Neutral Citation Number: [2022] EWCA Crim 962

Case No: 202101151

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT IN PRESTON
HHJ SLINGER QC
T20067558

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/07/2022

Before :

LORD JUSTICE WILLIAM DAVIS
MRS JUSTICE CUTTS DBE
and
HHJ DEBORAH TAYLOR
Sitting as a Judge in the Court of Appeal

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Between :

PAUL CRERAND	**Appellant**
- and -	
REGINA	**Respondent**

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- -

Mr Matthew Stanbury (instructed by **Youngs Law**) for the **Appellant**
Mr Peter Glenser QC (instructed by **The CPS**) for the **Respondent**

Hearing date: Thursday 30th June 2022

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

Covid-19 Protocol: this judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time of hand-down is 14:00 on Tuesday 12th July 2022

MRS JUSTICE CUTTS DBE :

1. On 30 June 2022 we heard this appeal and the psychiatric evidence at the conclusion of which we granted the application for leave to appeal against sentence and to adduce fresh evidence. We quashed the sentence and substituted a hospital order with a restriction under sections 37 and 41 of the Mental Health Act. These are our reasons.

2. On 11 December 2006 at the Crown Court at Preston, following his earlier plea of guilty to an offence of wounding with intent contrary to s.18 of the Offences Against the Person Act 1861, the applicant was sentenced to life imprisonment with a minimum term of 2 years, 9 months and 25 days.

3. He seeks an extension of time of approximately 14 years and for leave to appeal against that sentence on the basis that in the light of the evidence now available the appropriate disposal was a hospital order with restriction pursuant to ss. 37 and 41 of the Mental Health Act 1983.

4. There was no psychiatric report before the sentencing judge as the applicant did not wish to have a medical report. It is conceded therefore that the judge could not have imposed a hospital order at that time.

5. From 2009, whilst in custody the applicant has been receiving anti-psychotic medication. He remained within the custodial estate until he was transferred to Ashworth Hospital on 14 March 2017 under s.47 of the Mental Health Act 1983. A diagnosis of paranoid schizophrenia was considered in prison but was not made conclusively until after his admission to Ashworth hospital. It is the view of Dr Collins, his responsible clinician at Ashworth Hospital, that he was suffering from this condition at the time of the offence with which this appeal is concerned.

6. The outcome this appellant seeks to achieve is to have his release and terms of release determined by the First Tier Tribunal under the Mental Health Act 1983 and care after release being provided through health services rather than having a determination on release and the terms of release determined by the Parole Board and the regime after release superintended by the applicable licence regime and supervision by the Probation Service. The appellant seeks to appeal his sentence to achieve that objective in reliance on fresh evidence which he seeks to have admitted under s.23 of the Criminal Appeal Act 1968.

7. The question for this court is therefore whether to admit the fresh evidence and, if so, whether on the basis of that evidence, we can conclude that the sentence passed by the judge should have been a hospital and restriction order or whether the sentence of life imprisonment was correct. We agreed to hear the evidence of Dr El Metaal, a consultant forensic psychiatrist called by the applicant and to consider the reports of Dr Collins and Dr Cummings (the latter instructed on behalf of the respondent) de bene esse.

The facts and background

8. The applicant had a significant antecedent history before the offence with which this court is concerned. In June 1997, aged 14 years, he was sentenced to 5 years detention for possession of an explosive substance and violent disorder in which he was part of a gang that threw petrol bombs into a shop. On 21 May 2001 he received a sentence of two years detention for affray and criminal damage. Whilst in custody for those offences he and an associate imprisoned and attacked another detainee, pouring boiling water mixed with sugar on him and beating him with the leg of a chair. The prison authorities were unable to free the victim to give him medical attention for a period of five hours. The applicant was sentenced to five and a half years detention and was released on licence only two weeks before committing the offence, the sentence for which is the subject of this appeal. Between his conviction aged 14 and being remanded for that offence he had spent only fifteen weeks at liberty.

