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IN THE COURT OF APPEAL
CRIMINAL DIVISION



CASE NO 198804809/A2

NCN NO [2021] EWCA Crim 1955

Royal Courts of Justice

Strand

London

WC2A 2LL

Thursday 16 December 2021

Before:

LORD JUSTICE HOLROYDE

MRS JUSTICE MCGOWAN DBE

SIR ANDREW NICOL

REGINA

v

BARBARA CAROL MILLER

Computer Aided Transcript of Epiq Europe Ltd,
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MR E FITZGERALD QC & MS P WOODROW appeared on behalf of the Applicant.

MR L MABLY QC appeared on behalf of the Crown.

J U D G M E N T

(Approved)

LORD JUSTICE HOLROYDE: This applicant (now aged 63) has a sad personal history. She is of low intellect, with an IQ of 61. In her 30s, she was assessed as having a level of comprehension approximately equal to that of an 8-year-old child. She suffered sexual abuse, neglect and poverty during her childhood. She has been diagnosed as suffering from a personality disorder, learning disability and behavioural disorder linked to her abuse of alcohol and substances. Starting at the age of 15, she appeared before criminal courts on more than 20 occasions, for offences including arson. Then on 22 July 1987 (aged 29) she killed Vivienne Elliot, a family friend. She was charged with murder, but in the light of expert medical evidence her plea to manslaughter on the ground of diminished responsibility was accepted. On 21 July 1988, at the Central Criminal Court, she was sentenced by the Recorder of London (Sir James Miskin) to life imprisonment. Her minimum term was set at 10 years 1 day. An application for leave to appeal against that sentence was refused by the single judge. Application is now made for an extension of time of some 33 years to renew the application for leave to the Full Court.

It is sufficient for present purposes to summarise very briefly the circumstances of the offence.

It was committed by the applicant acting jointly with her niece, who was also of low intellect. The judge in his sentencing remarks made clear that he regarded the applicant as the dominant offender in a very serious crime. The unfortunate victim was tied to a chair, struck about the head with a rolling pin and then strangled to death with a washing line. It was a pre-planned and deliberate killing, possibly motivated by jealousy. The judge said of the applicant that her attack on the deceased, coupled with her "enthusiastic lying" about what she had done and her previous convictions, showed her to be "a continuing menace and danger to the public".

The medical reports before the judge unanimously stated that the applicant's mental

responsibility for the killing was substantially diminished by her psychopathic personality disorder and her "mental handicap". They also stated, however, that her disorder was not (or was not likely to be) susceptible to treatment, with the consequence that the criteria for making a hospital order pursuant to the Mental Health Act 1983 could not be met. In his oral evidence at the sentencing hearing, one of the doctors said for the first time that the applicant showed signs of being willing to respond to psychotherapeutic treatment. The judge rejected the suggestion that a hospital order might be made, saying that he regarded the applicant as "such a pathological liar and so totally unreliable" that there was a real risk that the doctor's view of an appearance of change may well turn out to be misconceived. He therefore sentenced the applicant to life imprisonment. He made the other offender subject to a Probation Order.

In the following years, the applicant moved between prison and mental hospitals. There were repeated episodes of self-harm and suicide attempts. The applicant displayed severe mood swings, including episodes of intense anger, and on occasions was verbally and physically aggressive both to staff and to other prisoners. There were also, however, periods when the applicant was relatively stable, and these periods gradually increased in length. In November 2005 - long after the expiration of her minimum term - she was moved from prison to a secure hospital pursuant to sections 47 and 49 of the Mental Health Act 1983 (which provide for the transfer to hospital of a serving prisoner who is suffering from mental disorder which makes it appropriate to detain him or her in hospital). She has remained under in-patient psychiatric care ever since, moving on occasions between medium-secure and low-secure wards when episodes of aggression, violence and self-harm recurred.

