychotic illness, that would imply a "chronic relapsing and remitting illness where the prospect of recovery/significant improvement is limited". (4) Based on the information available to him he preferred a dual diagnosis of psychotic illness and dissociative disorder. (5) Whilst a diagnosis of "dissociative disorder" remained in place it carried with it a level of unpredictability such that even if the appellant were to be free from dissociative episodes for a number of years and his paranoid psychosis were in remission, the risk of an unpredictable recurrence

would remain. (6) He could not contemplate any circumstances whereby the appellant (assuming he was detained and subject to an order under sections 47 and 49 of the MHA) might be recommended for conditional discharge at a time when he continued to represent a danger to the public "*as long as he was still diagnosed as suffering from mental disorder":* (Dr Hopley's emphasis). (7) Appropriate treatment was available in hospital for both dissociative disorder (psychological therapy) and psychopathic disorder. (8) There would be a significant risk of a deterioration in the appellant's mental state if he were to be remitted to prison.

45. When Dr Maganty gave oral evidence at the hearing before us he confirmed the opinions set out in his report. He added that the established view of the doctors on the diagnosis of the appellant was that he was suffering from schizophrenia. He said this was something which was often established in the patient's teenage years but progresses thereafter; a firm diagnosis is difficult at an early stage and doctors are reluctant to make it then. He said that there was a direct link between the appellant's mental disorder and violent actions by him. It was now clear to see that there was a direct link between the actual offence and the appellant's schizophrenia, although that would not have been clear at the time of the offence. There was no evidence that the appellant had been violent in his earlier teens or that there was any other personality trait that would lead to this offence.

46. Ms Brand asked Dr Maganty about the possible prospects of the appellant being released (conditionally) and he replied that there would have to be, first, an established long period of stability without any thought insertion or other episodes and, secondly, a long period of testing over some years, eg by closed escorted leave, before release could be contemplated. That was many years away.

47. Dr Maganty reported that the appellant was being treated with anti-psychotic medication and that he had made a remarkable improvement. He was presently on an acute rehabilitation ward and his social reaction had improved also. His dissociative thoughts had been much reduced. The appellant had accepted that he has a mental illness and that it is schizophrenia.

48. Dr Maganty repeated his written view that it would be detrimental for the appellant to return to prison. He said that patients with schizophrenia "do badly" in prison because of stress and prisons are stressful places. So a return to prison could lead to a relapse. If he then returned to a hospital only to be returned again to prison, the chance of recovery would diminish further.

49. There was no cross-examination by Miss Hancox.

VII. The legal framework in which the sentence was made

50. The appellant had pleaded guilty to manslaughter on the grounds of diminished responsibility, having been charged with murder. At the time that the appellant was convicted in August 2010, the provisions of Chapter 5 of Part 12 of the Criminal Justice Act 2003, dealing with "Dangerous Offender" were those as amended by the

Criminal Justice and Immigration Act 2008.[1] Under those terms manslaughter is a specified violent offence under Schedule 15 of the Criminal Justice Act 2003. The first question that the sentencing judge had to ask and answer was whether the appellant, as a person aged over 18 who had been convicted of a specified offence, constituted a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences; in short, whether he was "dangerous". On the facts of this case the answer to that question is obvious: the appellant was "dangerous".

51. The next question is, what, apart from the complications brought about by the appellant's mental illness, would have been the proper sentence. As the appellant was over 18 but under 21 when convicted, under the provisions in force at the time the judge would have to decide, pursuant to section 227(1)(c) of the 2003 Act as amended, whether the court was required, by section 225(2) of the 2003 Act, to impose a sentence of imprisonment for life.

52. Section 225(2)(a) and (b) which were not amended by the 2008 Act, provide:

> "**(2)** If—
>
> **(a)** the offence is one in respect of which the offender would apart from this section be liable to imprisonment for life, and
>
> **(b)** the court considers that the seriousness of the offence, or of the offence and one or more offences associated with it, is such as to justify the imposition of a sentence of imprisonment for life,
>
> The court must impose a sentence of imprisonment for life."

