Neutral Citation Number: [2017] EWCA Crim 1460

Case No: 201600193

IN THE COURT OF APPEAL (CRIMINAL DIVISION)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 06/10/2017

Before :

LADY JUSTICE THIRLWALL
MR JUSTICE WARBY
and
THE HONORARY RECORDER OF WESTMINSTER
(Sitting as a Judge of the Court of Appeal Criminal Division)

- -

Between:

	Regina	
	- v -	
	Mehmet Bala	

- -
- -

Mr M Stanbury appeared on behalf of the **Appellant**
Mr J Polnay appeared on behalf of the **Crown**

Hearing date: 7th July 2017

- -

Judgment Approved

LADY JUSTICE THIRLWALL :

1. On 15th December 2006, at the Central Criminal Court the appellant, then 20 years old, pleaded guilty to manslaughter on the basis of diminished responsibility. He had been charged with murder but the plea of guilty to manslaughter was accepted by the Crown.

2. On 22nd June 2007 he was sentenced by the late HHJ Goddard QC to Custody for Life with a minimum term to serve of 4 ½ years less 347 days spent on remand.

3. He is now 30 years old. Since 2013 he has been in hospital pursuant to sections 47 and 49 of the Mental Health Act (MHA) 1983. His applications for an extension of time of 10 years to apply for leave to appeal against sentence and to call fresh evidence were referred to the full court by the single judge. It is the appellant's case that instead of a sentence of Custody for Life the judge should have imposed a hospital order under section 37 Mental Health Act (MHA) 1983 together with a Restriction Order under section 41.

4. The application is based on an analysis of the evidence available to the judge at the time of sentence and upon recent psychiatric reports which were the subject of the application to receive fresh evidence. We received those reports and heard from two psychiatrists de bene esse.

Extension of time

5. The current solicitors were first instructed in June 2013. The original solicitors had been subject to an intervention by the Solicitors Regulation Authority which caused some delay in obtaining the original case papers. In November 2013 a psychiatrist was instructed to undertake a full assessment of the appellant but the report was not produced until May 2014, followed by a further written assessment in July 2014. There were no transcripts of the hearings, and no recordings from which transcripts could be made. Counsel advised that in those circumstances there were no prospects of a successful appeal. A further opinion was sought from Mr Stanbury who appeared before us and advanced the applications with skill and focus. He advised that there were grounds of appeal. It is not clear to us why there was no appeal at the time of or at least within six months of the sentence but whatever the reason it was not related to the appellant. We extend time and give leave to appeal.

Background

6. The appellant was born on 30th June 1986. At the time of the offence he was a voluntary inpatient on a psychiatric ward at Homerton hospital. This was his third voluntary admission. He had previously been a voluntary patient between 1st June and 21st October 2005 and between 28th March and 2nd April 2006. On 1st June 2006, he presented himself at the accident and emergency department at the hospital and was admitted to the psychiatric ward. On 22nd June he stated that he did not want to leave the hospital as he was concerned that he may do "bad things." His leave was cancelled as a result and he was advised to remain in the hospital. The responsible clinician decided that he should be detained under the Mental Health Act should he try to leave the ward. On the days that followed he reported further violent thoughts and on 25th June he became threatening to staff.

7. On 6th July the appellant was noted to be paranoid about living on the streets. His responses to a questionnaire were, it was believed, consistent with a diagnosis of borderline antisocial personality disorder. At this stage he was not expressing thoughts of violent behaviour. His antipsychotic medication was increased and he was allowed 2 to 3 hours escorted leave from the ward.

The offence

8. On 7th July 2006 the appellant had been out and had gambled away most of the money he had previously withdrawn from the bank account into which his benefits were paid. He returned to the hospital but left again. He arrived at Highbury and Islington underground station at approximately 5.55pm. He went onto the platform and deliberately pushed John Curran (a complete stranger, on his way home from work) in front of an oncoming underground train. Mr Curran was dragged along the platform and died at the scene. The appellant ran away. He returned to the hospital at about 7.15pm. He appeared anxious and worried. He said he had lost £150 gambling. He took his

medication and went to bed.