In February 2014 there was a breakthrough in the treatment of the applicant when she was

prescribed Clozapine, an antipsychotic medication which has been found to be effective in reducing aggressive behaviour. Treatment of the applicant with that drug has been very successful and it has continued to be prescribed. With the exception of a period of a few months in 2019, to which we will refer shortly, she has not been violent and has not self-harmed. She has engaged much better both with staff and with therapeutic intervention, and her risk level has reduced.

On 14 November 2017 the applicant applied to the First-tier Tribunal (Health, Education and Social Care Chamber) Mental Health, which held that if she had been subject to a restriction order under section 41 of the 1983 Act she would have been entitled to be conditionally discharged from liability to be detained in hospital for medical treatment, whilst remaining liable to be recalled to hospital for further treatment should it become necessary. In reaching its decision, the Tribunal noted the dramatic change in the applicant's presentation following the introduction of Clozapine. It assessed her as having only partial insight into the need for medication, but found that her risks were likely to remain low provided she complied with medication, remained drug and alcohol free and received a high level of support from mental health services.

Transition to treatment in the community was accordingly initiated. Unfortunately, the applicant proved unable to cope with the speed at which the transition progressed. Her condition deteriorated and she became increasingly anxious, apparently because of her fear that she may be returned to prison. In February 2019 she assaulted a fellow patient. In April 2019 she threatened staff and threatened to harm herself.

Consideration was given to moving the applicant to a low-secure setting, but that was thought to be unnecessary and she remained in a rehabilitation unit. She was able to enjoy both escorted and unescorted leave, although the outbreak of the Covid-19 pandemic reduced

the amount of leave she could be allowed and in particular has prevented any assessment of her response to unescorted leave lasting more than a short time. Her mental health appeared stable, but in July 2020 there were signs of inhalant abuse and a rapid response was necessary.

On 23 February 2021 there was a review hearing before a Mental Health Tribunal which concluded that the applicant was again suffering from mental disorder of a nature or degree which made it appropriate for her to be liable to be detained in a hospital for treatment. The Tribunal was satisfied that it was necessary for the health or safety of the applicant and for the safety of the others that she should receive such treatment.

The Tribunal was aware that the applicant's representatives intended to make the present application to this court, and aware that the proposed application was supported by the treating clinicians. At paragraphs 38-40 of its written decision, the Tribunal expressed a view which the applicant relies upon as a convenient summary of her case in this appeal:

"38. ... In our judgement Ms Miller needs to have a specialist team working with her when she is released who have expertise in mental disorder as any future risk is, on the evidence before us, inextricably linked to her mental health.

39. Equally, the regime under the Mental Health Act if it applied to her would provide the means to recall her to hospital in a speedy and effective manner for any further treatment she might need if, for example, any deterioration in her mental wellbeing was observed by those specialists working with her in the community. A release under licence would not have that benefit.

40. Therefore, the amendment of Ms Miller's sentence in the way proposed by [the applicant's representative] would, in our view, have the dual benefit of ensuring attentive and appropriate treatment in the community by specialist social supervisors and a forensic psychiatrist and could, in the proper framing of conditions attached to that discharge, provide protection to the public from future harm, reinforced by the power vested in the Secretary of State to recall her to hospital for further treatment."

The present application to this court was made on 3 September 2021. The applicant seeks a very long extension of time in which to renew her application for leave to appeal against sentence. She also seeks to rely on fresh evidence pursuant to section 23 of the Criminal Appeal Act 1968.

As we have indicated, the application for leave to appeal against sentence was refused by the single judge in 1988 and was not renewed within 14 days. By virtue of rule 12(4) of the Criminal Appeal Rules 1968, it was therefore treated as having been refused by the court. The applicant was however entitled to ask the court to extend the 14-day period (see paragraph 13.3 of the Guide to Proceedings in the Court of Appeal (Criminal Division) (1983) 77 Cr App R 138). The applicant's present legal representatives have explained that the availability of the evidence now relied upon first came to their attention when the applicant applied for release on licence. They have also explained the reasons why the present application to this court could not realistically have been made sooner than it was. We accept those explanations.