Section 227(1)(a), (b) and (c), as amended by the 2008 Act, provide:

> "**(1)** This section applies where-
>
> **(a)** a person aged 18 or over is convicted of a specified offence committed after the commencement of this section, and
>
> **(b)** the court considers that there is a significant risk to members of the public of serious harm occasioned by the commission by the offender of further specified offences but,
>
> **(c)** the court is not required by section 225(2) to impose a sentence of imprisonment for life."

[1] The provisions of Chapter 5 of Part 12 of the Criminal Justice Act 2003 as amended by the 2008 Act haven since been considerably re-amended by the Legal Aid, Sentencing and Punishment of Offenders Act 2012, which amendments came into force on 3 December 2012.

53. The effect of these two provisions is that the sentencing judge had to ask whether he was required to impose on the appellant a sentence of imprisonment for life. This court has considered in a number of cases the circumstances in which a sentence of life imprisonment should be imposed when an offender has been convicted (or pleaded guilty to) manslaughter by reason of diminished responsibility, in particular in the cases of: ***R v Kehoe (Bridie Joanna) [2009] 1 Cr App R (S) 9; R v Clive Wood [2009] 1 Cr App R (S) 2;*** and ***R v Welsh [2011] 2 Cr App R (S) 68.*** Lord Judge CJ stated in ***Wood,*** at [14], that a judge sentencing an offender for manslaughter by reason of diminished responsibility, remained bound by section 143 of the 2003 Act to assess the seriousness of the offence and the judge must do so by reference to the offender's culpability and the harm consequent upon his actions. But those two considerations are neither the paramount nor exclusive considerations in such cases. At [18] Lord Judge stated that the fact that the case was one of manslaughter on the grounds of diminished responsibility did not preclude a sentence of imprisonment (or, we would add, custody) for life. In such cases the sentence of imprisonment for life would be reserved for "particularly grave" cases, where the defendant's responsibility for his actions, although diminished, remained high. As Moses LJ pointed out in ***Welsh*** at [11], the "acute difficulty" in offences of manslaughter by reason of diminished responsibility where the mental illness is one such as schizophrenia is in assessing the degree of the offender's responsibility. In ***Welsh*** the court held that the appellant retained a substantial degree of mental responsibility for the killing of the victim.

54. Ms Brand did not have a "fall back" argument that if she were wrong in her primary submission that that the judge should have imposed orders under sections 37 and 41 of the MHA, the sentence should not have been one of custody for life under section 225(2) and 227(1)(c) of the 2003 Act. However, we think it right to point out that in a case such as the present, where, in our view, it is clear from all the medical evidence that we have reviewed that the appellant did not have much, if any, mental responsibility for his actions in killing Mrs Fort, the choice of sentence facing HHJ Davis was not necessarily one between custody for life or orders under section 37 and 41 of the MHA.

55. The next consideration in the sentencing judge's exercise is the fact that the appellant was suffering from a mental disorder. Section 37(1A)(c) of the MHA provides that "in the case of an offence the sentence for which would otherwise fall to be imposed by section 225(2)…of the Criminal Justice Act 2003….nothing in [that] provision shall prevent a court from making an order" under section 37(1) of the MHA for the admission of the offender to a hospital. Therefore the next question that the sentencing judge had to ask in this case was whether the terms set out in section 37(1), which refer to the conditions set out in section 37(2), had been fulfilled in this case and whether the most suitable method of disposing of this case was by means of an order under section 37, with or without a supplementary restriction order under section 41 of the MHA.

56. Section 37(1) to (2) of the MHA provide:

> "**(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,..., or is convicted by a magistrates' court of an offence punishable on

summary conviction with imprisonment, 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 or, as the case may be, place him under the guardianship of a local social services authority or of such other person approved by a local social services authority as may be so specified.

(1A) In the case of an offence the sentence for which would otherwise fall to be imposed—

(a) under section 51A(2) of the Firearms Act 1968,

(b) under section 110(2) or 111(2) of the Powers of Criminal Courts (Sentencing) Act 2000,...

(c) under section 225(2) or 226(2) of the Criminal Justice Act 2003,

or

(d) under section 29(4) or (6) of the Violent Crime Reduction Act 2006 (minimum sentences in certain cases of using someone to mind a weapon),

nothing in those provisions shall prevent a court from making an order under subsection (1) above for the admission of the offender to a hospital.

(1B) References in subsection (1A) above to a sentence falling to be imposed under any of the provisions mentioned in that subsection are to be read in accordance with section 305(4) of the Criminal Justice Act 2003.

