Neutral Citation Number: [2024] EWCA Crim 490

Case No: 2024/00651/A4

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT NOTTINGHAM
MR JUSTICE TURNER
U20231322

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 May 2024

Before:

THE LADY CARR OF WALTON-ON-THE-HILL
THE LADY CHIEF JUSTICE OF ENGLAND AND WALES
LORD JUSTICE EDIS
and
MR JUSTICE GARNHAM

- -

REFERENCE BY HIS MAJESTY'S SOLICITOR GENERAL
UNDER SECTION 36 OF THE CRIMINAL JUSTICE ACT 1988

Rex
v
Valdo Calocane

- -

Deanna Heer KC (instructed by **His Majesty's Attorney General**) for the **Attorney General**
Peter Joyce KC and Lucy Thandi (instructed by **Bhatia Best**) for the **Respondent**

Hearing date: 8 May 2024

APPROVED JUDGMENT

This judgment was handed down at 10.00am on Tuesday 14 May 2024 in Court 4 and released to the National Archives.

The Lady Carr of Walton-on-the-Hill, LCJ:

Introduction

1. In the early hours of the morning of 13 June 2023, Valdo Calocane went out on the streets of Nottingham, having armed himself with knives. He attacked and killed Barnaby Webber and Grace O'Malley-Kumar, two students walking home from a night out. Just over an hour later, he attacked a school caretaker, Ian Coates, who was on his way to work, killed him and stole his van. He then drove to the city centre, where he deliberately drove the van, at speed, into another man, Wayne Birkett, causing him a serious brain injury. Minutes later he deliberately drove into two other victims, Sharon Miller and Marcin Gawronski, also causing serious injury. These were random attacks: none of his six victims were known to the offender.

2. These offences understandably caused shock and concern throughout the country, and beyond.

3. On 28th November 2023, in the Crown Court at Nottingham, the offender pleaded guilty to three counts of manslaughter, and three counts of attempted murder.

4. On 24 January 2024, again at Nottingham Crown Court, the offender was sentenced by Turner J. The unanimous opinion of the medical experts retained by the prosecution and the defence was that the offender was suffering from paranoid schizophrenia at the time when he committed these offences. The judge sentenced the offender to a hospital and restrictions order, pursuant to ss. 37 and 41 of the Mental Health Act 1983 ("the 1983 Act") ("a hospital and restrictions order"), for each offence, to run concurrently.

5. The Solicitor General seeks leave to refer these sentences to this Court under s. 36 of the Criminal Justice Act 1988 on the basis that they are unduly lenient. It is said that the judge failed to reflect sufficiently the multiple aggravating features of the offending when arriving at an appropriate minimum term of imprisonment under a life sentence. Further, the judge failed to take sufficient account of evidence to the effect that the offender's culpability was not extinguished by his mental illness, and the extent of the harm caused. He was wrong not to include a penal element in the sentence. It is submitted that the overall seriousness of the case required the imposition of a life sentence of imprisonment with a hospital and limitation direction pursuant to s. 45A of the 1983 Act ("a hybrid order").

The facts

6. On 12 June 2023, the offender, who was then in London, inserted a new SIM card into his mobile telephone. At 19:00 he telephoned his brother, Elias Calocane, and told him:

> "This is the last time I will talk to you. After this I will leave you alone…Disassociate yourself from me. If anything happens don't come and see me in hospital…this is not mental illness, I am fine. I'm not ill but there is 2-way communication and 24 / 7 voices in my head, they are intelligent people and they are making threats…I will send you the files I sent to Mum at Christmas… I know what is happening is real."

7. The offender subsequently sent his brother some zipped files which included documents which referred to the offender hearing voices in his head and his belief that his brain was under surveillance and being controlled.

8. That evening, the offender travelled by train from St Pancras station to Nottingham where he was seen alighting from a train at 23:30. CCTV footage shows him leaving the station dressed in a black top and trousers and wearing a black beanie-hat, pulled down so as to cover the top half of his face. He was carrying a holdall and a rucksack which was subsequently found to contain multiple weapons, including three knives and a metal scaffolding pole.

9. At 03:03 on 13 June 2023 the offender turned off his mobile phone as he walked towards the area of Ilkeston Road where he hid in an alleyway.

Counts 1 and 2: Barnaby Webber and Grace O'Malley-Kumar

10. Shortly before 04:00 two students, Barnaby Webber and Grace O'Malley-Kumar, both aged 19 years, were walking home along Ilkeston Road following an end-of-term night out in the city centre. They were almost home when the offender emerged from his hiding place and attacked them.

11. Much of the attack was captured on CCTV footage. The offender took a knife from his bag and repeatedly stabbed Barnaby Webber, inflicting grave injuries which caused him to fall to the ground. Grace O'Malley-Kumar tried to intervene by pushing the offender away and into the road. However, the offender turned his attention to her and, during a fight which lasted over 30 seconds, he repeatedly stabbed her. Having done so, he returned to Barnaby Webber and continued his attack on him as he lay on the ground. The footage shows that, despite her injuries, Grace O'Malley-Kumar tried to follow him but her injuries were too severe and she collapsed. The offender then walked calmly away.

12. Neighbours, alerted by screams outside, called the emergency services who arrived at the scene within minutes. They found Barnaby Webber and Grace O'Malley-Kumar lying unresponsive on the ground. Both were taken to hospital but their injuries were un-survivable. Grace O'Malley-Kumar was pronounced dead at 04:51. Barnaby Webber was pronounced dead at 05:20.

13. Post mortem examinations were conducted. The cause of Barnaby Webber's death was stab wounds to the chest and abdomen. He had suffered 10 stabbing injuries which caused damage to his liver, lung and intestines. A stab wound to the pelvis entered the left common iliac vein resulting in profuse bleeding. This wound, in combination with the others, resulted in death. Barnaby Webber had also suffered defensive injuries to his left arm and hand.