9. Having been released on licence, the applicant returned to live with his mother and brother. On 26 July 2006 at just after 5 PM the applicant approached the victim from behind as he was sitting on the communal steps to the block of flats in which they both lived and struck him once to the head with a hammer in an unprovoked attack. The wound was pouring with blood and required stitches. A neighbour intervened and the applicant was arrested shortly afterwards. He was later to tell the author of the pre-sentence report that he would have been willing to continue the attack and did not care if he killed the victim but he noticed that there were children present who were upset. The motivation for the attack was said to be an earlier altercation between the victim and the applicant and tensions between the applicant's family and the victim which escalated when the applicant was released from prison.

Sentence

10. As we have said, the applicant, who was aged 24 years at the time of sentence, refused to have a medical report for the purpose of sentence. The judge had the benefit of a pre-sentence report dated 6 December 2006 written by a Probation Officer named Doug Smith. Mr Smith knew the applicant well as he had been his Supervising Officer since his release on YOI licence in February 2001. In the report Mr Smith set out the applicant's account of the offence which spoke of a history of problems between the victim and the applicant's family. On the day of the incident, after the earlier altercation, the applicant said he had gone for a walk to calm down but remained very angry and brooding. He then made the decision to attack the victim and cause him serious injury. The applicant said he was at pains to be very honest in his account to Mr Smith. He said he had no remorse or regret regarding the victim although on reflection he was relieved not to have killed him.

11. The report set out what was described as an "appalling record of violent or aggressive incidents" towards both staff and inmates since his incarceration. The applicant was not considered suitable for parole when serving either previous sentence. When asked to explain his violent offending the applicant would justify it in terms of reacting to some perceived insult or threat. On reflection sometime later he would say that perhaps they did not deserve it after all and that he over reacted. In the view of Mr Smith the applicant seemed unable to conceive of an alternative way of dealing with such problems as insult or threat. He reacted badly to perceived insults or provocations. His aggression had been a feature of his behaviour since childhood. Mr Smith knew of no psychiatric or psychological issues. He considered the applicant to be a very high risk to anyone with whom he became angry. With sadness he could

offer no arguments against a life sentence. The applicant himself said that he would prefer such a sentence to help him stay out of trouble when released.

12. In sentencing the applicant, the judge observed that he had a history of violent offending and causing danger to others. He noted that the applicant had said he did not wish a medical report which could have given the court wider information as to his position and might have set out reasons against the imposition of a life sentence. The judge accepted that the applicant recognised that he had a real problem and was anxious to receive help. The judge concluded that the applicant posed a significant risk of causing serious harm by the commission of similar offences and that with all he knew about the applicant the sentence had to be a discretionary life sentence with the minimum term we have already specified.

The applicant's history in custody.

13. In the course of his sentence the applicant has been placed in a number of prisons. In 2007 and 2008 he committed further acts of violence on staff and other inmates.

14. In April 2009 he engaged with psychology to look at the link between violence and his paranoid thoughts. A psychiatrist started him on antipsychotic medication.

15. On 6th October 2009 the applicant completed his tariff.

16. The applicant has remained on antipsychotic medication since April 2009 although there were occasions when he would stop taking it. At various times the dosage was increased and changed. He has received a total of fourteen adjudications in the course of his sentence. He has been denied parole on four occasions.

17. The applicant has most frequently spoken of recurring violent and paranoid thoughts which he has said began at the age of thirteen or fourteen. The frequency and intensity of them fluctuates over time. The applicant has said that not only have many of his assaults in prison been related to these thoughts but so were the offences he committed in 2001, 2002 and the offence the subject of this appeal in 2006. On two occasions in 2016 he handed in weapons he had made in the hope of assaults being prevented.

18. As we have already said the applicant was admitted to Ashworth hospital on 14 March 2017. He was seven years past his tariff at this point. It seems he settled there until the Spring and summer of 2018 when his symptoms exacerbated. He improved in October 2018 and in 2019 moved to a medium dependency ward where he remains. He started attending a course entitled "Life minus violence". On 7 February 2020 he was granted ground parole. The plan in 2020 was, if he remained settled, to be referred to his Regional Secure Unit for an assessment of suitability to transfer there which would require the agreement of the RSU and the Ministry of Justice.