(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."

57. Section 41 of the MHA provides:

"**Power of higher courts to restrict discharge from hospital.**

(1) Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section; and an order under this section shall be known as "a restriction order".

(2) A restriction order shall not be made in the case of any person unless at least one of the registered medical practitioners whose evidence is taken into account by the court under section 37(2)(a) above has given evidence orally before the court.

(3) The special restrictions applicable to a patient in respect of whom a restriction order is in force are as follows—

(a) none of the provisions of Part II of this Act relating to the duration, renewal and expiration of authority for the detention of patients shall apply, and the patient shall continue to be liable to be detained by virtue of the relevant hospital order until he is duly discharged under the said Part II or absolutely discharged under section 42, 73, 74 or 75 below;

(aa) none of the provisions of Part II of this Act relating to community treatment orders and community patients shall apply;

(b) no application shall be made to the appropriate tribunal in respect of a patient under section 66 or 69(1) below;

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

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

> **(ii)** power to transfer the patient in pursuance of regulations under section 19 above or in pursuance of subsection 3 of that section; and
>
> **(iii)** power to order the discharge of the patient under section 23 above;
>
> and if leave of absence is granted under the said section 17 power to recall the patient under that section shall vest in the Secretary of State as well as the responsible clinician ; and
>
> **(d)** the power of the Secretary of State to recall the patient under the said section 17 and power to take the patient into custody and return him under section 18 above may be exercised at any time;
>
> and in relation to any such patient section 40(4) above shall have effect as if it referred to Part II of Schedule 1 to this Act instead of Part I of that Schedule.
>
> **(4)** A hospital order shall not cease to have effect under section 40(5) above if a restriction order in respect of the patient is in force at the material time.
>
> **(5)** Where a restriction order in respect of a patient ceases to have effect while the relevant hospital order continues in force, the provisions of section 40 above and Part I of Schedule 1 to this Act shall apply to the patient as if he had been admitted to the hospital in pursuance of a hospital order (without a restriction order) made on the date on which the restriction order ceased to have effect.
>
> **(6)** While a person is subject to a restriction order the responsible clinician shall at such intervals (not exceeding one year) as the Secretary of State may direct examine and report to the Secretary of State on that person; and every report shall contain such particulars as the Secretary of State may require."

58. There are two conditions contained in section 37(2(a)(i). The first is that the court is satisfied on the written or oral evidence of two registered medical practitioners that the offender is suffering from a mental disorder which makes it appropriate for him to be detained in a hospital for medical treatment. The second is that medical treatment is available for him for the mental disorder from which the offender is suffering. Both conditions have to be satisfied before an order under section 37(1) can be made.

59. The differences between the effect of sentencing an offender to (on the one hand) either imprisonment (or custody) for life with a minimum term or a sentence for public protection under Chapter 5 of Part 12 of the 2003 Act and (on the other hand) making an order under section 37(1) of the MHA, coupled with a "restriction order" under section 41 of the MHA, are crucial. They were analysed in detail in ***Attorney-General's Reference No 54 of 2011 [2012] 1 Cr App R (S) 106*** in the judgement of

the court given by Hughes LJ, Vice-President, as he then was, particularly at [17] – [18]. In summary he said: the detention for public protection regime and that under sections 37/41 of the MHA have features in common. Under both, release is discretionary in the hands of the Secretary of State, effectively the Ministry of Justice. There is no absolute right to release. The test for the exercise of the discretionary decision to release is whether the offender is a danger to the public. Release is conditional and an offender is likely to be recalled.

60. Hughes LJ then emphasised the "absolutely crucial" difference between the two regimes. If a sentence for public protection is made, release is dependent upon the responsible authority being satisfied that the offender is no longer a danger to the public for ***any*** reason (Hughes LJ's emphasis); principally the risk of relapsing into serious crime. Moreover, under this regime, a release is upon licence and those licence conditions can be designed to try and prevent a relapse eg by preventing association with dangerous criminals. That licence can be revoked if the offender shows that he remains a danger to the public from committing serious crimes. However, under the MHA regime, release is dependent on the responsible authority being satisfied that the offender no longer presents any danger ***which arises from his medical condition*** (our emphasis). In this case the release is not upon licence and so no conditions can be set. The offender can be recalled under an MHA order, but ***only if the medical condition of the offender relapses*** (our emphasis). As Hughes LJ said: "simple crime does not trigger a recall under the hospital order regime". These differences in the conditions for release and recall under the hospital order regime were not in dispute in ***A-G's Reference No 54 of 2011*** because they had themselves been the subject of detailed analysis by Lord Bingham of Cornhill giving the opinion of the Appellate Committee of the House of Lords in ***R v Drew [2003] 1 WLR 1213,*** particularly at [21].