The fresh evidence application includes the written decisions of the Mental Health Tribunals on 14 November 2017 and 23 February 2021. We regard that part of the application as misconceived. The fact that a court or a tribunal made a particular decision might if necessary be the subject of a fresh evidence application, but the written reasons for that decision are not evidence of the kind contemplated by section 23 of the 1968 Act. The views of the tribunal panels concerned are of course entitled to respect, but this court is not bound by their reasoning and conclusions. Nor is it acting in this case as an appellate court in respect of their decisions.

The applicant is on stronger ground in seeking to rely on the evidence of expert witnesses who

can assist the court as to her recent and present state of mental health.

Dr Roy, a consultant psychiatrist and the applicant's Responsible Clinician for several years, has written three reports. In the first, dated 30 April 2020, he noted that the applicant lacked capacity to consent to her medical treatment. He recorded that her attendance at individual psychology sessions had improved over the previous 4 years, but that she remained reluctant to admit to any ongoing difficulties or need for further interventions. There had been no signs of aggression or self-harm since June 2019. He recommended a gradual and well-monitored step down into community care. His opinion was that it would not be in the applicant's best interests to be returned to prison: such a move would result in a significant deterioration in her mental state and a risk of suicide.

In an addendum dated 30 July 2020, Dr Roy reported that the applicant had again been misusing inhalers. She had been using her unescorted leave to buy inhalants from a local shop. Steps were taken to prevent her doing so; but she then took or requested deodorant aerosols from other patients and inhaled those in order to intoxicate herself, with adverse consequences. That conduct was addressed and the applicant quickly returned to stable mental health.

In his third report, dated 2 December 2020, Dr Roy stated that the applicant was compliant with her treatment and well behaved, but assessed that compliance as being largely due to her detention in hospital. She lacks insight into her illness or its treatment, and there was a continuing high risk of noncompliance with her medication if she was not in hospital and was living independently without supervision. In such circumstances, there would also be a risk that she would resort to violence to address her dysfunctional coping skills. His opinion was that the applicant should therefore continue to be detained for treatment.

Dr Went, a forensic psychiatrist, prepared a report dated 17 May 2021 and gave oral evidence to

this court. She noted that the applicant blamed her niece for the killing in 1987. She assessed the applicant as still being highly vulnerable to relapse when subject to stress, and still in need of treatment in hospital.

As to the future pathway, Dr Went, in her report, expressed the opinion that a hospital order with restrictions, pursuant to sections 37 and 41 of the 1983 Act, would offer the best protection for the public. The applicant's treatment with Clozapine will require close monitoring by psychiatric services. The applicant's learning disability renders her vulnerable and she will need to be in suitable supported accommodation. An extended period of leave will be necessary to ensure that her risks are fully tested, that she has established a therapeutic alliance with the Community Mental Health Team and support workers in her home and that she has stabilised in that environment. Dr Went said in her report that this would not be possible if she were released on licence. Nor would the necessary rigorous supervision be available if the applicant were released on licence: her treatment would fall to the generic mental health services, who would not be compelled to take on her care or effective management of her risks. The Parole Board would not be able to impose a requirement of compliance with medication, which is key to the risk management. If the applicant were to breach the conditions of a release on licence, she would be returned to prison and a relapse of her mental disorder would be inevitable.

In her oral evidence, Dr Went expanded upon her reasons for regarding the mental health pathway as providing better protection for the public than release on licence from the life sentence. She emphasised, amongst other points, the need for a very gradual transition to the community. She doubted whether the applicant would be able to manage in the community if she had the continuing prospect of a potential recall to prison.

Dr Nwogwugwu, a consultant psychiatrist and the applicant's present Responsible Clinician,

provided a report indicating that he is of the same opinion as Dr Went. The two witnesses helpfully prepared a joint report in which they confirmed that the applicant continues to meet the criteria for detention under section 37 and that suitable treatment is available. They gave the following reasons for regarding the mental health pathway as the appropriate way of dealing with the applicant's case:

3.2 The mental health pathway with a MHA section 41 restriction order will ensure that she is subject to continued supervision of her mental disorders and that she remains on treatment for those disorders. This cannot be guaranteed if she is released under the criminal justice pathway.