14. The cause of Grace O'Malley-Kumar's death was also stab wounds to the chest and abdomen. She had suffered 23 stabbing injuries together with bruising and abrasions. There were injuries to her liver, kidney, the left ventricle of her heart, the pleural cavity including the lungs, the 5th rib and 6th rib cartilage and the organs of the abdominal cavity She also suffered defensive injuries to her left arm and hand.

15. Having killed Barnaby and Grace, the offender walked towards the city centre. At 04:47 he turned his telephone back on and phoned his brother, Elias. He said, '*This will be the last time I speak to you. Take the family out of the country*'. Elias asked him: '*Are you going to do something stupid?*' The offender replied, '*It's already done*'.

16. At 05:01 the offender arrived at Seely Hirst House, a hostel for vulnerable homeless adult men, and tried to get into the building, firstly through a ground floor window and subsequently through a second floor window. However, he was confronted by a security guard and a resident, who punched him in the face, causing him to retreat. He initially walked away up the road but returned two minutes later. Having checked the road for witnesses, he struck a window repeatedly using the metal scaffolding pole from his backpack before walking away. His fingerprints were later identified on a window at Seely Hirst House.

Count 3: Ian Coates

17. As the offender was trying to smash his way into Seely Hirst House, Ian Coates, aged 65 years of age, was driving past in his Vauxhall Vivaro van on his way to work as a caretaker at a nearby school. He stopped his vehicle within a few hundred yards of Seely Hirst House and was then attacked by the offender. This incident was not captured on CCTV footage. The offender was later to tell a consultant psychiatrist, Professor Blackwood, that he came across Ian Coates in his van, and stabbed him in the driver's seat before taking the vehicle from him to continue his assault.

18. A witness in another vehicle saw the offender stabbing Ian Coates multiple times. The offender then took Ian Coates' van, leaving him for dead, and followed the witness a short distance before driving away in a different direction.

19. Police and paramedics arrived to find Ian Coates lying unresponsive in the road, bleeding heavily. All efforts to save him were unsuccessful and he was pronounced dead at the scene at 05:52.

20. Following post mortem examination, the cause of his death was given as stab wounds to the chest. Mr Coates had suffered 15 stab wounds together with abrasions and bruises, The stab wounds had caused internal injuries including to both ventricles of his heart and his right lung, which resulted in profuse bleeding. Injuries to his sternum and fractures to his ribs indicated that these wounds had been inflicted with severe force. He also had defensive injuries to his right thumb and left hand.

21. The offender drove to the city centre where, by 05:15, there were multiple pedestrians on the pavements.

Count 4: Wayne Birkett

22. Wayne Birkett, aged 59 years, was crossing Milton Street in the city centre and had almost reached the opposite pavement when the offender violently changed direction and deliberately drove at him, colliding with him from behind before driving away.

23. Wayne Birkett's body was thrown into the air before he landed on the pavement causing injury to his head. He was taken to hospital where CT scans revealed bruising to the brain. In addition, he had suffered fractures of the skull, fractures to the pelvis and a

fractured rib. An X-ray revealed an injury to his right shoulder which had become separated from his collar bone. He was discharged to a rehabilitation unit for patients with brain injuries. Although the long term effects of his brain injury are difficult to predict, it is likely that it will have a significant impact upon him for many years. Common long-term complications include, seizures, headaches, changes in personality, depression, tiredness and difficulties with concentration and memory.

24. About 5 minutes later, at 05:29, the van driven by the offender was spotted by the police as it travelled along South Sherwood Street towards Market Street. The officers activated the blue lights on their marked police car but the offender did not stop and instead accelerated away.

Counts 5 and 6: Marcin Gawronski and Sharon Miller

25. At 05:30 Marcin Gawronski, aged 40 years, and Sharon Miller, aged 44 years, were walking to work. They were on a pedestrian central reservation in Market Street when the offender deliberately changed direction and drove into them at speed from behind, propelling their bodies on to the pavement.

26. They were taken to hospital. Marcin Gawronski was found to have suffered a fractured rib, a cut to his head and pain over his left chest and right leg. He was admitted overnight for observations and discharged the following day with pain relief. Sharon Miller had fractures to two ribs, a broken toe and a suspected laceration of the spleen. There were large abrasions to her right arm and right thigh and she had pain in her right chest, hip and left foot.

Arrest

27. The offender returned to the carriageway and drove towards Radford. By now the van had significant damage to the windscreen and the bonnet, resulting from the collisions with the pedestrian victims.

28. Officers in a marked police vehicle followed the offender to Bentinck Road, where the offender stopped. He was found sitting in the driver's seat holding a knife in his hand. When police officers deployed their Tasers, he dropped the knife into the footwell. At 05:35 he was arrested.

29. The offender's hands and clothing were bloodstained. Blood on his hands matched that of Ian Coates, and the blood of Barnaby Webber and Grace O'Malley-Kumar was found on his clothing. The knife was also stained with the blood of Grace O'Malley-Kumar and Ian Coates.

30. A rucksack was recovered which contained a knife, a Gerber survival knife, and a length of scaffold pole.

31. The van was examined. Although there was impact damage to the bonnet and windscreen, there were no other faults which could have caused or contributed to the collisions. Subsequently, a collision investigator, having considered the evidence, ruled out the possibility that either collision was anything other than deliberate.

32. The offender was taken to Nottingham Custody Suite. He initially refused to engage and declined to provide samples for toxicology. At 16:00 he was assessed to be fit for interview in the presence of an Appropriate Adult but throughout subsequent interviews he made no comment to all questions.

The offender's history, and the medical evidence that was placed before the Court

33. The offender was born on 4 September 1991. He was therefore aged 31 at the time of the offences and is now aged 32.

34. He was born in Guinea-Bissau and came to the United Kingdom with his family when he was 16 years old, settling in Wales. He left school in 2011 and worked as a labourer or cleaner. He moved to Birmingham and undertook a Higher Education course, gaining a place to study mechanical engineering at Nottingham University. He completed his course and obtained a class 2:1 degree in June 2022.

35. The offender's mental health problems do not appear to have started until 2019, and he has no previous convictions recorded against him.