61. The upshot of this analysis is that in a case such as the present (in particular under the sentencing regime extant at the time this sentence was passed), the sentencing judge has to evaluate whether, given the history of the offender up to the time that the relevant offence was committed, the risk of committing further offences is one that would be triggered by virtue a relapse in the mental condition of the offender or by virtue of a relapse into a criminal lifestyle. Cases both before and subsequent to the decision in ***A-G's Reference No 54 of 2011*** have emphasised that if, in the opinion of the court, the offender poses a significant risk of serious harm to members of the public occasioned by the commission of serious offences, even if his mental disorder were to be cured or substantially alleviated, then the sentence to be imposed must recognise and focus on that residual risk. See: ***R v Welsh [2011] EWCA Crim 73*** at [17]; ***R v Shane Jenkins [2012] EWCA Crim 2557, [2013] 2 Cr App R(S) 15*** at [24] and ***R v Ruby [2013] EWCA Crim 1653*** at [38]. As Pitchford LJ emphasised in ***Ruby,*** at [36], "clinical advantage" is not the test as to whether the appropriate sentence is detention under section 37 of the MHA. It is the test set out by Hughes LJ in ***AG's Ref No 54 of 2011*** which we have reproduced above.

62. HHJ Davis appears to have reached the conclusion, at page 4G of the transcript of his sentencing remarks, that the appellant could be discharged from hospital under a section 37/41 hospital order and still present a danger to the public. Therefore, he concluded, the proper sentence was one of life imprisonment pursuant to section

227(1) and 225(2) of the 2003 Act as amended by the 2008 Act. The question for us is whether than conclusion was correct.

VIII The basis for the appeal and the "fresh evidence".

63. In ***R v Ruby*** at [37], Pitchford LJ reiterated, in a sentence appeal where the appellant suffered from mental disorder, the well-established principle that this court will not interfere with a sentence that was appropriate at the time that it was imposed merely because the offender has made progress since then during his sentence. He emphasised that this court can only interfere with a sentence if it was unlawful, wrong in principle or manifestly excessive.

64. In ***R v Mohammed Mokshud Ahmed [2013] EWCA Crim 1393,*** the appeal concerned a young man who had pleaded guilty to wounding with intent to do grievous bodily harm, contrary to section 18 of the Offences Against the Person Act 1861. He was sentenced to detention for public protection. On appeal it was argued that, at the time of sentence, he was suffering from a mental disorder such that the sentencing judge should have ordered that the appellant be detained pursuant to section 37/41 MHA hospital order. The appellant was granted leave to adduce fresh psychiatric evidence on appeal. At [37] Pitchford LJ stated that the burden was upon the appellant to demonstrate that, at the time of sentence, the appellant was suffering from a mental disorder of a nature or degree that made it appropriate that he should be detained in a hospital for mental treatment under section 37 of the MHA, whether or not that order was to be coupled with one under section 41. With respect, we agree with that analysis.

65. It must follow, therefore, that the aim of any "fresh evidence" that this appellant wishes the court to receive on appeal pursuant to section 23 of the Criminal Appeals Act 1968 (as amended) must be to assist in satisfying the burden upon him that: (i) at the time of sentence he was suffering from a mental disorder that was susceptible to treatment; (ii) the reason for the offence was the appellant's mental disorder; (iii) the appellant does not pose a significant risk of serious harm to members of the public occasioned by the commission of serious offences if his mental disorder were to be cured or substantially alleviated, so that (iv) the sentence of custody for life was wrong in principle.