9. Police attended at the hospital in the early hours of the morning with an image of the suspect taken from CCTV footage. The appellant was identified by staff and was asked to speak to the police. He asked "Did the man die?" and later, "I killed a man didn't I? I know what I did".

10. He was assessed by two psychiatrists on 8th July. During the course of the assessment interview he said that he had felt like attacking someone because he had gambled and lost around £90. He needed to give his mother £60 to renew his passport and felt that he would be discharged from hospital without any identity. He said that he did not know whether it was his "right side" or his "left side" that was responsible for the incident. He told the psychiatrist that he had considered he might die as well if the man had pulled him with him. He said his mind was blank at the time he pushed Mr Curran under the train. He said he knew that his actions were wrong. He said that after the offence he left the tube station quickly, took off his T-shirt, then took the 242 bus to Hackney. He put his T-shirt back on and made his way back to the Homerton Hospital where he waited for the police to come and get him. He expressed remorse and then said, "the guy lost his life for £150." Towards the end of the interview he said "I know I'm a lifer now - thankfully I'm in UK and not USA where I would be executed." The psychiatrist concluded that the appellant was suffering from a paranoid psychotic illness but did not need to be taken to a mental hospital; he was fit to be interviewed and detained.

11. After the police interview the appellant was charged with murder and remanded to Feltham Young Offenders Institute. He was admitted to the healthcare centre for assessment. Anti-psychotic medication was prescribed for him. On 12th July 2006 he was transferred to HMP Belmarsh. He was assessed on 27th July 2006 and in her report of 26th September 2006 the locum consultant forensic psychiatrist expressed the view that the appellant presented a grave and immediate danger to others. She advised that he be referred to Broadmoor Hospital.

12. The defence obtained a report from Dr Duffield, consultant psychiatrist, on 12th October 2006. He concluded that the appellant was suffering from paranoid schizophrenia and was unfit to plead. He advised that a full assessment be carried out. He recommended urgent transfer to hospital for treatment.

13. There were hearings before judges of the Central Criminal Court on 16th October and 27th November 2006. Each was adjourned so that further medical evidence could be obtained. Dr Chesterman, consultant psychiatrist, was instructed by the Crown. His report, dated 26th November 2006, recorded his assessment and conclusion that at the time of the killing the appellant was experiencing active symptoms of schizophrenia which would have amounted to an abnormality of mind within the meaning of Section 2 of the Homicide Act 1957. He concluded "although I recognise that this would be a matter for the jury, in my opinion, Mr Bala's mental illness at the time would have substantially impaired his responsibility." He went on to say that notwithstanding the symptoms of schizophrenia the appellant "was aware of

his actions and that they were wrong." It was Dr Chesterman's view that Mr Bala was fit to plead and to stand trial. He expressed the view that if a plea to manslaughter on the grounds of diminished responsibility were accepted by the court this was a case for a hospital order under Section 37 of the MHA 1983 together with a restriction order under Section 41, without limit of time. He agreed with the earlier view that the appellant posed a grave and immediate danger to others and that any treatment of his mental disorder should take place in conditions of maximum security.

14. On 11th December before the then Recorder of London, the Crown said that in the light of the report by Dr Chesterman, a plea of guilty to manslaughter on the grounds of diminished responsibility would be accepted. The case was adjourned for medical experts to attend to assist on the question of sentence. At this stage, according to the notes prepared by both prosecuting and defence counsel for the ultimate sentencing hearing, the Recorder was minded to make a hospital order on the basis of the two expert reports available at the time, but subject to an assessment of the appellant at Broadmoor.

15. On 30th January 2007 the matter was mentioned before HHJ Goddard QC. She adjourned the case for a three month assessment at Broadmoor to which the appellant was admitted on 2nd February 2007. The assessment, which took place under Sections 48 and 49 MHA 1983 was carried out by Dr Andrew Payne, consultant forensic psychiatrist, and his team at Broadmoor Hospital. Dr Payne took a different view from those who had previously assessed the appellant. In his report dated 20th April 2007 he concluded: –

    "the symptoms of psychosis were unlikely to have been a significant cause of the appellant's behaviour in committing the index offence."