36. During the course of proceedings, the offender's mental health was assessed by the following consultant forensic psychiatrists, whose reports were before the Court:

    i. Dr Leo McSweeney was instructed on behalf of the offender and provided reports dated 25 August 2023 and 12 January 2024;

    ii. Dr Mohammed Shaffiullha was instructed on behalf of the offender and provided a report dated 19 November 2023;

    iii. Professor Nigel Blackwood was instructed on behalf of the prosecution and provided reports dated 23 November 2023 and 22 January 2024.

37. In addition, Dr Richard Latham was instructed on behalf of the prosecution to review these assessments, providing a report dated 23 December 2024. Dr Mirvis, the offender's treating clinician at Ashworth High Secure Hospital, also provided a report prior to sentence, dated 14 January 2024.

38. These reports provide a detailed history of the offender, which can be summarised as follows:

    i. On 23 May 2020 the offender presented at A&E, believing he was having a heart attack. He returned to his flat 13 hours later and knocked a door down to gain entrance to a neighbouring flat. He was arrested for causing criminal damage. An assessment under the 1983 Act by Liaison and Diversion psychiatric services concluded that he was psychotic, and suffering from paranoid delusions that his mother was being detained and harmed in a neighbour's house, but that the risk to others was low, and that he should be referred in the first instance to the Crisis Team for review at home. The offender was released without charge.

    ii. Upon his return home an hour later he knocked down another door to a different flat. He was again arrested for criminal damage. Following a re-assessment, he

was detained under the 1983 Act and admitted to Highbury Hospital on 25 May 2020. He was treated with an anti-psychotic medication and on 17 June 2020 he was discharged to the care of the Nottingham City Crisis Team. He was advised to take the medication for a minimum of 6 to 9 months, and to seek medical advice if he wished to stop taking it.

iii. Between 14 and 31 July 2020 the offender was readmitted to Highbury Hospital under s. 3 of 1983 Act, having stopped taking his medication and forced his way into another apartment. He was diagnosed with paranoid schizophrenia and his anti-psychotic medication was restarted and increased. Thereafter he was managed in the community by the Early Intervention in Psychosis team. His medication was increased twice.

iv. It was whilst the offender was at university that his brother, Elias Calocane, became aware that the offender was suffering from mental health problems, believing that he was being spied on by his housemates and by MI6 and that his family was under threat. Elias Calocane believes that the offender was prescribed medication but that he stopped taking it, leading to further declines in his mental health.

v. In May 2021 the offender attended at MI5 at Thames House asking to be arrested. At this stage, the offender's family had become concerned about his mental health again. Themes included voices telling him that his family members would die. This was not reported during a home visit review by medical staff on 10 August 2021. It is now apparent that the offender was, at that stage, actively concealing symptoms of psychosis.

vi. Whilst the offender asserted that he was content to continue taking medication, it appears he was not in fact compliant. On 31 August 2021 he admitted that he had stopped taking his psychotropic medication and had no intention of continuing with his treatment. He set out his view that he had never been mentally unwell but that he was the victim of a conspiracy and the voices he experienced were the creation of mental health services.

vii. The offender subsequently evaded contact with the community team, and a warrant under s. 135 of the 1983 Act was secured to gain entry to his property in order that an assessment could be conducted. The warrant was executed on 3 September 2021, on which occasion he assaulted a police officer. A bag of unused medication dating from February 2021 was discovered in the flat. He was charged with assaulting an emergency worker but subsequently failed to attend Court and a warrant was issued for his arrest. This warrant remained outstanding at the time of the offences on 13 June 2023.

viii. The offender was admitted to inpatient services under s. 2 of the 1983 Act and managed between September and October 2021. Thereafter he had limited contact with his community team, appearing confrontational and missing appointments.

ix. In mid-January 2022 the offender was involved in an altercation with a flat-mate. An assessment under the 1983 Act concluded that he could continue to be

treated in the community; however, he did not engage adequately thereafter with the Home Treatment Team.

x. On 27 January 2022, a further 1983 Act assessment was conducted at the offender's flat, and he was admitted as an inpatient pursuant to section 2, where he was treated for 3 weeks. He was discharged on 24 February 2022 to the care of the City South team.

xi. On 14 March 2022 the offender was reviewed in an outpatient clinic, on which occasion he presented well. Thereafter he attended the community service intermittently to collect his medication until early July 2022, but was noted to appear unkempt and to look suspicious.

xii. In mid-July 2022 the offender was prompted to collect his medication, but claimed that he was not in the country.

xiii. On 4 August 2022 the offender was not at home on a visit to his discharge address, and the resident stated that no one of that name lived there.

xiv. In September 2022 the Mental Health Team responsible for the offender's care lost contact with him and discharged him to the care of his GP.

xv. On 1 May 2023 the offender started working in the Avarto Warehouse in Kegworth, Leicestershire. On 5 May 2023 he attacked two employees. Following that incident efforts were made to contact him to tell him that he was not allowed back on the premises, but he never answered. On Friday 9 June 2023 the offender contacted his recruitment consultant and demanded that the company delete all records relating to him: he was told that this could not be done. The offender said he would be in touch again on Monday 12 June 2023.

xvi. On 1 November 2023 the offender was transferred from prison to Ashworth High Secure Hospital.

39. The psychiatric opinion evidence was largely agreed and can be summarised as follows:

i. The offender was suffering from a recognised mental condition, namely paranoid schizophrenia. He had been diagnosed with this condition prior to the offences and continued to suffer from it at the time of the offences and subsequently.

ii. Although he was able to understand the nature of his conduct (although Dr Shaffiullha did not agree with that assertion), at the time of the offences, his recognised medical condition resulted in an abnormality of mental functioning, namely psychosis, which substantially impaired his ability to form a rational judgement and to exercise self-control.

iii. His symptoms included persecutory delusional beliefs, hallucinations, thought alienation and disturbed behaviour.

iv. His mental functioning explained the offences: had he not been experiencing symptoms of acute psychosis which grossly distorted his interpretation of reality, he would not have perpetrated the acts.

v. There was no evidence to suggest that the offender's mental illness was precipitated or exacerbated by illicit drug use.

vi. There was no evidence of criminal behaviour by the offender prior to the onset of his mental illness. All his previous acts of violence and aggression appeared to be closely linked to psychotic episodes.

vii. The offender's insight into his mental health was limited. This was a symptom of his mental illness.