66. In the context of conviction appeals, this court has emphasised that fresh expert evidence, (which in many cases concerns the mental state of the appellant) will not automatically be received by the court pursuant to section 23 of the Criminal Appeal Act 1968: see ***R v Erskine; R v Williams [2010] 1 WLR 183.*** Reception will depend on the facts and circumstances of the particular case. Whilst the court must have regard to the matters set out in section 23(2), ultimately the test is the broad one set out in section 23(1), viz. whether this court thinks it "necessary or expedient in the interests of justice" to receive the proposed "fresh" evidence.

67. Similar flexibility must be appropriate on sentence appeals which concern the mental state of the appellant at the time of the original sentence. Thus we note that in ***R v Charles de Silva (1994) 15 Cr App R(S) 296,*** this court received fresh medical evidence on the mental condition of the appellant. It was argued, successfully, that the fresh evidence demonstrated conclusively that the previous medical view that there was no connection between the appellant's mental illness and his offence, was

wrong: see page 298. In this case the Crown does not oppose the court receiving the evidence of Dr Maganty and Dr Hopley in their reports and in the oral evidence of the former given at the hearing before us. We have concluded that it is expedient to receive all that evidence in the interests of justice in this case. However, we point out that it should not be assumed on all sentence appeals concerning an appellant who is said to suffer from a mental disorder at the time of sentence, that the reception of further expert evidence on appeal will be automatic. The appellant must satisfy the court that it is "necessary or expedient in the interests of justice" that it receives the fresh expert evidence.

IX Discussion and Conclusions

68. Ms Brand advanced two arguments in support of the appeal. The first was that HHJ Davis had either misunderstood or had not properly taken account of evidence given by Dr Memon at the sentencing hearing, particularly that quoted at [32] above. Ms Brand submitted that the effect of Dr Memon's evidence at that point in particular was that if the appellant's schizoid personality disorder were to be sufficiently alleviated and his morbid thoughts resolved and if it were demonstrated that he did not have any further episodes of dissociation, then there would be no further significant residual danger to the public of a risk that he would commit further serious violent crimes. In short, that the evidence of Dr Memon supported a hospital order disposal upon the basis of the analysis of Hughes LJ in ***AG's Ref No 54 of 2011*** which we have set out above. Ms Brand submitted that the judge was therefore wrong to conclude, as she said he did at page 4G of his sentencing remarks, that the appellant could be discharged from a section 37/41 hospital order "..even though he, as a matter of fact, still [presented] a danger to the public", thus leading to the judge's conclusion that a sentence of custody for life must be imposed.

69. We are not particularly impressed with this argument. In our judgment, Dr Memon did not squarely deal with the issue of whether the appellant would remain a residual danger to the public even if his mental disorders to be sufficiently resolved to enable him to be released under a section 37/41 hospital order. Nor, in the passage of Dr Memon's oral evidence relied on by Ms Brand, did the witness deal with the issue of whether the cause of the offence and, indeed, the cause of other violent acts by the appellant, was solely his mental disorder. By that phrase we mean the combination of his schizoid personality disorder, his morbid thoughts of violence and his episodes of dissociation.

70. Therefore, we cannot accept the argument that the judge either misunderstood or did not taken into account properly this evidence of Dr Memon. Effectively, the judge had to make that evaluation on all the evidence before him at the time. The issue is whether, in the light of the full evidence, his evaluation was wrong.

71. Ms Brand's second argument is based on the new reports of Dr Maganty and Dr Hopley and the oral evidence of the former before us. The submission is that this evidence demonstrates conclusively that the mental state of the appellant at the time of sentence was that the risk of a violent reaction by the appellant leading to injury or worse to others is directly related to his mental disorder. Ms Brand particularly relied on the parts of Dr Maganty's report quoted at [41] and [43] above and his oral evidence, as summarised at [45] above. Ms Brand also relied on Dr Hopley's report, in particular the point summarised at (6) in [44] above.

72. We have to ask whether, in the light of this evidence, we are satisfied that the appellant has demonstrated that, at the time of passing sentence, the judge erred in concluding, effectively, (page 4G of his sentencing remarks) that the appellant would continue to pose a significant risk of serious harm to members of the public occasioned by the commission of serious offences, even if his mental disorder were to be cured or substantially alleviated. As we understood from Ms Hancox, the Crown accepted that if the appellant did demonstrate that the judge had erred in this respect, then it would follow that a section 37/41 order would be appropriate and the sentence of custody for life would be wrong in principle.