19. It is said by Dr Collins, the applicant's responsible clinician, that in the three years since his admission to Ashworth there has been no consideration of him being returned to prison. His illness is difficult to treat and he is prescribed the strongest of the available antipsychotic agents. His symptoms are now so reduced that in the protected environment of Ashworth and with the support of staff he can manage his

behaviour. He complies with his medication even though it causes him significant side effects. He is compliant with his care plan.

The fresh evidence

20. The applicant seeks to rely on the fresh psychiatric evidence from Dr Collins in the written report to which we have already referred and the written and oral evidence of Dr El-Metaal, a consultant forensic psychiatrist.

21. Dr Collins considers that the applicant suffers from paranoid schizophrenia. That is a diagnosis with which all psychiatrists, including Dr Cumming for the respondent, agree. In his view the applicant was suffering from this condition at the time of the offence with which we are concerned. It has been the dominating influence in his life and the main instigator of his repeated aggression. In consequence his adult life has been spent almost entirely in one or other form of secure detention. In reaching this conclusion, Dr Collins relies on the applicant's account, his mitigation in 2006 to the effect that he overreacted to perceived insults and the pre-sentence report in which the author spoke of his violent response to perceived insults or threats.

22. In Dr Collins' view the applicant's decision not to have a medical report at his sentence was understandable in circumstances where he had had little contact with psychiatric services, did not know that he was suffering from a mental illness and feared the stigma in custody of being thought to have a mental illness. In Dr Collins' opinion, had the applicant been willing to see a psychiatrist whilst on remand and had spoken about his experiences as openly as he has at Ashworth, a hospital order with a restriction would have been a suitable disposal of the case. It is his view and that of his current care team that he is better managed in the mental health system rather than the prison system.

23. In his written report and in his oral evidence before us, Dr El-Metaal agrees with the opinions of Dr Collins. The applicant he says is suffering from paranoid schizophrenia and it is more likely than not that he was suffering from this condition at the time he committed the offence with which this appeal is concerned. It was due to his decision not to be assessed by a psychiatrist that the court did not have significant psychiatric evidence that may have been relevant to sentencing. In his oral evidence, Dr El-Metaal observed that the applicant suffers from a learning disability in addition to paranoid schizophrenia. In his view it is the combination of these conditions which most likely explains the applicant's unwillingness in 2006 to comply with the obtaining of a psychiatric report.

24. In Dr El-Metaal's opinion there is significant reliance in managing risk on the applicant complying with his prescribed medication regime. He currently has capacity to consent to his medication and has the ability to withdraw that at any time. Therefore the mainstay of his future risk management would be in the treatment of his psychotic illness, careful monitoring of his mental state and of his medication compliance. The expertise required to effectively achieve that would be via mental health services and in the first instance a community forensic mental health team. It is clear that when he is assertively treated with antipsychotic medication there is a significant improvement in the applicant's mental state and a concurrent reduction in violent incidents. In Dr El-Metaal's view the applicant will need lifelong treatment and supervision by mental health services for his mental disorder.

25. In his view it is important that individuals with the right level of mental health expertise are involved in leading and monitoring the applicant's presentation. It is essential that he has access to urgent psychiatric treatment when required, particularly in the review of early signs of relapse and for him to have clear accessible urgent psychiatric treatment without delay if insight is lost via the Mental Health Act. He points out that prison has been unsuccessful in treating and containing the applicant's risk to others and he would have concerns about the suitability of the prison in managing any future risk relevant paranoid episodes. The applicant has benefitted from the well-established rehabilitation pathways in secure psychiatric services. An order under s.37/41 of the Mental Health Act would ensure that pathways into hospital are clear and immediate in the event the applicant breaches his mental health conditions in the community.

26. In his oral evidence Dr El-Metaal assisted the court further on the applicant's present situation and the best way to protect the public should he be released.

    i) There is little if any prospect of the applicant being returned to prison from hospital. If he were to be returned to prison there would be every prospect of him being sent back to hospital before he could attend any parole board. His treatment does not only consist of medication but also the support of the nursing staff and psychological and other interventions which are not available in prison. In the doctor's view he is likely to relapse if returned to prison. He will remain a patient indefinitely.