40. As to disposal, those psychiatrists who expressed an opinion, namely Professor Blackwood and Drs McSweeney and Mirvis, agreed that a hospital order with restrictions was appropriate. The views they expressed, in summary, were as follows:

i. The offender was suffering from a mental disorder, namely paranoid schizophrenia, which was of a nature and degree which made it appropriate for him to be detained in hospital for medical treatment pursuant to s. 37 of the 1983 Act. The required treatment was available at Ashworth High Secure Hospital.

ii. The offender is dangerous. He posed a risk of grave harm to others which is strongly linked to his susceptibility to losing touch with reality in the context of psychotic episodes. Therefore, a restrictions order pursuant to s. 41 of the 1983 Act was required for public protection.

iii. In Professor Blackwood's opinion, whilst the harm caused by the offender was at the highest level, the offender's 'retained responsibility' was nevertheless at the:

> "… lower end of the spectrum. He retains some responsibility in that he was not insane at the time of the index assaults. However, there was substantial impairment of his ability to form a rational judgment and to exercise self-control, and the assaults would not have occurred but for his psychotic symptoms. The offending was in my view entirely attributable to his mental illness. His failure to comply with the prescribed oral anti-psychotic medication in (at least) the twelve months before the index offence was in my view not a culpable omission, but rather one determined by his lack of insight into his illness, an integral feature of the disorder."

iv. A 'hybrid' order would not provide the public with the same level of public protection as would a hospital and restrictions order:

a) Since the offending was strongly linked to the offender's paranoid schizophrenia, public safety was reliant on effective treatment, in this case, clozapine and therapeutic treatment.
b) If effective, a hybrid order would result in the offender being transferred to prison to serve the remainder of his sentence. However, in a prison setting, the offender could not be compelled to receive treatment. Given his lack of insight, there was a real risk of relapse. Further, clozapine could be challenging to manage in prison.

c) Release from prison is governed by the Parole Board and monitoring in the community would be conducted by a probation officer who may be less able to identify signs of relapse and whose recall powers are less responsive than the recall provisions following conditional discharge from a hospital order.
d) A hospital and restrictions order would likely result in the offender remaining in hospital for many years. Discharge is determined by the Secretary of State or the First Tier Tribunal (Mental Health) ("the Tribunal"). A conditional release into the community would be under medical supervision allowing swift recall to hospital were the offender to stop complying with his treatment regime.

The proceedings, and the victim impact statements

41. The offender was charged on 16 June 2023 and appeared before the Nottingham Magistrates' Court on 17 June 2023, when his case was sent to the Crown Court. The Defendant gave no indication as to plea but indicated that the issue was '*fitness to plead*'.

42. On 28 November 2023 the case was listed for a plea and trial preparation hearing when the offender was arraigned. He was charged with the murder of Barnaby Webber, Grace O'Malley-Kumar, and Ian Coates, and with the attempted murder of the other three victims. On counts 1 – 3 he pleaded not guilty to murder but guilty to manslaughter. On counts 4 – 6 he pleaded guilty. By that stage psychiatric reports were available from Dr McSweeney, Professor Blackwood and Dr Shaffiullha. As a result of concerns raised by members of the bereaved families, the prosecution applied for an adjournment to obtain a further report from Dr Latham, who was asked to review the psychiatric evidence.

43. On 19 December 2023 the prosecution indicated that the offender's pleas of not guilty to murder but guilty to manslaughter were acceptable. The matter was adjourned for sentence administratively.

44. A number of victim personal statements were put before the Court. The key points included the following:

i. Emma Webber and David Webber (Barnaby Webber's parents) spoke of their rage at the fact their son was stolen from them, their feelings of guilt that they could not protect him, the devastation that the offender had caused to their family and their determination to ensure that justice was done and that the offender was properly punished. Charlie Webber (Barnaby's brother) described how he wanted to set the world on fire when he heard of his brother's killing, such was his anger and grief. A family friend, Tom Yap, described how his life had been permanently changed by the offender's actions. Emily Yap described how she had become scared and anxious about her safety and that of her friends and family, such that she couldn't sleep and her relationship with her partner had broken down.

ii. Drs Sanjoy and Sinead O'Malley-Kumar (Grace O'Malley-Kumar's parents) described their absolute desolation and unfathomable grief at her loss. Her mother, a Consultant Anaesthetist, found that she could no longer perform her

role in the operating theatre, knowing how her daughter had been "butchered". Her father described his feelings of grief and his inability to accept any psychiatric evidence that reduced the offender's responsibility for what he had done. James O'Malley-Kumar (Grace's brother), Shashi Kumar (her grandfather), Sunil Kumar (her uncle), Catherine O'Malley and Emma Kumar (her aunts), Helen Prescott-Morrin (her teacher) and a number of family friends all spoke of their pride in Grace, who was also studying to be a doctor, and their inconsolable grief at the loss of someone so loved and with so much promise.

iii. James Coates (Ian Coates' son) explained how his father, having worked hard all his life, was only weeks away from retirement when he was killed. His partner, Elaine Newton, could no longer sleep such was her anxiety and she struggled to eat properly and function day to day. Susan Coates (his sister) said life had become a daily battle of emotions and vulnerability.

iv. Wayne Birkett explained how he had lost his independence and was now fully dependent on his partner, Tracey Hodgson, being unable to carry out basic functions. He had lost his memory such that he was unable to recognise his family or recall his life before the incident. Only now was his memory starting to return. The pelvic injuries meant that he struggled to walk and suffered immense pain in his legs which interfered with his sleep. His normal life had been ruined and sometimes he felt like ending it. His partner had given up work to be his full-time carer. Financially, they had suffered. She described how Wayne Birkett's personality had altered as a result of the brain injury, becoming childish and stubborn and suffering mood swings. Their life had completely changed as a result of the incident.

v. Marcin Gawronski remained in hospital for 24 hours before being discharged and was off work for several weeks. Although he did not feel fully recovered, he returned to work because he could no longer afford not to. He did not feel safe in public anymore but anxious and scared that someone might just run him over. After the incident he struggled to sleep and suffered nightmares. He had been prescribed anti-depressants and had received counselling.

vi. Sharon Miller remained in hospital for several days but following discharge, she had been housebound, not only due to the physical injuries but also the emotional impact of the attack upon her. She was too scared to go out alone and no longer worked. She was now dependent on benefits. She struggled to sleep, suffered nightmares and had lost her self-confidence.