    In Dr Payne's view the behaviour was more likely to be related to his anger at having lost money gambling, his failure to achieve his objectives on that day and his anger in relation to earlier sexual abuse and other matters.

16. It was Dr Payne's firm view that the appellant was not suffering from a mental illness but instead from a personality disorder which was not currently treatable due to his lack of truthfulness and persistent requests to remain in hospital and take medication. Although his psychopathic disorder may warrant his detention in hospital for medical treatment such treatment was not currently likely to alleviate or prevent a deterioration of his condition. It was more likely to aggravate his complaint of psychotic symptoms, his demands for medication, and his avoidance of the psychological difficulties which have resulted from his previous experiences.

17. Dr Payne and his clinical team considered that the psychotic symptoms the appellant was describing were not genuine. For that reason a decision was taken to stop his medication on 13th March 2007. Dr Payne concluded "I am therefore unable to make any medical recommendations to the court with respect to sentencing."

18. The appellant was returned to custody on 3rd May 2007.

19. The prosecution instructed Dr Chesterman to review his report in the light of Dr

Payne's report. In his first addendum report of 26th April 2007 Dr Chesterman appeared to accept Dr Payne's conclusion that the offence was more likely to have been caused by an untreatable personality disorder rather than mental illness and so any intervention was unlikely to reduce the risk of further offending.

20. At the sentencing hearing listed for 27th April 2007 the judge granted a defence application for a further adjournment to obtain a further psychiatric report. They obtained a comprehensive report from Dr Oyebode dated 30th May 2007. In the meantime Dr Duffield had produced an addendum report dated 14th May 2007. Having read Dr Payne's report he remained of the opinion that the most likely principal diagnosis was one of paranoid schizophrenia. Dr Chesterman then produced a second addendum report in which he restated his opinion that at the time of the killing the appellant was suffering from schizophrenia. In the light of Dr Payne's report the prosecution had reconsidered their decision to accept a plea of guilty to manslaughter but ultimately maintained their original stance.

21. Dr Oyebode reviewed in detail all the previous psychiatric assessments and then interviewed the appellant on 9th May 2007. Mr Bala told him "I just decided to turn up to the train station and push someone to the death, because I told people what I would do, I should have got away with it, why am I in so much psychological trauma." He could not state whether there was any specific planning nor was he able to give any great clarity about his thoughts before the index offence except for the fact that he had said he would do it. When asked how he then felt about the killing he said "as time goes on, I feel less and less guilty because the incident is moving away from me. I have accepted it, I don't care who I have killed. I want to start afresh."

22. Dr Oyebode spoke to Dr Payne on 4th May 2007. He records that Dr Payne remained of the view that on the basis of the assessment at Broadmoor Hospital the appellant was not treatable. When Dr Oyebode spoke to him again on 18th May 2007, Dr Payne repeated that he did not consider that the appellant needed to be in hospital for treatment. Dr Oyebode expressed the view that the appellant was then currently mentally ill and required treatment in hospital. Dr Payne said that in the light of their own assessment Broadmoor could not take the appellant. He is reported to have suggested that the court could dispose of the case by way of a prison sentence and "he can have a look at him again in about three months' time."

23. Dr Oyebode concluded that at the time of the killing the appellant was probably suffering from the symptoms of paranoid schizophrenia. Notwithstanding previous drug use, he did not consider that the psychosis was drug induced. He acknowledged that there was persistent misbehaviour during his teenage years but noted that a conduct disorder was not diagnosed at that time. He considered it would be difficult to arrive at a firm diagnosis of a personality disorder in the absence of a clear diagnosis of a conduct disorder. He recommended to the court that the appropriate disposal was a hospital order under Section 37 MHA 1983 together with a restriction order under Section 41

without limit of time. In a report dated 3rd June 2007 Dr Chesterman agreed with Dr Oyebode's diagnosis of paranoid schizophrenia.