    ii) He is unable to apply for parole in the ordinary way whilst a patient in hospital as a result of a transfer under s.47 of the Mental Health Act. Before he could apply for parole, the applicant first would have to obtain a determination from the First Tier Tribunal that the criteria for detention in hospital no longer were met. Only then would he be able to apply for parole. As a general rule that application will be made from hospital. The test for release on parole is different to the criteria for detention in hospital. If the applicant were not to satisfy that test, the Ministry of Justice would consider whether to return the applicant to prison or whether he should remain in hospital.

    iii) The applicant is highly treatment resistant which means that he does not respond to normal anti-psychotic medication. He is on almost 200% of what would be considered as the normal dose. This has significant side-effects which he has been willing to accept. The risk of relapse is high if there is even a slight adjustment to his medication.

    iv) There is compelling evidence that when his medication is optimally prescribed and taken the risk of violence is effectively minimal. This is evidenced by the fact that the applicant has been moved from conditions of high security to a medium dependency ward.

    v) The applicant is going to need a significant support package if he is deemed suitable for release. In all probability he will be placed in accommodation which is run 24/7 by trained medical staff who will monitor him. He is likely to have a care plan which requires him to take his medication in the presence of staff. Should he not comply with requirements set by the FTT he would immediately be recalled to a secure psychiatric setting. He would be unable to

change his accommodation without the express approval of the Ministry of Justice who would be notified significantly in advance of any proposed move. He would be graded and assessed all the time.

vi) Dr El-Metaal also drew the court's attention to chapter 22 of the Code of Practice issued for the Mental Health Act 1983 which governs the recall of conditionally discharged restricted patients. Paragraph 22.79 requires quarterly reports from the patient's clinical and social supervisors which should detail his progress, current presentation and any concerns about risks to themselves or others. If at any other time the clinical teams become concerned over a patient's behaviour or presentation they must investigate them and contact the Ministry of Justice straight away. Paragraph 22.82 sets out that a patient will be recalled where it is necessary to protect the public. Public safety will always be the most important factor. Recall does not require evidence of deterioration in the patient's mental health, only a change since the discharge decision. Because recall decisions always give precedence to public safety considerations this may mean that the Secretary of State for Justice will decide to recall on public safety grounds even if the patient's supervisors are of the view that recall would be counter therapeutic for the patient. Dr El-Metaal said that he had seen that happen on occasions.

27. Dr Cumming in his written report confirms the diagnosis of paranoid schizophrenia both now and at the time of the offence. He does not consider that in 2006 a diagnosis of mental illness would have been high on the list of explanations for the applicant's behaviour given his peer group and the impulsive nature of his offending. As time has gone on there has been the opportunity for further exploration of reasons for his behaviour. Having a psychiatric report at sentence would not therefore have necessarily led to the diagnosis of mental illness. He defers to the applicant's treating team on the question of whether the applicant is likely to be safe to be released in the foreseeable future.

Appeal

28. Mr Stanbury, who appears for the applicant today although not in the court below, submits that on the basis of the fresh evidence the appeal should be allowed and a hospital order with restriction substituted in its place.

29. He submits that the explanation for not adducing psychiatric evidence at sentence as explained in Dr Collins' report is understandable in circumstances where the applicant did not know that he had a mental illness and sought to avoid the stigma of a possible diagnosis. It is clear that the applicant requires lifelong treatment or his illness. The evidence of Dr El-Metaal shows that the index offence was a manifestation of the applicant's chronic persecutory belief system and attributable to his illness. Although serious, the offence was committed by reason of his illness by which his culpability was reduced and the primary need therefore is for treatment as opposed to punishment. The appropriate regime upon release, to provide maximum protection for the public is on the evidence that under the Mental Health Act.

30. Mr Glenser QC on behalf of the respondent submits that the sentence imposed by the judge was neither wrong in principle nor manifestly excessive. He points to the fact that although the applicant was first seen by a psychiatrist in April 2009 and

prescribed antipsychotic medication, he was not transferred to hospital until 8 years later in 2017. Dr Cummings has stated that the diagnosis might not have been made even if the applicant had been assessed by a psychiatrist before sentence. In this regard the applicant is in no different position from any other prisoner serving an indeterminate sentence that develops into a psychiatric illness whilst in custody. Further he submits there may be a tension between what is best for the applicant and what best protects the public. Should the court decide to quash the sentence imposed he invites us to substitute a hybrid order under s.45A of the Mental Health Act in its place.