73. On the evidence of Dr Maganty, which is not contradicted by anything in Dr Hopley's report, we are satisfied that this appellant would not continue to pose a significant risk of serious harm to members of the public occasioned by the commission of serious offences ***once*** his mental disorder, in all its three manifestations , has been cured or substantially alleviated such as to enable him to be discharged (albeit conditionally) from a section 37/41 order.

74. We are satisfied, on the oral and written evidence of Dr Maganty and the written evidence of Dr Hopley (who are both registered medical practitioners under the MHA), which we have set out above, that the appellant is suffering from mental disorder and that this mental disorder is of a nature which makes it appropriate for him to be detained in a hospital for treatment. We are also of the opinion that, having regard to all the circumstances including the nature of the offence and the character and antecedents of the appellant and to all other available methods of dealing with him, that the most suitable method of disposing with this case is by means of an order under section 37 of the MHA. On the basis of the test set out in ***AG's Ref No 54 of 2011,*** we are satisfied that the judge did err in imposing a sentence of custody for life as opposed to a section 37/41 hospital order. We add that Ms Brand fully accepted that an appropriate restriction order under section 41 had to be made in this case.

75. Therefore we allow the appeal against the sentence of custody for life on that basis.

X The order under section 45A of the MHA

76. As we have already noted at [3] above, it was accepted on behalf of both the appellant and the Crown that the order made by HHJ Davis on 2 March 2012 pursuant to section 45A of the MHA was unlawful, because such an order could not be made on someone who was under 21 at the time of conviction and was thus being considered for a sentence of custody for life, as opposed to a sentence of imprisonment, as would be the case on a person over 21 at the date of conviction. The conclusion that section 45A was not available in those circumstances was reached by this court in ***AG's Ref No 54 of 2011*** at [22]. Having re-examined the legislation we are, respectfully, in agreement with Hughes LJ's conclusion. Like the court in ***AG's Ref No 54 of 2011,*** we do not understand the policy behind this restriction. Section 45A was introduced by the Crimes (Sentencing) Act 1997, therefore before the Powers of the Court (Sentencing) Act 2000 which contemplated that the adult prison regime would be applicable from the age of 18, so the lack of reference to "detention" is not explained by that consideration, as Hughes LJ tentatively suggested at [22].

77. We think we should explain precisely how we respectfully agree with the conclusion of the court in ***AG's Ref No 54 of 2011***. The appellant was under 21 when convicted. Therefore he could not lawfully be sentenced to a term of imprisonment even if he attained 21 by the time he was sentenced: see section 89 of the Powers of Crimnal Courts (Sentencing) Act 2000 and ***R v Danga (Harbeer Singh) [1992] QB 476 at 480-1.*** Where an offender aged between 18 and 21 is convicted of an offence for which the sentence is not fixed by law and for which, if he were over 21 he would be liable to imprisonment for life, the court "shall, if it considers that a sentence for life would be appropriate" sentence the offender to "custody for life": section 94 of the Powers of Criminal Courts (Sentencing) Act 2000. That is not a sentence of imprisonment, as is clear from the provisions of section 95 of the same Act which stipulates that a person who is sentenced to custody for life will be detained in a Young Offender Institution (YOI) unless the Secretary of State orders that the person is to be detained in a prison or remand centre rather than a YOI.

78. Section 45A, which is in Part III of the MHA, provides as follows:

> "*Power of higher courts to direct hospital admission*
>
> 45A.-
>
> **(1)** This section applies where, in the case of a person convicted before the Crown Court of an offence the sentence for which is not fixed by law-
>
> **a)** the conditions mentioned in subsection (2) below are fulfilled; and
>
> **(b)** the court considers making a hospital order in respect of him before deciding to impose a sentence of imprisonment ("the relevant sentence") in respect of the offence.
>
> **(2)** The conditions referred to in subsection (1) above are that the court is satisfied, on the written or oral evidence of two registered medical practitioners—
>
> **(a)** that the offender is suffering from mental disorder;
>
> **(b)** that the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
>
> **(c)** that appropriate medical treatment is available for him.
>
> **(3)** The court may give both of the following directions, namely—
>
> **(a)** a direction that, instead of being removed to and detained in a prison, the offender be removed to and detained in such hospital as may be specified in the direction (in this Act referred to as a "hospital direction"); and

(b) a direction that the offender be subject to the special restrictions set out in section 41 above (in this Act referred to as a "limitation direction").

