IN THE COURT OF APPEAL
CRIMINAL DIVISION

Royal Courts of Justice
The Strand London WC2
3 May 1989

B e f o r e:

LORD JUSTICE MUSTILL

MR JUSTICE SAVILLE

and

MR JUSTICE MCKINNON

R E G I N A

-v-

BEULAH BIRCH

Nemone Lethbridge (assigned by the Registrar of Criminal Appeals) appeared on behalf of the **Appellant**.

Timothy Langdale appeared on behalf of the **Crown**.

Hearing dates: 7 March 1989 and 3 May 1989

MUSTILL LJ:

1. On 4 August 4 1988, in the Crown Court at Southwark, Beulah Birch pleaded not guilty to a charge of murder but guilty to manslaughter on the ground of diminished responsibility. The plea was acceptable to the prosecution and to the judge (His Honour Judge Butler QC). After hearing evidence and submissions, the learned judge made a hospital order, coupled with a restriction order under section 41 of the Mental Health Act 1983 without limitation of time.

2. The appellant now appeals against the restriction order by leave of the single judge.

3. This is a difficult case which raises a number of issues, some of which have not been discussed in any reported case, and since we shall have to express opinions upon them in the context of this appellant's individual circumstances, we shall summarise the facts and medical evidence at greater length than would ordinarily be appropriate.

4. The appellant, who is 47 years of age, was born and raised in Jamaica. At the age of 19 she married and went to live in Canada. During 1970 the appellant was twice admitted for in-patient treatment at a psychiatric hospital, on each occasion after taking an overdose of drugs. The first incident was associated with excessive drinking. Judging by the reports there were doubts about the seriousness of these apparent attempts at suicide, although she spoke of several previous suicide attempts. Eventually the marriage broke down, according to the appellant because she left her husband in consequence of his infidelity.

5. The appellant then moved to Germany, where in 1974 she formed a relationship with Paul Birch, a British soldier 12 years younger than herself, whom she subsequently married. For much of the time the marriage seems to have been difficult. According to the appellant her husband was feckless and prone to heavy drinking. There appear to have been two widely spaced incidents of physical violence between the couple, the details of which are not known. Eventually the husband bought himself out of the Army and the appellant found him a job in Kingston-upon-Thames, where she set up her own business as a hairdresser.

6. It is plain that both the marriage and the appellant's mental condition went seriously downhill during 1986 and 1987. The husband took up with a woman named Carol, of whom the appellant was intensely jealous. The appellant's depressive condition became worse, and her general practitioner prescribed medication, although he suspected that she did not take it regularly. Her consumption of alcohol increased. She quarrelled with her husband about money as well as his unfaithfulness, and during a particularly violent episode she struck him on the head with a bottle, inflicting a wound which had to be stitched.

7. On the following day she was admitted to hospital with a self-inflicted injury to her wrist. By June 1987 her condition was such that her doctor felt (according to a statement made after the event) that things were coming to a head between herself and her husband, but that it was much more likely that the appellant would do harm to herself than her husband. Be that as it may, it is plain in retrospect that the appellant was preparing herself for an act of violence. She succeeded in obtaining a shotgun and two cartridges from some illicit source with a view (so she afterwards said) to committing suicide. At some time – it is impossible to know whether before or after she bought the gun – the barrel was shortened. The doctor thought that she was building up a stock of medicaments with a view to suicide. She began uttering to her friends a series of threats directed towards Carol, her husband and herself.

8. On 25 August 1987, matters reached a crisis. During the previous evening she had made a long and rambling tape recording, the gist of which (so far as it is possible to make sense of it) was that she intended to commit suicide and to take her husband with her: although it is a feature of the tape that she spoke of her husband as if he were already dead. It may be noted that she spoke on the tape of having taken Paul's life because of the way in

which he had treated her, and that "It was the greatest pleasure I have ever had in my entire life, pulling that trigger."

9. The appellant spent part of 25 August in drinking. She also conceived a plan to lure the husband to her flat – by now the two were living apart – by keeping the keys to the family car instead of leaving them for him so that he could use the car after work, as was the usual practice. In company with a friend she waited for the husband to arrive so that, as she told the friend, she could compel him to talk about bills that were not being paid; and for this purpose (again according to her own account) she took out the shotgun so that she could show him that she meant business. It was arranged that the friend would lock the door to prevent him from getting out.