Discussion

31. It is plain that at the time of sentence the judge had no power to make a hospital order under the Mental Health Act. There was no evidential basis for him to do so. It is clear that the judge would have liked a psychiatric report to assist him in sentencing but the applicant's refusal in that regard gave him no choice but to impose the discretionary life sentence that he did. The applicant was plainly dangerous. No possible criticism can be made of the judge in that regard.

32. It is now common ground amongst the psychiatrists that the applicant suffers from paranoid schizophrenia and in all likelihood did so at the time of the offence. It is important to observe that even if the judge had a report to that effect, he was not bound to impose a hospital order on the applicant. As this court made clear in *R (Vowles) and Secretary of State for Justice and the Parole Board [2015] EWCA Civ 56* it is for the judge to decide the proper disposal of the case on all the evidence in the case. The judge must consider the alternative sentences open to him or her.

33. This case was sentenced in 2006. If the judge had been in possession of a psychiatric report which contained a diagnosis of paranoid schizophrenia and a recommendation under s.37 and 41 of the Mental Health Act he would have had two options – either to make such an order or to impose a sentence of imprisonment. The so called hybrid order under s.45A of the Act was not open to him. Until the amendment of the section which came into effect in 2008, such an order could only be made where the offender suffered from a psychopathic disorder. Dr El-Metaal said that although this would have been explored as a possibility in 2006 it is now known that the explanation for the applicant's behaviour is his paranoid schizophrenia. That is not a psychopathic disorder.

34. As *Vowles* makes clear at [54(iii)] where a court is considering a life sentence under the Criminal Justice Act 2003, (following the guidance in *R v Burinskas [2014] EWCA Crim 334*) as the judge was in this case, if the mental disorder is treatable, once treated there is no evidence he would be in any way dangerous and the offending is entirely due to that mental disorder, a hospital order under s.37/41 is likely to be the correct disposal. The judge should also consider whether the powers under s.47 of the Mental Health Act for transfer to prison for treatment would, taking account of all the other circumstances, be appropriate. In this regard the judge would be considering the extent of culpability attributable to the mental disorder, the need to protect the public and the regime on release.

35. Against that background we have considered the fresh evidence in this case. We are grateful to Dr El-Metaal who was thorough in his approach and a distinctly impressive witness.

36. It is clear on that evidence that the applicant was suffering from paranoid schizophrenia at the time of the offence in 2006 and that the offending was attributable to that illness. We were concerned that it was by the applicant's own refusal to co-operate that no psychiatric report was before the judge for his sentence but are satisfied on the evidence that this was likely due to the combination of his learning disability and mental illness.

37. We have considered what was said in *Vowles* at [48]. We acknowledge that the court must examine with care the broader issues of the need to protect the public and of the regime on release. We note what was said in relation to the second of those issues in *Attorney-General's Reference (No 54 of 2011)* [2012] Cr App R (S) 635. Attention was drawn to the distinction between the recall regime when a person is released from a prison sentence and the recall regime applicable to a patient subject to an order under the Mental Health Act. Whatever the position then, we consider that the Code of Practice to which we have referred at [26(vi)] above and which was published in 2015 has diminished the distinction significantly. Accepting that, in the case of someone like the applicant, public safety must be a primary concern, that concern in the circumstances of this case can be met by a disposal under the Mental Health Act.

38. We note that the applicant is highly unlikely ever to be returned to prison for the reasons Dr El-Metaal gave. In those circumstances it is highly unlikely that he will be considered for release by the Parole Board. It is appropriate in our view for the doctors who are responsible for his care to consider whether he is suitable for release and, if so, to propose the necessary conditions for a First Tier Tribunal to consider and determine.

39. We conclude that, taking into account the nature of his mental illness, its causal connection with the offence, its treatability and the clear evidence that his condition will be better managed on release under the Mental Health Act regime and the public better protected, this appeal succeeds. We grant leave for an extension of time, for leave to appeal and to adduce fresh evidence. We quash the sentence of life imprisonment and substitute for it a hospital order under s.37 with a restriction under s.41 of the Mental Health Act.