(4) A hospital direction and a limitation direction shall not be given in relation to an offender unless at least one of the medical practitioners whose evidence is 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.

(6) If within the said period of 28 days it appears to the Secretary of State that by reason of an emergency or other special circumstances it is not practicable for the patient to be received into the hospital specified in the hospital direction, he may give instructions for the admission of the patient to such other hospital as appears to be appropriate instead of the hospital so specified.

(7) Where such instructions are given—

(a) the Secretary of State shall cause the person having the custody of the patient to be informed, and

(b) the hospital direction shall have effect as if the hospital specified in the instructions were substituted for the hospital specified in the hospital direction.

(8) Section 38(1) and (5) and section 39 above shall have effect as if any reference to the making of a hospital order included a reference to the giving of a hospital direction and a limitation direction.

(9) A hospital direction and a limitation direction given in relation to an offender shall have effect not only as regards the relevant sentence but also (so far as applicable) as regards any

other sentence of imprisonment imposed on the same or a previous occasion."

79. Section 45A thus gives a court which is considering the imposition of a "sentence of imprisonment" on an offender (as opposed to hospital orders under both sections 37 and 41 of the MHA) the power to sentence the offender to imprisonment but, at the same time, to give a direction for the offender's removal to hospital for treatment together with a limitation direction which is the equivalent of a restriction order under section 41 of the MHA. Such an order can only be made if the conditions set out in section 45A(2) are fulfilled. An order made under this section is to be contrasted with the situation where a court has imposed a sentence of imprisonment and then there is a pause and then the Secretary of State makes an order for a transfer to a hospital under section 47 of the MHA.

80. It is important to note the precise wording used in sub-section 45A(1)(b). Thus the section applies when the court "considers making a hospital order[2] in respect of [the offender] before deciding to impose a sentence of imprisonment…". There is nothing in section 45A which indicates that this phrase is to be extended to "deciding to impose a sentence of detention". Normally, if it is the purpose of a provision to apply to both sentences of imprisonment and sentences of detention, then this will be expressly stipulated either in the relevant section itself or in an interpretation section.

81. Section 55 of the MHA provides the interpretation to be given to terms found within Part III of the Act. Section 55(6) states that: "references in this Part of this Act to persons serving a sentence of imprisonment shall be construed in accordance with section 47(5) above." Section 47(5) states that: "references in this Part of this Act to a person serving a sentence of imprisonment include references—(a) to a person detained in pursuance of any sentence or order for detention made by a court in criminal proceedings…". That extension of the definition does not apply to section 45A(1)(b) because that provision is not dealing with a situation where an offender is "serving" a sentence of imprisonment; it is dealing with the position when a court is about to decide whether to impose a "sentence of imprisonment" on an offender.

82. We note that section 37(8) states that: "…for the purposes of this subsection "*sentence of imprisonment"* includes any sentence or order for detention". Therefore the extension of the meaning of "sentence of imprisonment" only applies to that subsection. There is no more general definition of "sentence of imprisonment" in any other section of the Act. Moreover, if it were intended that section 55(6) of the Act should apply more widely than to those "serving a sentence of imprisonment", then the definition in section 37(8) of the Act would be redundant. We think it is clear, therefore, that the extension of the phrase "sentence of imprisonment" in section 55(6) applies only to persons who are actually "serving" a sentence.

83. Given our conclusion that the extension of the phrase "serving a sentence of imprisonment" provided for in section 55(6) cannot extend to the phrase

[2] This term is defined in section 37(3) as being "an order for the admission of an offender to a hospital".

"deciding to impose a sentence of imprisonment" in section 45A(1)(b) so as to include "deciding to impose a sentence of detention or custody for life", and given that the court could not lawfully impose a sentence of imprisonment on this appellant as he was under 21 upon conviction, it must follow that the judge had no power to make an order under section 45A of the MHA. That is why that order must be rescinded.

XI Disposal

84. For the reasons we have given we will: (1) allow the appeal in respect of the sentence of custody for life. That sentence will be quashed and replaced by a hospital order under section 37 and a restriction order under section 41 of the MHA; (2) we set aside the order made under section 45A of the MHA as being unlawful.