The sentencing hearing

24. It is most unfortunate that there are no transcripts of any of the sentencing hearings in this case. Sadly the sentencing judge died some years ago. Her notebooks have been destroyed. As a result, we are reliant on the collective recollection of counsel who appeared at that time and who have provided an agreed note for which we are grateful. We also have the following documents:-
    (i) Prosecution opening note
    (ii) Prosecution submission on approach to sentencing
    (iii) Defence skeleton argument and mitigating factors
    (iv) Defence advice on sentencing options
    (v) The contemporaneous log of the sentence hearing on 22nd June 2007. This is informative but it was compiled to assist in identifying where on the transcript any particular matter would be found and so it is a series of snapshots. A great deal is missing.

25. The judge had all the contemporaneous medical reports. Drs Duffield, Oyebode and Chesterman attended the hearing.

The sentences open to the judge

26. There were four sentences available:-
    Custody for life;
    Indefinite detention for public protection (DPP);
    A determinate sentence;
    A hospital order under Section 37 MHA 1983 with a Restriction Order under Section 41.

27. A hybrid order under Section 45A MHA 1983 was not available because the appellant was under 21 years of age (see *AG's reference no 54 of 2011* [2011] EWCA Crim 2276) but given the proximity of his 21st birthday, 8 days later, had this been a realistic possibility the case could have been adjourned. That it was not considered may reflect the fact that as at 2006 orders under Section 45A were rarely used.

28. Under section 47 MHA 1983 the Secretary of State for Justice had (and has) power to transfer to hospital a person sentenced to imprisonment/detention where the person is suffering from a mental disorder, the mental disorder makes it appropriate for the prisoner to be detained in hospital for medical treatment and appropriate medical treatment is available.

The judge's approach

29. Mr Gursoy (who appeared for the appellant below) recalled that he "urged the sentencing judge to grant a hospital order as this was the best disposal of the case in the circumstances but there were difficulties in finding available beds at the time." When asked to clarify for the purposes of this hearing whether the judge did not impose a hospital order due to the lack of a bed or because she did not regard it as a suitable disposal in any event he recalled that "the Judge did not regard it as a suitable disposal as a primary matter, however, there were concerns that there was a shortage of beds." Mr Stanbury says that

Mr Gursoy must be mistaken and that the judge's approach was dictated by the fact that there was no bed available for the appellant and no way of obtaining one, notwithstanding several adjournments for that purpose. She did not consider the merits of the various psychiatric opinions at all, he says.

30. Mr Rees QC (who appeared for the Crown) could not recall whether the enquiry about the availability of the bed was made merely to see what options were open to the judge or whether it was the fact that there was no bed that was determinative of her decision.

31. The record shows that the judge was prepared to hear from the doctors but it is not clear whether they gave evidence (although in the Respondent's notice it is asserted that they did and were cross examined). Whatever the position as to live evidence it is clear that the judge was being told that in the absence of a hospital bed it was not open to her to make an order under section 37.

Discussion

32. The judge was presented with conflicting medical evidence on the question of the appropriateness of a hospital order as a disposal. She had granted an adjournment so that there could be full assessment of the appellant. The outcome was not the one that had been expected by the other psychiatrists; the psychiatrist responsible for the assessment did not consider that a hospital order was appropriate and had written a detailed report explaining why he and his team took that view. He was not prepared therefore to make a bed available at Broadmoor. This was not about a shortage of beds. It was Dr Payne's professional view that treatment would not be effective and so there was no bed. Dr Payne's report, produced after three months' assessment, would have weighed heavily with the judge, particularly when the views expressed in the reports produced by other psychiatrists were reached after much shorter assessments. She would also have been reassured by Dr Payne's suggestion that he would reassess the appellant were he to be subject to a custodial sentence. If appropriate, it would be for the Secretary of State to act under section 47.