10. As contemplated, the husband did arrive at the flat to collect the keys and the friend did leave, locking the door behind her. Not long afterwards she heard a shot. The police were called, and arrived after the appellant had been alone in the flat with the husband for some 10 or 15 minutes. They called out and heard the husband calling for help. On forcing an entry they found the husband lying on his back on the floor of the living room, with the appellant astride him. Both were screaming. Between their two bodies was a knife which had been the source of five wounds to the husband's chest, one of them 9 cm deep, and several superficial wounds.

11. The husband had severe injuries to the left thigh, caused by a shot at a range of about three feet. Subsequent investigation showed that this resulted from an upward shot, fired when the husband was on or near the top of the stairs. In some way he must afterwards have dragged himself, or been dragged, into the living room. The appellant herself had a gunshot wound in her shoulder. She was saying that: "He tried to kill me, so I stabbed him," but also: "I shot him, I wanted to blow his balls off."

12. The husband soon afterwards succumbed to shock and haemorrhage. The gunshot wound and the knife wounds would each have been sufficient to cause death. Subsequently, in the course of long and difficult interviews with the police, the appellant gave a number of accounts of what had happened, some consistent with an accident, others with acts done in self-defence; and she asserted that the injury to her shoulder was caused by a shot fired by the husband as he lay on the ground in the living room.

13. We now turn to the medical evidence before the Crown Court which came from four sources.

14. First, there was a report from Dr NA Hindson, Senior Medical Officer at HM Prison, Holloway, where the appellant had been kept throughout her 12 months of remand: a doctor approved under section 12(1) of the Mental Health Act 1983. Dr Hindson had familiarised himself with the witness statements as well as the appellant's own account of events. He expressed the view that the appellant had a premorbid personality with histrionic traits, and that she suffered from diminished responsibility at the material time in the shape of depressive illness.

15. He also stated that in his opinion:

> The defendant requires continued psychiatric treatment and it is appropriate that such treatment be given under formal powers of the Mental Health Act 1983 and

> recommendations are included should the Court make such an order (sec. 37). Treatment is offered by Dr. Holton, on Addison Ward, Long Grove Hospital. I do not feel that she constitutes a danger to the public or represents a serious threat to absconding and so would commend such a placement to the Court.

16. The second report was from Dr EL Udwin, Regional Consultant Forensic Psychiatrist, an approved practitioner under section 12 . His conclusion was that the appellant was suffering from mental illness within the meaning of the Act, of a nature or degree which made it appropriate for her to be detained in a hospital for medical treatment. The doctor gave as his reason for concluding that detention was appropriate: "She remains depressed to the point of being a substantial suicide risk. The matter is complicated by her 'wry facade' of denial – and lack of insight."

17. The third report was from the general practitioner. After an account of her clinical history, he stated that: "I am quite sure that had she not been as ill as she was she would not have harmed her husband."

18. Finally, there was a detailed report by Dr Anthony Holton, another Consultant Psychiatrist approved under section 12. His opinion was based on an interview with the appellant, discussions with the doctors at Holloway Prison and with her general practitioner, and on a study of at least some of the papers. The report concludes with a formal statement of the various preconditions of an order under section 37 of the Act and with an offer of a bed for the appellant on Addison Ward at Long Grove Hospital, Epsom.

19. In the body of the report Dr Holton said:

> The offence with which Mrs Birch is now charged arises as a result of her own mental state and behaviour but the contribution of her husband is by no means insignificant and, for this reason, provided Mrs Birch does not get into a similar situation again, I do not feel that repetition is likely and I do not feel that Mrs Birch is a risk to the general public.

20. It was on this evidence that the pleas which we have mentioned were tendered and accepted. The result was that the circumstances of the victim's death, of which the appellant was the only living witness, and which were obscured by the appellant's poor recollection and quite possibly by some degree of prevarication, were never explored in evidence. The facts were opened on behalf of the Crown in terms of a premeditated killing, planned for some time and actuated by jealousy. On this view the first gunshot wound was deliberate and unprovoked; the injuries were inflicted with the knife over a substantial period of time; and the injury to the appellant was self-inflicted.