3.3 The mental health pathway enables her to be required to take medication as a condition. This is not possible under the criminal justice pathway.

3.4 Mental health services are better able to assess when she is becoming unwell and when intervention including readmission to hospital is necessary.

3.5 Whilst the criminal justice pathway supervises risk of reoffending, they would require a community mental health team to supervise her mental disorder. There is no guarantee that the community mental health team will provide this.

3.6 It is our view that Ms Miller's offending occurred in the context of her mental disorders. The criminal justice pathway alone is not equipped to supervise this aspect of her offending. However, those supervising patients under a section 41 restriction are equipped to assess and manage both her risk of relapse of her mental disorder and her risk of committing further violence.

3.7 It is our view that the criminal justice system alone will not provide the necessary supervision and risk management to prevent further risk to the public.

3.8 If she is recalled under the criminal justice system, she will be returned to prison which in our opinion would result in further deterioration of her mental disorder and an increase in her risk. Whilst she could then be transferred to hospital there is likely to be a considerable delay in her receiving suitable treatment whilst the necessary assessments and applications are completed.

3.9 If she is recalled under a mental health restriction order she will be returned to hospital where specialist treatment will be available immediately.

This is therefore in our opinion the pathway which will provide the public with the greatest protection."

Dr Nwogwugwu also gave oral evidence. He confirmed that if a hospital order is made, the applicant can continue to be accommodated and cared for in the rehabilitation unit where she presently resides. He emphasised that the risk which the applicant presents is associated with a potential breakdown in her mental health, and expressed the opinion that it would therefore be best for the applicant to be managed in the community by an expert mental health team. Because of her learning disability, the applicant is liable to misunderstand the words and actions of others and has a low level of tolerance if she perceives herself to be mistreated.

It is convenient to refer next to relevant statutory provisions and case law.

So far as material for present purposes, section 37 of the Mental Health Act 1983 provides:

"(1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, . . . and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order ...

(2) The conditions referred to in subsection (1) above are that—

(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that either—

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and [appropriate medical treatment is available for him; or

(ii) ...

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."

Section 41 of the same Act, so far as material provides:

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

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

For convenience, we shall refer to a hospital order with a restriction order as a "section 37/41 order".

In R v Vowles [2015] EWCA Crim 45; [2015] 1 WLR 5131, this court gave guidance as to the approach to be taken when a judge has to sentence an offender who is suffering from a mental disorder and is considering whether to impose an indefinite sentence or to make a section 37/41 order. At [51] Lord Thomas CJ said that where the conditions in section 37(2)(a) are met, a judge in considering what is the appropriate disposal should have regard to the extent to which the offender needs treatment for the mental disorder from which he suffers, the extent to which the offending is attributable to the mental disorder, the extent to which punishment is required and the protection of the public including the regime for deciding release and the regime for after release. There must always be sound

reasons for departing from the usual course of imposing a penal sentence.

At [54] Lord Thomas went on to say that where the medical evidence suggests that the offender is suffering from a mental disorder, that the offending is wholly or in significant part attributable to that disorder, that treatment is available and that a hospital order may be an appropriate way of dealing with the case, a court should first consider whether that mental disorder can appropriately be dealt with by a hospital and limitation direction under section 45A of the 1983 Act. If so, the court should make such a direction. If such a direction is not appropriate, the court should then consider, if the medical evidence satisfies the condition in section 37(2)(a), whether the condition set out in section 37(2)(b) would make that the most suitable method of disposal. It is essential that the court gives detailed consideration to all the factors in section 37(2)(b). The court must also consider whether other methods of dealing with the case are available including the powers under section 47 of the 1983 Act of transfer for treatment.