45. The prosecution submitted at the sentencing hearing that a sentence with a significant penal element was called for, and that the appropriate disposal was by way of a sentence of imprisonment for life with a hybrid order.

46. It was submitted on behalf of the offender that a hospital order with restrictions was the appropriate disposal.

The sentencing remarks

47. In his sentencing remarks, the judge described the offender's actions as sickening crimes which shocked the nation and wrecked the lives of his victims. He described the

offender as an intelligent man who had, in 2019, started to show symptoms of mental disorder. He said that he had considered the reports of five distinguished consultant psychiatrists and heard evidence from Professor Blackwood and Drs McSweeney and Mirvis but noted that he was not bound by their evidence. He referred to key parts of the reports. He concluded that the prosecution had been right to acknowledge that the offender's mental health condition satisfied the requirements of the partial defence of diminished responsibility on counts 1 – 3, thus leading to the acceptance of a plea to manslaughter. The defence of diminished responsibility did not apply to attempted murder.

48. The judge noted that it was the unanimous conclusion of the relevant experts that but for the offender's schizophrenia he would not have committed these offences. He had no other motive for committing them. There was no evidence that the offender was liable to be violent prior to the onset of his condition. He had no relevant religious, ideological or political affiliations. He believed that voices, with the power to harm his family if he failed to comply, were controlling him. He remained under that impression and believed that he did not suffer from any mental disorder at all. The offender's failure to take prescribed medication was as a consequence of his mental disease, rather than a rational choice. The preparatory acts identified by the prosecution were also governed by his delusions. It followed that, notwithstanding the extreme gravity of his crimes, the level of responsibility the offender retained was at the lower end.

49. He noted that the starting point in the Sentencing Council Definitive Guideline on Manslaughter by reason of Diminished Responsibility for a single offence was 7 years' imprisonment (with a range of 3 – 12 years). He said that a very significant upward adjustment would be required to take account of the number of victims and the three offences of attempted murder: a life sentence would be appropriate. An appropriate minimum term of imprisonment would be thirty years before a reduction of one third to reflect the offender's guilty pleas, and of a further third to reflect what would have been the date of eligibility for parole in respect of a determinate sentence. The minimum term of imprisonment would therefore have been 13 years and 4 months.

50. The judge said that the offender was plainly dangerous. This factor needed to be reflected in the Court's approach to sentence and provided relevant context to the appropriateness of a mental health disposal. It was undoubtedly the case that the offender was currently suffering from a mental disorder, namely paranoid schizophrenia, for which he required treatment. It was necessary and appropriate to make a hospital order. In considering the extent to which punishment was required, the court bore in mind the devastating impact of the offending. The judge noted that the diagnosis of treatment resistant schizophrenia meant that it was very likely that the offender would never be released.

51. The sentencing options were limited to a hospital and restrictions order or a hybrid order. The judge reminded himself of the importance, where appropriate, of reflecting a penal element in the sentence but noted that, whichever sentence he passed, the offender was unlikely to be released in any event. The judge accepted the evidence of Professor Blackwood who concluded that, because the offender's risk to others was driven by his psychotic illness, the risk he posed was best managed by forensic psychiatric services. Periods of leave and progress through the secure hospital system would be effected by his responsible clinician in close communication with the Secretary of State; any potential discharge to the community would be subject to the

independent consideration of the Tribunal; any release would be subject to conditions, including compliance with medication, and monitoring by a forensic team; and any deterioration in the offender's mental condition, which was the driver of the risk, would lead to a prompt recall to a psychiatric hospital. The regime under a hospital and restrictions order avoided situations in which the risk posed by the offender might increase, or his mental condition worsen, because of delays in recalling and re-hospitalising him.

52. By contrast, a period of imprisonment risked non-compliance with medication, a deterioration in the offender's mental state, and an increased risk to others. The Parole Board would be likely to follow the recommendation of the clinicians and Tribunal as to release. Monitoring would principally be by a probation officer: recall to prison, and subsequent transfer to hospital, might take some time.

53. In these circumstances, the judge said that the regime which provided the greatest level of protection for the public was a hospital and restrictions order. Under a hybrid order the offender would not be supervised by a team of mental health experts reporting to the hospital and the Secretary of State, but rather by a probation officer who would not be trained to spot the subtle signs of mental health deterioration, or have the powers to intervene to arrest any such deterioration. In the event of a relapse in a prison environment the offender would present a real danger to prison officers and fellow prisoners.

54. The judge concluded that the proper sentence was a hospital order and, because of the nature of the offences, the offender's history, and the risk he posed, that order would be subject to a section 41 Restrictions Order.

The statutory framework

55. The maximum sentence for the offence of manslaughter, and for the offence of attempted murder, is life imprisonment. Both are schedule 19 offences for the purposes of section 285 of the Sentencing Act 2020 (life imprisonment) and schedule 15 offences for the purposes of section 279 of the same Act (extended sentences).

56. Where the offender suffers from a mental disorder, however, the court should consider whether a hospital order under the 1983 Act should be imposed instead. The potential options, in a case like the present, are a hospital order, pursuant to s. 37 of the 1983 Act accompanied, if appropriate, by a restrictions order under s. 41 of the same Act (ie a hospital and restrictions order), or a sentence of imprisonment with a hospital direction and limitation direction, pursuant to s. 45A of the 1983 Act (ie a hybrid order).