21. The defence had come prepared with an expert's report, the effect of which was that there were reasons for doubting whether the prosecution's account of events could be reconciled with the known facts, including the trajectory of the shotgun pellets, and the location of the wounds and the resulting bloodstains. Miss Lethbridge, who represented the appellant, could not of course suggest that there was any material justifying a defence of accident or self-defence (although one of the expert's reports made use of that expression), but the submission was that the appellant's conduct, whilst deeply serious, was by no means as bad as the prosecution had sought to make out.

22. Miss Lethbridge then called Dr Holton, whose report had of course already been studied together with the other medical evidence by the learned judge. In essence he repeated the views already expressed, and added some information about the locked ward to which he proposed that the appellant should be admitted. He also said this:

> I feel that the offence that took place was a combination of her state at the time and relationship at the time. Unless she has a similar relationship combined with a similar mental state she would not be a danger to the general public.

23. The learned judge then very properly pressed Dr Holton about this answer and said that as regards the general public the opinion that the appellant would not be a danger might be right, but that he was concerned about the danger to the girlfriend. The doctor replied that it was hard to comment, not having spoken to the appellant about her feeling towards the girlfriend. There followed a discussion between the judge and counsel in the course of which the judge made it clear that he would make a restriction order under section 41 unless persuaded that it was impracticable from the hospital's point of view, in which case he would have to reopen the whole matter. Although the judge did not say so, he was plainly indicating that the alternative was a sentence of life imprisonment. At this point Miss Lethbridge prudently ceased to oppose an order under section 41. We are satisfied that in the circumstances she had no alternative and that she is not now precluded from maintaining that such an order was wrong.

24. The learned judge then proceeded to make a hospital order and also made a restriction order without limitation of time, giving the following reasons:

> I do so because quite apart from your history of mental illness, this was a serious offence of violence carried out with some degree of premeditation. Nor can I rule out – indeed I must take into account – the risk of you committing further offences of violence.

25. The appellant thereupon sought leave to appeal against the restriction order. For this purpose a further report was prepared by Dr Holton, who had by now been in charge of the appellant's stay at Long Grove Hospital for several months. This gave a picture of substantial improvement, and also dealt specifically with the restriction order in relation to the two factors mentioned by the judge.

26. As to the violence of the offence, Dr Holton repeated the opinion that the offence resulted from a combination of a depressive illness from which she had been suffering for some months; the difficulty of her matrimonial relationship; and her abuse of alcohol and tranquilising medication. He continued:

> I do not believe that she is a violent person who is prone to causing other people harm and I do not feel there is a likelihood of her committing further offences if set at large unless similar circumstances arise.

27. As to the risk to the girlfriend, Dr Holton said that it appeared that the appellant did not harbour any malice towards her. This further report concluded:

> It is always difficult to predict the risk of somebody committing further offences. However, in view of the exceptional circumstances which surrounded the offence, and the way in which Mrs Birch talks about these things now, I do not feel there is much

risk of further offending and I would therefore support her appeal against the Restriction Order.

28. When the appeal came on for argument Dr Holton was in attendance at the suggestion of the single judge, and told us of developments during the further three months which had elapsed since his latest report. We were grateful for his assistance, and wish to make it clear that although Dr Holton had a proper concern for the welfare of his patient, he was also fully sensible of the public interest in avoiding premature release. Dr Holton explained that the appellant's condition had continued to improve, and that with the consent of the Secretary of State she had on more than one occasion been allowed to leave the hospital either with a nurse escort or in the company of friends.

29. In response to questions from the Court Dr Holton repeated what he had previously said about the origins of the offence, adding that in his opinion the appellant did not create a general risk of violence, in the sense that if discharged she was liable to go out and start assaulting somebody. As to the girlfriend Dr Holton thought it very unlikely that she was in danger. If the Court were to lift the restriction order, the appellant would not immediately be discharged, but would remain in hospital for "a number of months."

30. These are the facts and opinions in the light of which we must consider the appellant's single ground of appeal: "The learned judge erred in making a restriction order under section 41 Mental Health Act 1983 when there was no evidence that the appellant posed a threat to public safety and three doctors had argued in clear terms to the contrary."