33. In a note prepared for the final hearing on 22nd June 2007 Mr Gursoy submitted that on the balance of the medical evidence a hospital order was the correct outcome in this case but Dr Payne had concluded that the appellant should not be admitted to Broadmoor. He submitted to the judge that she should make an order under section 38 of the MHA (an interim order) but, unsurprisingly, the judge did not take that course. Many months had now passed since the first psychiatric report had been obtained and the assessment was unhelpful. We assume therefore (and the log supports this) that Mr Gursoy then addressed the judge on the basis set out in his note ie that the defendant had pleaded to a count of manslaughter by reason of diminished responsibility but a hospital order was not available. His detailed and lengthy document dealt with the psychiatric evidence and the sentencing options by reference to statute and the authorities.

34. The judge rightly considered that the appellant was dangerous within the meaning of the Criminal Justice Act 2003. She imposed Custody for life with a minimum term of 4.5 years. In the light of the evidence before her that sentence was, in our view, inevitable.

35. The appellant was returned to custody. On 17th October 2007 he was transferred to Broadmoor under section 47 MHA 1983 where he remained until October 2013 when he was transferred to the John Howard centre, a medium secure unit. He has more recently been transferred to the Wolfson House low secure unit. He remains subject to an order under section 47 and to a restriction order, pursuant to section 49 MHA 1983. The life sentence remains in place.

Grounds of Appeal

36. Although three in number the grounds essentially come to this: the judge was wrong to impose a life sentence. The sentence was, Mr Stanbury submits, wrong in principle. The judge should have imposed a hospital order with a restriction order under ss.37 and 41 of the MHA 1983 given the nature of the appellant's illness; the causal connection between that illness and his offending; the availability of treatment and the beneficial release arrangements that would be conferred by the substitution of a hospital order.

Fresh Evidence

37. As we have already said, the sentence imposed was inevitable in the light of the evidence before the judge. We were asked to consider as fresh evidence the reports of three consultant psychiatrists: Dr Witharana (16th May 2014); Dr Nimmagadda (2nd July 2014 and 31st May 2016); and Dr Ajaz (9th December 2016). All three psychiatrists were of the view that a hospital order was and is the most appropriate disposal in this case. We heard from Dr Ajaz, the appellant's responsible clinician at Wolfson House, and from Dr Nimmagadda who performed a review of all of the evidence and conducted his own assessment of the appellant in 2017. The latter included a retrospective assessment of the appellant's mental health at the time of the offence. We are grateful to both doctors for the clarity of their helpful opinions.

38. It is Dr Ajaz's opinion that the appellant suffers from schizophrenia and he has a personality disorder (albeit of a different type from that diagnosed by Dr Payne in 2007). He points out that the presence of these two diagnoses is likely to have contributed to the difference of opinion regarding diagnosis at the time of sentencing.

39. The schizophrenia is now well controlled with medication and there is currently a low risk of serious life threatening violence in the appellant's current placement, and a low risk of low-grade physical aggression. The appellant has been having escorted community leave for over 6 months and there have been no concerns about his risk to the public. There is an unquantified risk of sexual offending but there has been no evidence of such behaviour during his current admission, and this will continue to be monitored. The risk of violence increases as a direct consequence of the symptoms that he experiences when he is unwell. He has already had some short periods of unescorted leave which have gone well.

40. The personality disorder is lifelong. Many of its features are still present, Dr Ajaz says. The appellant has undertaken a prolonged period of talking therapy directed to his personality disorder. The present proposal is to work towards a conditional discharge from hospital. Dr Ajaz expressed concern that

were the appellant returned to prison in accordance with his sentence his mental state would deteriorate significantly. He accepted in cross examination that it was not inevitable that the appellant would be returned to prison. Were the Parole Board to agree to the appellant's release into the community he would be entitled to support pursuant to section 117 MHA 1983. It was his view however that the more effective support would be provided under the auspices of a section 37/41 disposal.

41. Dr Witharana was of the opinion that the appellant was suffering from a schizophrenic illness at the time of the offence and that the illness was of a sufficient nature and degree for detention under s.37 of the MHA at the time of the sentencing, together with a restriction order under s.41. As to Dr Payne's view that the appellant had a personality disorder, Dr Witharana considered that whilst the appellant was demonstrating some traits suggestive of a personality disorder, the clinical picture was predominantly that of a schizophrenic illness.