Hospital Order, s. 37 of the 1983 Act

57. A hospital order may be imposed where an offender has been convicted of an offence punishable by imprisonment, other than murder.

58. The court must be satisfied of the following before it can make such an order:

    i. Under subsection (2)(a): On the written or oral evidence of two doctors, at least one of whom must be approved under s. 12 of the 1983 Act, that the offender is suffering from mental disorder of a nature or degree which makes

it appropriate for the offender to be detained in a hospital for medical treatment, and appropriate medical treatment is available;

ii. Under subsection (2)(b): 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 the offender, that a hospital order is the most suitable method of dealing with the case;

iii. Under subsection (4): On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case, or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the period of 28 days starting with the day of the order.

Restrictions Order, s. 41 of the 1983 Act

59. Pursuant to s. 41, where the court makes a hospital order, the court may also make a restrictions order where:

i. At least one of the doctors whose evidence is taken into account by the court before deciding to give the hospital order has given evidence orally;

ii. Having regard to the nature of the offence, the antecedents of the offender, and the risk of the offender committing further offences if set at large, the Court thinks it necessary for the protection of the public from serious harm for the person to be subject to the special restrictions which flow from a restrictions order.

60. The effect of a restrictions order is to provide that the Secretary of State's consent is required before an offender can be discharged, and the Secretary of State's consent is required before an offender can be granted a leave of absence from hospital or moves hospitals (ss. 41(3)(c) and 42). The Secretary of State also has power to order an offender's detention or return to hospital after release (s. 42). The responsible clinician must provide the Secretary of State with a report on the offender at least once a year (s. 41(6)). The offender may appeal to the Tribunal, which may order their release (ss. 70 and 73). Such an appeal may only be made once in every 12-month period.

Hybrid orders

61. A hybrid order may be imposed by the Crown Court on an offender, over the age of 21, who has been convicted of an offence punishable by imprisonment (other than murder) if:

i. The court is satisfied on the written or oral evidence of two doctors, at least one of whom must be approved under s.12, and at least one of whom must have given evidence orally, that the offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment, and appropriate medical treatment is available;

ii. The court has considered making a hospital order under s. 37 but has decided instead to impose a sentence of imprisonment;

iii. The court is also satisfied, on the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the 28 days starting with the day of the order.

62. Under s. 45A, where the period of imprisonment is indeterminate, if a patient's health improves such that his responsible clinician or the Tribunal notifies the Secretary of State that he no longer requires treatment in hospital under the 1983 Act, the Secretary of State will generally remit the patient to prison under s. 50(1) of the Act. On arrival in prison, the hybrid order will cease to have any effect whatsoever. Release will be considered by the Parole Board in the usual way, after the minimum term has expired. If a s. 45A patient remains in hospital beyond the expiry of the minimum term and the Tribunal notifies the Secretary of State that he is ready for conditional discharge, the Secretary of State may notify the Tribunal that he should be so discharged (s. 74(2)). In that case, the offender would be subject to mental health supervision and recall in the usual way. However, the Secretary of State would, in practice, refer the offender to the Parole Board.

63. A key difference between a hospital and restrictions order, on the one hand, and a hybrid order, on the other, is that if an offender who is subject to a hospital and restrictions order recovers so that they no longer need to remain in hospital, they will be released into the community. In contrast, if an offender who is subject to a hybrid order recovers such that they can be discharged from hospital, they will be transferred to prison (at least before expiry of the minimum term). The other key difference is that, where an offender is under a hospital and restrictions order, the decision whether they will be released into the community will subject to the consent of the Secretary of State, after consultation with the responsible physician, whereas if an offender is subject to a hybrid order, and has been discharged from hospital, the decision about whether they should be released from prison will be a matter for the Parole Board.

The Sentencing Council Guidelines

64. The Sentencing Council Definitive Guideline on Manslaughter by Reason of Diminished Responsibility requires the court to assess the level of responsibility that is retained by the offender for the offending, taking account of the medical evidence and all the relevant information available to the court. The court should take account of the extent, if at all, to which the offender's actions or omissions contributed to the seriousness of the mental disorder at the time of the offence. The guidelines require the court to consider mental health disposals. In so doing, the court should consider all sentencing options, including a hybrid order, and should consider the importance of a penal element in the sentence, taking into account the offender's level of responsibility. The court should take into account all relevant evidence, including the psychiatric evidence and the regime on release, and should review whether the sentence as a whole meets the objectives of punishment, rehabilitation and protection of the public in a fair and proportionate way.

65. Before a hospital order is made under s. 37 (with or without a restrictions order under s. 41), the court should consider:

> *"whether the mental disorder can appropriately be dealt with by custody with a hospital and limitation direction under section 45A. In deciding whether a section 45A direction is appropriate the court should bear in mind that the limitation direction will cease to have effect at the automatic release date of a determinate sentence. If a penal element is appropriate and the mental disorder can appropriately be dealt with by a direction under section 45A, then the judge should make such a direction."*

66. The Sentencing Council Definitive Guideline on Attempted Murder states that a case will fall into the Lesser Culpability category if the offender's culpability is substantially reduced by mental disorder. The options of a hospital and restrictions order and of a hybrid order apply to those convicted of attempted murder as they do to those convicted of manslaughter.

67. The Sentencing Council Overarching Guideline on Sentencing Offenders with Mental Disorders states that culpability may be reduced if an offender was at the time of offending suffering from a mental impairment or disorder, and if there is a sufficient connection between the offender's impairment or disorder and the offending behaviour. A careful analysis of all the circumstances of the case and all relevant materials is required to determine the extent, if any, that the impairment or disorder be relevant to culpability.

The authorities

68. This court has given guidance in a number of cases on the correct approach to be adopted in cases where the appropriate disposal is either a hospital and restrictions order or a hybrid order. Three cases are of particular assistance: *R v Vowles* [2015] EWCA Crim 45, [2015] 1 WLR 5131; *R v Edwards* [2018] EWCA Crim 595, [2018] 4 WLR 64; and *R v Nelson* [2020] EWCA Crim 1615, [2021] MHLR 219.