31. Since this ground of appeal raises difficult questions of principle, we invited the attendance of counsel for the Crown. We are indebted to Mr. Langdale for his helpful submissions.

The Statutory Framework

32. The Mental Health Act 1959 brought about a revolution in the treatment of mentally disordered offenders. The philosophy of that Act and of its successor has been to assimilate the position of an offender subject to a hospital order without restriction on discharge to that of a civil patient compulsorily admitted and detained pursuant to what is now section 3 of the 1983 Act. Thus, for example, two of the three conditions which must be satisfied before an offender can be admitted and detained in hospital, either because he is sent there directly by a criminal court under section 37 or because he comes from prison pursuant to a transfer direction by the Secretary of State under section 47, are the same as those which apply to the compulsory admission of a civil patient under section 3, namely: (1) he must suffer from mental illness, severe mental impairment, psychopathic disorder or mental disorder (which we will call "the four disorders"), and (2) in the case of the two last-mentioned of the four disorders, the proposed medical treatment must be likely to alleviate or prevent a deterioration of his condition.

33. Only as regards the third condition which must be satisfied does the position of the disordered offender differ from that of his civil fellow-patient. For the latter, it must be shown that treatment is necessary for his health or safety or for the protection of other persons and that it cannot be provided unless he is detained. In the case of an offender, the discretion is wider. Under section 37 the Court must consider whether, 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, "the most suitable" method of disposing of the case is to make a hospital order. Under section 47 the Secretary of State must consider before making a transfer direction whether, having regard to the public interest and all the circumstances, "it is expedient so to do".

34. Once the offender is admitted to hospital pursuant to a hospital order or transfer order without restriction on discharge, his position is almost exactly the same as if he were a civil patient. In effect he passes out of the penal system and into the hospital regime. Neither the Court nor the Secretary of State has any say in his disposal. Thus, like any other mental patient, he may be detained only for a period of six months, unless the authority to detain is renewed, an event which cannot happen unless certain conditions, which resemble those which were satisfied when he was admitted, are fulfilled. If the authority expires without being renewed, the patient may leave. Furthermore, he may be discharged at any time by the hospital managers or the "responsible medical officer". In addition to these regular modes of discharge, a patient who absconds or is absent without leave and is not retaken within 28 days is automatically discharged at the end of that period (s18(5)) and if he is allowed continuous leave of absence for more than six months, he cannot be recalled (s17(5)).

35. Another feature of the regime which affects the disordered offender and the civil patient alike is the power of the responsible medical officer to grant leave of absence from the hospital for a particular purpose, or for a specified or indefinite period of time: subject always to a power of recall (except as mentioned above).

36. There are certain differences between the positions of the offender and of the civil patient, relating to early access to the Review Tribunal and to discharge by the patient's nearest relative, but these are of comparatively modest importance. In general the offender is dealt with in a manner which appears, and is intended to be, humane by comparison with a custodial sentence. A hospital order is not a punishment. Questions of retribution and deterrence, whether personal or general, are immaterial. The offender who has become a patient is not kept on any kind of leash by the Court, as he is when he consents to a probation order with a condition of inpatient treatment. The sole purpose of the order is to ensure that the offender receives the medical care and attention which he needs in the hope and expectation of course that the result will be to avoid the commission by the offender of further criminal acts.

37. In marked contrast with the regime under an ordinary hospital order, is an order coupled with a restriction on discharge pursuant to section 41. A restriction order has no existence independently of the hospital order to which it relates; it is not a separate means of disposal. Nevertheless, it fundamentally affects the circumstances in which the patient is detained. No longer is the offender regarded simply as a patient whose interests are paramount. No longer is the control of him handed over unconditionally to the hospital authorities. Instead the interests of public safety are regarded by transferring the responsibility for discharge from the responsible medical officer and the hospital to the Secretary of State alone (before 30 September 1983) and now to the Secretary of State and the Mental Health Review Tribunal. A patient who has been subject to a restriction order is likely to be detained for much longer in hospital than one who is not, and will have fewer opportunities for leave of absence.