In R v Ahmed [2016] EWCA Crim 670, the court pointed out at [29], that in deciding whether to release an offender the Parole Board adopts a broad focus, considering both the likelihood of reoffending and the risk to the public resulting from it, whereas under a section 37/41 order, the decision as to this discharge focuses entirely on the offender's mental health.

In R v Edwards [2018] EWCA Crim 595; [2018] 4 WLR 64, the court made clear that Vowles did not provide a "default" setting of imprisonment. It required a judge first to consider whether a hospital order may be appropriate. If so, the judge must then consider all the available powers, including a section 45A order, because there must be sound reasons for departing from usual course of imposing a sentence with a penal element. Hallett LJ at [12] observed that:

"... the graver the offence and the greater the risk to the public on release of

the offender, the greater the emphasis the judge must place upon the protection of the public and the release regime."

In R v Cleland [2020] EWCA 906; [2021] 1 Cr App R(S) 21, the court at [48] confirmed that:

"... following the admission of fresh evidence as to the offender's mental health at the time of sentence, the court has the power to substitute the sentence which it considers is (and, as the evidence now shows, always was) appropriate."

The court went on to say at [49], that if fresh evidence shows the offender's mental state at the time of sentence:

"... was otherwise than the judge believed it to be, the court has power to quash the original sentence if it considers that the appellant "should be sentenced differently", and to impose such sentence as it considers appropriate."

The court also confirmed at [55], that in circumstances such as these this court, when deciding whether an offender should now be sentenced differently, is entitled to take into account the extent to which punishment has already been imposed.

We turn to a very brief summary of the detailed submissions of counsel.

Mr Fitzgerald QC accepts on behalf of the applicant that the judge was entitled to sentence as he did on the basis of the medical evidence then available, but submits that the fresh evidence shows that the sentence was wrong in principle and/or manifestly excessive because it can now be seen that the applicant's mental disorder was and is treatable. The fresh evidence satisfies the requirements of section 37(2)(a) and should lead the court to conclude in accordance with section 37(2)(b), that a section 37/41 order is the most suitable method of disposing of the case.

In relation to the first three of the four matters mentioned in [51] of the judgment in Vowles,

Mr Fitzgerald submits that the applicant has a lifelong need for intensive specialist treatment, that the offence was to a significant extent attributable to her mental disorder and that the need for punishment has been more than fulfilled by the many years which the applicant has spent in prison or detained in hospital. It is further submitted that a return to prison, and even the destabilising effect of the risk of recall to prison post-release, would be likely to undermine the applicant's rehabilitation.

Recognising that the fourth factor may be the most contentious in the circumstances of this case, Mr Fitzgerald submits that a section 37/41 order is likely to provide better protection for the public than release on licence. The risk of reoffending is closely linked to the applicant's mental state, and therefore the effective monitoring and treatment of her disorders is the most important factor in protecting the public. In that regard, he submits that the mental health pathway has significant advantages: in particular, it can impose strict conditions as to medication, which the Parole Board would not have the power to direct. It is the only regime which can guarantee that a consultant psychiatrist and a social worker or psychiatric nurse would be involved in the applicant's care post-release. Any deterioration in her mental condition would quickly be observed by the specialist working with the applicant in the community, and under a section 37/41 order, she could speedily be recalled to hospital if necessary. Furthermore, release on licence could not achieve the gradual and supported transition to the community which is necessary in the applicant's case.

Mr Mably QC accepts on behalf of the respondent that if the fresh evidence is received by this court, and is found to show that the applicant's mental condition was at the time of sentence different from what the judge believed it to be, then the court would have the power to allow the appeal if it concluded, in accordance with section 11(3) of the 1968 Act

that the applicant should be sentenced differently. He questions, however, whether there is any material difference between the state of the applicant's mental health as shown by the evidence available to the judge, and that shown by the fresh evidence. He submits that the judge regarded the applicant as unlikely to engage with any treatment and for that reason regarded any attempts at treatment as likely to fail. If the position has subsequently changed, Mr Mably submits, that reflects a change in the applicant's willingness to engage with treatment, which is not something which could provide a ground of appeal against sentence.