69. In *Vowles*, Lord Thomas, CJ said this:

> "51. It is important to emphasise that the judge must carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions. A judge must therefore consider, where the conditions in section 37(2)(a) are met, what is the appropriate disposal. In considering that wider question the matters to which a judge will invariably have to have regard to include
>
> (1) the extent to which the offender needs treatment for the mental disorder from which the offender suffers,
>
> (2) the extent to which the offending is attributable to the mental disorder,
>
> (3) the extent to which punishment is required and
>
> (4) the protection of the public including the regime for deciding release and the regime after release.
>
> There must always be sound reasons for departing from the usual course of imposing a penal sentence and the judge must set these out.
>
> 52. … a judge when sentencing must now pay very careful attention to the different effect in each case of the conditions applicable to and after release. … this consideration may be one matter leading to the imposition of a hospital order under section 37/41.

> 53. The fact that two psychiatrists are of the opinion that a hospital order with restrictions under section 37/41 is the right disposal is therefore never a reason on its own to make such an order. The judge must first consider all the relevant circumstances, including the four issues we have set out in the preceding paragraphs and then consider the alternatives in the order in which we set them out in the next paragraph.
> 54. Therefore…a court should, in a case where (1) the evidence of medical practitioners suggests that the offender is suffering from a mental disorder, (2) that the offending is wholly or in significant part attributable to that disorder, (3) treatment is available, and it considers in the light of all the circumstances to which we have referred, that a hospital order (with or without a restrictions) may be an appropriate way of dealing with the case, consider the matters in the following order:
>
> *(i)* As the terms of section 45A(1) of the MHA require, before a hospital order is made under section 37/41, whether or not with a restrictions order, a judge should consider whether mental disorder can appropriately be dealt with by a hospital and limitation direction under section 45A.
>
> *(ii)* If it can, then the judge should make such a direction under section 45A(1). ...
>
> *(iii)* If such a direction is not appropriate the court must then consider, before going further, whether, if the medical evidence satisfies the condition in section 37(2)(a) (that the mental disorder is such that it would be appropriate for the offender to be detained in a hospital and treatment is available), the conditions set out in section 37(2)(b) would make that the most suitable method of disposal. It is essential that a judge gives detailed consideration to all the factors encompassed within section 37(2)(b)."

70. In *Edwards*, Hallett LJ, VP emphasised that:

> "6. The First Tier Tribunal (Mental Health) decides when the offender should be released when an order is made under ss.37/41. However, for section 45A orders the release regime differs depending on whether an offender is serving a determinate or indeterminate sentence of imprisonment.
> 7. If a s.45A patient's health improves so that his responsible clinician or the Tribunal notifies the Secretary of State ("SoS") that he no longer requires treatment in hospital under the MHA, the SoS will generally remit the patient to prison under section 50(1) of the MHA to serve the rest of his sentence. On arrival in prison, the s.45A order would cease to have effect and the offender would be released from prison in the usual way.
> 8. If there has been no improvement at the automatic release date, the limitation direction aspect of s.45A falls away. At that point, the patient remains in hospital but is treated as though they are subject to an unrestricted hospital order so that the point at which he is discharged from hospital is a matter for the clinicians, with no input from the SoS."

71. At [12] she stated that a "*level of misunderstanding of the guidance offered in Vowles appears to have arisen as to the order in which a sentencing judge should approach*

the making of a s.37 or a s.45A order and the precedence allegedly given in Vowles to a s.45A order". She continued:

> "Section 45A and the judgment in Vowles do not provide a 'default' setting of imprisonment, as some have assumed. The sentencing judge should first consider if a hospital order may be appropriate under section 37 (2) (a). If so, before making such an order, the court must consider all the powers at its disposal including a s.45A order. Consideration of a s.45A order must come before the making a hospital order. This is because a disposal under section 45A includes a penal element and the court must have 'sound reasons' for departing from the usual course of imposing a sentence with a penal element. Sound reasons may include the nature of the offence and the limited nature of any penal element (if imposed) and the fact that the offending was very substantially (albeit not wholly) attributable to the offender's illness. However, 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."

72. At [14] she said:

> "It follows that, as important as the offender's personal circumstances may be, rehabilitation of offenders is but one of the purposes of sentencing. The punishment of offenders and the protection of the public are also at the heart of the sentencing process. In assessing the seriousness of the offence, s. 143 (1) of the Criminal Justice Act provides that the court must consider the offender's culpability in committing the offence and any harm caused, intended or foreseeable."

73. In *Nelson*, Dingemans LJ said this:

> "33. …. The purposes of a hospital order are rehabilitation of the offender and protection of the public, it is not concerned with punishment.
> 34. Further matters for the court to consider are the release regimes which will apply to the offender on release. A restrictions order under section 41 of the MHA gives the Secretary of State for Justice a role in the release and recall of offenders who have been sentenced under hospital orders. A restrictions order under section 41 of the MHA should not be passed just to mark the seriousness of the offence, but only where it is required to protect the public from serious harm. …
> 35. Section 45A of the MHA permits, in effect, the combination of sentences of imprisonment with hospital and restrictionss orders where the sentence is not fixed by law. The evidence before us showed that section 45A MHA orders were particularly appropriate in two situations: the first was where, notwithstanding the existence of the mental disorder, a penal element to the sentence was appropriate; and the second was where the offender had a mental disorder but there were real doubts that he would comply with any treatment requirements in hospital, meaning that the hospital would be looking after an offender (who might be dangerous) who was not being treated. …

> 37. Any court considering whether to impose a section 45A MHA hybrid order will need to make a careful assessment of the culpability of the offender, notwithstanding the presence of the mental disorder, in accordance with the guidance given in Vowles and Edwards. Practical guidance about how to do that is set out in the Guideline."

Discussion

74. This is a challenge to the decision of a highly experienced judge who was immersed in the procedural history and detailed evidence of the case. His decision was reached after two days of submissions and oral evidence from three appropriately qualified medical experts.