38. Under the Act of 1959 the power of the court and the Secretary of State had the following features in relation to a restriction order. Before the order could be made, first, the court was required to have regard to: (a) the nature of the offence, (b) the antecedents of the offender and (c) the risk of his committing further offences if at large. For some reason the second factor related, and still relates, only to the antecedents of the offender, and not to his character and antecedents, as in the case of the conditions for a hospital order. Secondly, the court had to decide, in the light of these factors, whether it was necessary for the protection of the public to order that the offender should be subject to special restrictions.

39. The effect of a restriction order was essentially that the responsibility for the return of the patient to the community was transferred from the hospital authorities to the Secretary of State. He alone could consent to leave of absence, and decide to recall the patient from such leave. If the patient went absent without leave, the automatic discharge for prolonged absconders did not apply. Neither did the provisions for expiry and renewal of the authority to detain, so that the patient could not be discharged whilst the restriction order remained in force: and the power to lift the restriction was vested in the Secretary of State. The nearest relative could not procure the discharge of the patient. The Review Tribunal could advise the Secretary of State, but not procure the release of the patient.

40. Although the regime created by section 65 of the 1959 Act was often regarded as a merciful alternative to imprisonment, it was not always so regarded by the patient, and as a result of criticisms and the decision of the European Court of Human Right in *X v United Kingdom* (1981) 4 EHRR 188 it was modified by the 1983 Act in two fundamental respects, designed to make a restriction order less readily available, and to enlarge the opportunities for the patient to obtain his discharge.

41. The first effect of the 1983 Act was to modify the criterion for imposing a restriction order, so that an order under section 41 can now be made only if it appears to the court that such an order is "necessary for the protection of the public *from serious harm*". We return to the effect of this important change at a later stage.

42. Secondly, the Mental Health Review Tribunal, which previously tendered advice to the Secretary of State in relation to restricted patients and in particular with regard to their discharge, was given a power on its own account to discharge such patients which operates in parallel with that of the Secretary of State. It is important to note that the powers of the Tribunal involve no element of discretion. The Tribunal is required simply to ascertain whether certain conditions are satisfied. If they are, the Tribunal must act in a particular way; if they are not, it must not so act.

43. There remain the terms on which the patient is discharged. If the Tribunal is satisfied that it is not appropriate that the patient remains liable to be recalled to hospital for further treatment, it must discharge the patient absolutely: section 73(1). The hospital order then falls away, taking the restriction order with it (s73(2)), and the patient is completely at liberty. But if this further condition is not satisfied the patient must be discharged conditionally, in which case he remains liable to be recalled to hospital by the Secretary of State and must abide by any conditions imposed by the Tribunal or the Secretary of State.

44. As we have said, the powers of the Review Tribunal over restricted offenders operate in parallel with those of the Secretary of State who retains the right himself to discharge the patient and to terminate the restriction.

45. The position of a prisoner transferred to hospital from prison is different. If the transfer direction under section 47 is coupled with a restriction direction by the Home Secretary under section 49 (as in practice it usually is), the offender's position is in many ways the same as if he had been sent straight to hospital with orders under sections 37 and 41, but the following special provisions apply: (1) Where the offender was sentenced to a fixed term of imprisonment, the restriction will automatically lift on the expiry of his sentence (allowing for remission): section 50(2). (2) Where the responsible medical officer or the Review Tribunal concludes that the offender no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given, the Secretary of State may – (a) release him on parole (if he is eligible), (b) return him to prison to serve out his sentence, or (c) take no action.

Principles to be applied

46. Against this statutory background we turn to the issue raised on the appeal.

47. The question most directly raised by the single ground of appeal is this: Did the judge in the Crown Court have jurisdiction to make an order under section 41, where those doctors who expressed an opinion on the matter were unanimous that the appellant was not dangerous? It is in our judgment quite clear that the answer is "Yes". There is a contrast between the language of section 37(2) and 41(1) and (2). Before a hospital order can be made, the court must be satisfied of the stated conditions "on the written or oral evidence of two practitioners". But where a restriction order is in question, section 41(2) requires no more than that the court shall hear the oral evidence of one of the medical practitioners. It need not follow the course which he recommends. Section 41(1) makes the assessment of the risk, in the light of the factors there identified, one for the court. In our judgment *Blackwood* (1974) 59 Cr App R 170 and *Royse* [1981] Crim LR 426 are just as good law under the 1983 Act as they were under the earlier statute.