As to the matters mentioned at [51] in Vowles, Mr Mably accepts that the applicant continues to require treatment and that her offending was to a significant extent attributable to her mental disorder. Her offence was serious and punishment was clearly necessary, but Mr Mably acknowledges that she has served the minimum term which was the period intended to impose appropriate punishment. He submits that the protection of the public is an important factor, and the fresh evidence shows that the applicant continues to present a risk to others. Before considering the post-release regime, therefore, it is necessary first to consider whether it is safe to release the applicant. That decision should be taken by the Parole Board rather than by clinicians focused on the applicant's mental health. Mr Mably further submits that if the applicant is released under a section 37/41 order, those supervising her will be assessing her purely from a mental health perspective and not by reference to issues of wider concern. He therefore questions whether a section 37/41 order can be considered the most suitable disposal in all the circumstances.

We are grateful to counsel for their submissions. Having reflected on them, we reach the following conclusions.

We are satisfied that the written evidence of Dr Roy, and the written and oral evidence of

Dr Went and Dr Nwogwugwu, satisfies the criteria in section 23(2) of the 1968 Act. Their evidence is clearly capable of belief. It may afford a ground for allowing this appeal. It would have been admissible in the proceedings below. There is a reasonable explanation for the failure to adduce it below, in that the beneficial result describing Clozapine for this applicant was not then known. We receive that fresh evidence. It is unnecessary to make any decision as to whether any of the other medical reports should be received. We decline to receive as evidence the decisions of the First-tier Tribunal.

We are satisfied that the judge sentenced in the belief that the applicant's mental disorder was inherently untreatable. That was the view unanimously expressed by the psychiatrists in the reports which were provided to the judge. The judge rejected the suggestion in oral evidence that a hospital order may be appropriate, on the basis that the doctor concerned may well have been misled by a pretence of co-operation on the part of the applicant. Having done so, the judge was left with the written evidence which showed the applicant's mental health problems to be untreatable.

In accordance with the principles stated in Cleland, we accept that the fresh evidence establishes that the mental disorder from which the applicant suffers is treatable and was treatable at the time of sentence. The judge can therefore now be seen to have fallen into error in sentencing on the basis that the disorder was inherently untreatable. The fresh evidence further establishes that the mental disorder is of a nature which makes it appropriate for her to be detained in a hospital for medical treatment and that appropriate medical treatment is available for her. We therefore accept that the conditions set out in section 37(2)(a) of the Act are satisfied.

We must accordingly consider whether the applicant should be sentenced differently for the offence. That requires us to consider, in accordance with section 37(2)(b) of the 1983

Act, whether in all the circumstance a hospital order is the most suitable method of disposing of the case.

Following the approach set out in Vowles and considering the first three of the four factors mentioned at [51] of the judgment in that case, our views are as follows:

- i) The applicant requires treatment and will do so for the rest of her life. Because of her learning disability she has limited insight into her condition, and therefore cannot be relied upon to comply with her medication unless closely monitored and supported. She currently needs treatment in hospital. She is able to receive appropriate treatment in hospital whether she is serving her life sentence or is subject to a section 37/41 order. Under the former regime however, she faces the possibility of a transfer back to prison. The medical evidence shows that would be likely to undo much of the progress that she has made and that the continuing possibility of a return would of itself increase the applicant's level of anxiety and therefore have an adverse impact on her care.

- ii) In view of the evidence which resulted in the acceptance of the applicant's guilty plea to manslaughter, we are satisfied that her mental disorder contributed to a significant degree to her commission of the offence.

- iii) It was a very serious offence, but the punitive element of the life sentence has been served and the applicant has been detained either in custody or in hospital for more than three times the length of her minimum term. Moreover, a sentence under section 45A of the 1983 Act was not available to the judge and so is not available to us. In those circumstances we are satisfied that there are "sound reasons" why it is not now necessary to impose a penal sentence.