42. Dr Nimmagadda conducted a comprehensive review of the papers and assessed the appellant himself, as we have said. He too concluded that the appellant was and is suffering from schizophrenia and in his view there was overwhelming evidence to suggest that he was suffering from schizophrenia at the time of the offence. He did not consider that it was open to Dr Payne to diagnose a personality disorder without first addressing the mental illness. We would observe that even if that view were correct, it is inescapable that it is now well established that the appellant has a personality disorder, and has done throughout his adult life. The fact that no diagnosis of conduct disorder was made while he was under 18 is no longer relevant.

43. Dr Nimmagadda was asked to consider and report upon the extent to which the schizophrenia had caused the appellant to commit the offence. In his addendum report he said that "although the appellant's mental disorder had not rendered him not guilty by the reason of insanity, he still was able to have a defence of diminished responsibility, a psychiatric defence." He added, "It could be concluded that his offending was at least partly attributable to his mental disorder."

44. Dr Nimmagadda was cross examined, with particular focus on his view that the offending could be "at least partly attributable" to his mental disorder. He developed his view to the point of saying that but for his mental disorder (schizophrenia) the appellant would not have committed the offence, irrespective of any personality disorder. He considered that the appellant had not fully appreciated the consequences of what he was doing. He added that the appellant undoubtedly "had the volition" to commit the offence. It is plain to us from the records of his conversations with psychiatrists shortly after the offence that the appellant had understood what he was going to do before he did it, intended to do it and acknowledged immediately afterwards what the consequences were: a man was dead and he would be serving a life sentence. We do not accept Dr Nimmagadda's developed view. We do accept Dr Nimmagadda's earlier conclusion as set out above, ie that the offending was "at least partly attributable to the mental disorder."

45. In *R v Vowles* [2015] EWCA Crim 45 this court set out in detail the approach

to be taken by sentencing judges dealing with offenders with mental disorders. At paragraph 54, having earlier set out the statutory framework, the court described the situation in which a section 37/41 order is likely to be the correct disposal in a case where a life sentence is being considered. It is that 1) the mental disorder is treatable 2) once treated there is no evidence the offender would be in any way dangerous, and 3) the offending is entirely due to that mental disorder.

46. In this case the new evidence does not demonstrate that the offending was entirely due to the mental disorder. We are quite satisfied, on the evidence available at the time and the more recent evidence, that the appellant's behaviour when committing the offence was affected by both mental illness and his personality disorder. On the face of it therefore this case did not come within the situation described as likely to lead to a section 37/41 order as described in *Vowles*. To that we would add the reminder in *Vowles* that consideration should be given to whether the powers of the Secretary of State under section 47 to transfer a prisoner for treatment would, taking into account all the other circumstances, be appropriate. It is clear from the court log that the judge had well in mind those powers, in the light of Dr Payne's reference to a further review after three months. We are satisfied therefore that even on the fresh evidence the judge could not have concluded, as required by section 37(2)(b), that *"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 [section 37.]"* In short the judge's conclusion was correct at the time and, with hindsight and fresh evidence, remains correct.

47. The real purpose of this appeal was to move the appellant from the release regime consequent upon a life sentence to the regime consequent on a hospital order. That is not a proper basis for an appeal if the original sentence was not wrong in principle. There are some, relatively few, cases where medical evidence obtained years after sentence convincingly demonstrates that the sentencing court proceeded on the wrong basis because of an error by an expert – see eg *R v Ahmed* [2016] EWCA Crim 670. On analysis that is not this case. The sentence was not wrong in principle.

48. The arrangements for release will be for the FTT (with information and advice from the responsible clinician), the Secretary of State and, ultimately, for the Parole Board. Release can only be directed if the Parole Board is satisfied that it is no longer necessary for the protection of the public that he be confined (see S27, Crime (Sentences) Act 1997).

49. Accordingly, notwithstanding the focussed and helpful submissions of Mr Stanbury this appeal is dismissed.