48. It might be suggested that *Courtney* (1988) 9 Cr App R (S) 404 points the other way. We do not agree. That was a case of the not uncommon type where a husband suffering from depressive illness, with no background of violence, killed his wife in the course of a quarrel, as a result of a brief loss of control. The gist of the evidence, as we understand it, was that the appellant had only been a momentary danger to one person, namely his wife, and that he had in effect rid himself of all dangerous tendencies by killing her. In those circumstances there was nothing to suggest to the court that a restriction order was necessary. But we do not read the judgment as deciding that the views of the doctors foreclose the decision which the court has to make under section 41(1).

49. In these circumstances in a case involving a degree of mental disorder the judge has available to him a variety of options, which he may conveniently approach in the following order.

50. First, he should decide whether a period of compulsory detention is apposite. If the answer is that it is not, or may not be, the possibility of a probation order with a condition

of in or outpatient treatment should be considered. We say no more about this here, since nobody has suggested that such an order would be appropriate for Mrs. Birch.

51. Secondly, the judge will ask himself whether the conditions contained in section 37(2)(a) for the making of a hospital order are satisfied. Here the judge acts on the evidence of the doctors. If left in doubt, he may wish to avail himself of the valuable provisions of sections 38 and 39 (which are not used as often as they might be) to make an interim hospital order, giving the court and the doctors further time to decide between hospital with or without restrictions and some other disposal, and to require the Regional Health Authority to furnish information on arrangements for the admission of the offender. If the judge concludes that the conditions empowering him to make an order are satisfied, he will consider whether to make such an order, or whether "the most suitable method of disposing of the case" (s37(2)(b)) is to impose a sentence of imprisonment.

52. Finally, he should consider whether the further condition imposed by section 41(1) is satisfied. If it is, then he may make a restriction order; but he is not obliged to do so, and may again consider sending the offender to prison, either for life or for a fixed term (*Speake* (1957) 41 Cr App R 222, a pre-1959 case which we believe to be still good law). If he does decide on a restriction order, he must then choose between an unlimited order, or one for a fixed term.

53. The third stage often presents the judge with a difficult decision, which has not been made any easier by the important changes in the law in 1983. He is required to choose between an order without restrictions, which may enable the author of a serious act of violence to be at liberty only a matter of months after he appears in court, and a restriction order which may lead the offender to be detained for a long time: longer in some cases than the period which he would serve if sent to prison: see *Haynes* (1981) 3 Cr App R (S) 330. It is moreover a choice which depends on a prognosis, the ultimate responsibility for which is left with the judge.

54. This responsibility may be hard to discharge, since the judge will often have nothing on which to base his decision, if he feels reservations about the medical evidence, apart from the considerations stated by the statute, namely the nature of the offence and the antecedents of the offender: which will often consist only of a single episode of fatal violence and a blank criminal record. Where there is a trial the judge can form an impression of the defendant as the case unfolds which may enable him to make his own assessment of his dangerousness. But in the more usual case where a plea of guilty to manslaughter on the grounds of diminished responsibility is accepted by the prosecution and the court, this opportunity is largely absent, and did not exist at all in the present case, where the appellant was too distressed to remain for the hearing in the Crown Court. Nor have we seen her, since she elected not to be brought up for the appeal.

55. Nevertheless, section 41(1) is there and the judge must apply it. Quite plainly the addition of the words "from serious harm" has greatly curtailed the former jurisdiction to make a restriction order: most particularly because the word "serious" qualifies "harm" rather than "risk". Thus the court is required to assess not the seriousness of the risk that the defendant will re-offend, but the risk that if he does so the public will suffer serious harm. The harm in question need not, in our view, be limited to personal injury. Nor need it relate to the public in general, for it would in our judgment suffice if a category of

persons, or even a single person, were adjudged to be at risk: although the category of person so protected would no doubt exclude the offender himself. Nevertheless the potential harm must be serious, and a high possibility of a recurrence of minor offences will no longer be sufficient.