The fourth factor, namely the protection of the public, is therefore of particular importance to our decision as to the most appropriate sentence. In that regard the following considerations are, in our view, significant.

First, the applicant has benefited greatly from the expert care and treatment she has received and the prescription of Clozapine has very substantially reduced the incidents of violence or aggressive behaviour on her part. It cannot, however, be said that she has been or ever will be "cured". As Dr Went says, she remains highly vulnerable to relapse in the context of stresses. Moreover, she is easily led by others and lacks insight into her condition. Her return to inhalant abuse, involving a degree of cunning in getting round the steps which had been taken to stop her buying products, is a worrying feature of her recent history. She accordingly continues to present risks to herself and others. Continuing monitoring and maintenance of her medication will remain essential to the management of those risks.

Secondly, we see force in Mr Mably's point that under the present life sentence, the decision as to whether the applicant can be released on licence will be taken by the Parole Board, which will be able to consider a range of factors including in particular the safety of the public. In contrast, if a section 37/41 order is made, the decision as to discharge into the community will primarily be taken by doctors whose focus will, understandably, be on the mental health and the welfare of their patient, and who may not be able to give appropriate weight to the safety of the public. As against that, however, the evidence shows that any decision as to conditional discharge from a section 37/41 order, will be taken by the First-tier Tribunal, and the Ministry of Justice would in principle be able to make representations to the Tribunal as to whether it was safe to discharge the applicant.

Thirdly, we accept that any transition into the community will have to be gradual and

carefully-managed. That will be possible under a section 37/41 order. It will be difficult if not impossible under the life sentence, because there would be a stark choice between release on licence or continuing detention.

Fourthly, we accept that if granted conditional discharge from a section 37/41 order the applicant will receive more extensive care, support and supervision than could be guaranteed if she were released on licence from her life sentence. Supervision in the community, pursuant to a section 37/41 order will be made by those with particular expertise in treating her mental disorder working in conjunction with the relevant MAPPA. There is a greater prospect that signs of a deterioration in her mental condition post-release will be picked up at an earlier stage and effectively addressed by a speedy return to hospital, rather than by a return to prison which is likely to undo much of the improvement in the applicant's condition. If released on licence, in contrast, she will be supervised by the Probation Service and a breach of her licence conditions might well result in her being returned to prison, which will be likely to have adverse consequences for her mental health. By virtue of section 117 of 1983 Act, where a person who has been detained in hospital pursuant to a hospital order ceases to be so detained and leaves hospital, the local Clinical Commissioning Group or Local Health Board, and the local Social Services authority, are under a duty to co-operate with other relevant agencies and to provide aftercare services. There is no corresponding statutory duty where a prisoner is released on licence and there is therefore less certainty as to whether specialist medical supervision and care will be provided.

In addition, and most importantly, the conditions which may be attached to conditional discharge from a section 37/41 order will make it possible to require the applicant to maintain appropriate medication, which could not be made a condition of a release from prison on

licence.

We regard these considerations as finely balanced. We are however satisfied that the risk to the public arises from the applicant's mental disorder and that the appropriate management of her disorder is accordingly the key factor in reducing that risk. For that reason, a decision as to conditional discharge from a section 37/41 order, though focused on the patient, will also reflect the interests of the public. Post-release, the making of a section 37/41 order will in practice ensure better monitoring of the applicant's condition and better maintenance of her medication than would be achieved if she were released on licence from her life sentence.

We are therefore persuaded that in all the circumstances a section 37/41 order is the most suitable form of disposal. For those reasons we grant the necessary extension of time. We grant leave to appeal against sentence. We allow the appeal and quash the sentence of life imprisonment. We substitute for it a hospital order and restriction order under sections 37 and 41 of the Mental Health Act 1983.

Epiq Europe Ltd hereby certify that the above is an accurate and complete record of the proceedings or part thereof.

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