56. Thus we do not consider that cases such as *Smith* (1974) Current Sentencing Practice, F.2.4(b), *Toland* (1973) *ibid*. F.2.4(c) (appellant was a recidivist young burglar, described as "an anti-social person … a pest") and *Eaton* (1975) *ibid*. T.4(d) (restriction order on appellant with behavioural difficulties, who had broken two panes in a telephone kiosk), would be decided the same way under the new legislation in the absence of special factors. This was, as it seems to us, precisely the result which the 1983 Act was intended to achieve.

57. *Khan* (1987) 9 Cr App R (S) 455 was, if we correctly understand the facts, a case where the offences themselves, whilst not of great gravity, included reckless driving of a very bad nature by a very disturbed young man with a megalomaniac approach to his driving prowess which, if repeated, would create a risk of serious harm to the public. We pause to note that there is nothing in the Act which requires a causal connection between the offender's mental state and what the professionals call the "index offence". It is sufficient for section 41 that the defendant is a convicted offender, and that the conditions of section 41 are satisfied: see *Hatt* [1962] Crim LR 647.

58. It would however be a mistake to equate the seriousness of the offence with the probability that a restriction order will be made. This is only one of the factors which section 41(1) requires to be taken into account. A minor offence by a man who proves to be mentally disordered and dangerous may properly leave him subject to a restriction. In theory the converse is also true. *Courtney* (*supra*) shows that a serious offence committed by someone who is adjudged to have a very low risk of re-offending may lead to an unrestricted hospital order.

59. Nevertheless, the Court will need to be very sure of its ground in such a case, and we consider that there is nothing in the 1983 Act to derogate from the following statement of principle by Lord Parker CJ in *Gardiner* (1967) 51 Cr App R 187, 192, [1967] 1 WLR 464, 469:

> Thus, for example, in the case of crimes of violence, and of the more serious sexual offences, particularly if the prisoner has a record of such offences, or if there is a history of mental disorder involving violent behaviour, it is suggested that there must be compelling reasons to explain why a restriction order should not be made.

60. In this connection we should mention the possible effect on the judge's discretion of the fact that the restricted patient may now be released, through the medium of the Review Tribunal, earlier than he might have been under the former regime. On the argument of the present appeal, counsel were disposed to agree that the judge should leave this out of account; just as, when sending an offender to prison or to detention under section 53(2) of the Children and Young Persons Act 1933, he should concentrate on fixing the right terms, without allowance for the possibility that through parole or executive action by the Home Secretary the offender might be released before the expiry of such term.

61. At the time we were inclined to agree, but now we are not so sure. We are not here concerned with a free discretionary release acting upon a term fixed judicially, but rather with a judicial decision by the Mental Health Review Tribunal based on statutory norms, co-existing with the Secretary of State's discretion. When weighing up the respective merits of prison and hospital, and of restricted and unrestricted hospital orders, we see no reason why the practical effect of all the orders which the Court might be contemplating should not be taken into account: and the Review Tribunal's powers have an important effect in minimising the starkness of the practical difference between restricted and unrestricted orders, and in qualifying the relative merits, so far as public safety is concerned, of hospital and prison, with or without a subsequent transfer under section 47.

62. Since we have mentioned a prison sentence as one of the options, it is convenient to deal with this now, because it is perhaps an option which requires closer attention that it did before the 1983 Act. We may do so quite briefly.

63. Nobody in the present case considered a medium fixed-term prison sentence. The possibility of a life sentence was, it is true, hinted at in the Crown Court. But we could not properly substitute such a sentence on this appeal since – (i) it is at least doubtful whether we would have the power to do so under section 11(3) of the Criminal Appeal Act 1968 (see, in the converse situation, *Bennett* (1968) 52 Cr App R 514, [1968] 1 WLR 988 and *Gardiner* (*supra*); and (ii) the appellant is plainly getting better in hospital, and it would do no service to the offender, the prison authorities or society at large to send her back to Holloway.

64. For present purposes it is, we believe, sufficient to note that the choice of prison as an alternative to hospital may arise in two quite different ways: (1) If the offender is dangerous and no suitable secure hospital accommodation is available. Here the judge will be driven to impose a prison sentence, see section 37(4) and *Jones* (1976) Current Sentencing Practice, F2.3(b). (2) Where the sentencer considers that notwithstanding the offender's mental disorder there was an element of culpability in the offence which merits punishment. This may happen where there is no connection between the mental disorder and the offence, or where the defendant's responsibility for the offence is "diminished" but not wholly extinguished. That the imposition of a prison sentence is capable of being a proper exercise of discretion is shown by *Morris* (1961) 45 Cr App R 185, [1961] 2 QB 237 and *Gunnell*. Nevertheless the more recent decision in *Mbatha* (1985) 7 Cr App R (S) 373 strongly indicates that even where there is culpability, the right way to deal with a dangerous and disordered person is to make an order under sections 37 and 41.

65. In the absence of any question of culpability and punishment, the judge should not impose a sentence of imprisonment simply to ensure that if the Review Tribunal finds that the conditions under section 73 are satisfied and is therefore constrained to order a discharge, the offender will return to prison rather than be set free: *Howell* (1985) 7 Cr App R (S) 360 and *Cockburn* (1967) 52 Cr App R 134.

66. Finally we would make two further points on section 41. First, the sentencer should not impose a restriction order simply to mark the gravity of the offence (although this is an element in the assessment of risk), nor as a means of punishment: for a restriction order merely qualifies a hospital order and a hospital order is not a mode of punishment. Secondly, the observations of Lord Parker CJ, in *Gardiner* (*supra*) as to the imprudence

in any but the most exceptional case of imposing a restriction for a fixed period rather than for an unlimited period still hold good under the 1983 Act: *Haynes* (1981) 3 Cr App R (S) 330.

67. How does the defendant's appeal stand in the light of these principles? The possibility of a determinate prison sentence was not canvassed. Such a sentence will on occasion be an alternative to a hospital order which the judge must consider: but this is clearly not such a case. The learned judge in the present case does seem to have had a life sentence at the back of his mind, as an alternative to a hospital order without a section 41 order, perhaps because the doctors did not favour such an order. We do not think this could have been the right course. If the judge was satisfied that the appellant was dangerous enough to warrant an inhibition on her release, the right course would be to override the doctors, and make an order: which is what the judge in fact did. Nor in principle would it be right to regard life imprisonment as a valid alternative to a section 41 order, for although the crime was brutal and premeditated, it seems on all the evidence to have been a crime of illness and not wickedness.

68. Once this point has been reached, the question is simply whether (in the light of the statutory factors of the nature of the offence, the appellant's "antecedents", and the risk of further offences) an order under section 41 without limitation of time is *necessary* for the protection of the public *from serious harm*.

69. This was a very serious offence and a low risk of repetition would justify a restriction order. But is there even a low risk here? What is the likelihood that a relapse, combined with slipping back to alcohol and tranquillisers, will put another person in peril? It seems to us that we have nothing to go on except the evidence of the doctors, which has struck us as responsible, and which is not patently unsound.

70. We have no basis for a personal judgment which we could prefer to theirs. They have studied the appellant, we have not. Dr Holton has seen her repeatedly and has had an opportunity to judge the improvement in her condition. We have not. The evident disproportion between the premeditated taking of life, and a period of confinement unlikely (judging by what we were told) greatly to exceed two or three years, makes a restriction order attractive, on the basis that if the prognosis is as favourable as the doctors suggest, it will not be long before the Review Tribunal will find that the appellant must be discharged, and that it is prudent to leave the Tribunal and the Secretary of State with the intermediate option of a conditional discharge.

71. Attractive as it is, this reasoning is not what the Act contemplates: and we do not for a moment suggest that the learned judge fell into this error. It might perhaps have been better if the conflicting social policies reflected in the Act had been expressed in terms which set less stringent conditions for a restriction order, with perhaps a more flexible regime for discharge. As it is the choice between a disposal which risks being too severe and one which with hindsight may be shown disastrously to have been not severe enough is posed in the terms of section 41 which we have more than once quoted. We cannot find here that, taking into account the three relevant factors, there is material justifying the conclusion that a restriction order was necessary to protect the public from serious harm. Differing in this from the learned judge, we must allow the appeal.

72. The appeal will therefore be allowed to the extent that the restriction order under section 41 will be quashed and the hospital order under section 37 will remain.

This document was prepared for Mental Health Law Online, based on the words of the judge as stated in (1990) 90 Cr App R 78, with the addition of paragraph numbering and some typographical amendments.