75. It is accepted that the judge made no error of principle in his approach. As it was put fairly in the Solicitor General's Reference: "*[it]is accepted that the Learned Judge approached the sentencing process in accordance with the relevant guidelines*". Instead, the challenge is to the judge's evaluative assessment of which option was appropriate.

76. Here the choice for the judge was stark and binary: either a hybrid order or a hospital and restrictions order. It was not suggested by either party that a hospital and restrictions order would be wrong in law or as a matter of principle. Instead the parties advanced competing submissions as to whether one option was better than the other. For the prosecution it was said that a hybrid order was appropriate; the defence advocated a hospital and restrictions order.

77. None of this is a promising platform for the Solicitor General, who faces the hurdle of establishing not only that the judge's sentences were lenient, but that it was unduly so. A sentence is unduly lenient "… *where it falls outside the range of sentences which the judge, applying his mind to all the relevant factors, could reasonably consider appropriate*" (*Attorney General's Reference No 4 of 1989* [1990] 1 WLR 41, Lord Lane CJ). In *R v Edwards* [2012] EWCA Crim 2746 2012 WL 7092526 (at [19]) Hughes LJ commented that the scheme is designed to deal with cases where judges have fallen into "*gross error*".

78. The Solicitor General argues that in determining the offender's level of retained responsibility the judge failed to give sufficient weight to the evidence that his culpability was not extinguished. However, it is plain that the judge recognised that the offender's culpability was not extinguished; the weight he gave that factor reflected the level of retained responsibility as described by the psychiatric evidence before him.

79. The Solicitor General submits that the judge erred in imposing hospital orders with restrictions "*since it was necessary to impose a sentence with a penal element*" and that "*the overall gravity of the offending was such that it required a penal element*". However, as the authorities to which we have referred make clear, in sentencing an offender who satisfies the criteria in s. 37, the court has to have regard to both the need for punishment and the protection of the public.

80. The need for punishment is a function of the seriousness of the consequences of the offending and the level of responsibility which the offender bears for that offending. Here, as the judge plainly recognised, the consequences of the offending were of the

greatest seriousness. But, as the expert evidence made clear, the offender's mental condition was such that the level of responsibility he retained for that offending lay at the lower end of the scale. That being so, any need for punishment needed to be balanced carefully against the need to protect the public from the risk the offender posed. The Sentencing Council Guidelines on Manslaughter by Reason of Diminished Responsibility make clear that in deciding to impose a hybrid order the court should consider not only whether a penal element is appropriate but also whether the mental disorder can appropriately be dealt with by such an order.

81. The Solicitor General contends that there were a number of aggravating features which required an uplift from the starting point for a single offence. That is plainly correct. However, the judge acknowledged that there were multiple offences of manslaughter and attempted murder and that others were put at risk during the course of the offending.

82. The Solicitor General suggests that the offender's criminality was also aggravated by the fact that the offender planned the attack and purchased knives for the purpose. In our view, that submission is misconceived. The evidence was that these actions were all part of his illness. During the oral evidence of Professor Blackwood, the following exchange with defence counsel took place:

> "Q. When it's put that there are aggravating features of planning and so on, as you've heard, we're actually talking, are we not, about one psychotic episode in which all these other events took place?
> A. Yes. All the features that were mentioned in terms of purchasing weapons, changing SIM cards, calling his brother, changing his shoes, discarding the holdall et cetera, all occur in the context of an active psychosis, yes.
> Q. You've seen the documents, the sentencing notes for the prosecution and the defence. You've seen all the authorities that have been provided to the court. You've seen all the witness statements, all the assertions as to his conduct over time. It, in fact, comes down, does it not, to this: all those aggravating features that say make it worse are, in fact, part of one psychotic episode of intense severity?
> A. Yes."

83. In our judgment, the uplift to the starting point adopted by the judge was appropriate. In any event, the critical question is whether the final disposal adopted by the judge was one properly open to him. In our judgment, it clearly was.

84. In determining the final disposal, the judge, as he recognised, had to consider whether a penal element was necessary. Because the offender's level of retained responsibility was low, and in circumstances where the offending would not have taken place but for the offender's schizophrenia, the judge was entitled to conclude that a penal element was unnecessary. That is so, despite the number of victims and the extent of the harm caused. The schizophrenia was the sole identified cause of the crimes: thus, for example, there was no history of independent offending (unrelated to the schizophrenia), no evidence of substance abuse, no evidence of any culpable failure to take medication or any motive for attacking these victims.

85. The key factor in a case like this, when deciding whether or not a penal element is required, is the strength of the link between the offender's impairment and the offending in question. Here, in the words of Professor Blackwood, at the time of the assaults the

offender was "*in the grip of a severe psychotic episode…entirely driven by the psychotic process".*

86. The judge properly took into account, first, that under the s.45A regime, the Parole Board would be likely to follow the release recommendation of the clinicians and Tribunal; secondly, that monitoring thereafter would be carried out principally by a probation officer rather than a mental health practitioner; and thirdly, that recall to prison, and subsequent transfer to hospital, might take some time. He reached what was the perfectly reasonable conclusion that a period of imprisonment, as might follow the making of a hybrid order, risked non-compliance with medication, a deterioration in the offender's mental state, and a consequential increased risk to others.

87. By contrast, as the judge said, the ss. 37/41 regime avoided situations in which the risk posed by the offender might increase, or his mental condition worsen, because of delays in recall and re-hospitalisation. Such an approach, focussing on the question of public protection, was entirely in line with the comments in *Edwards* at [12] as set out above, namely "*the graver the offence and the greater the risk to the public…the greater the emphasis the judge must place upon the protection of the public…*"

88. We would add this. The report of Dr Mirvis, as the treating clinician who has had most contact with the offender, is of particular significance. In it, he says that the correct diagnosis of the offender's condition is "treatment-resistant schizophrenia". He says that it has been only partially responsive to treatment and that it will be necessary to trial another drug, clozapine.

> "*His illness appears to be partially responsive to first line antipsychotic treatment; he continues to report hearing voices on a daily basis despite being on the maximum dose of olanzapine for several months……. The establishment of antipsychotic medication has led to an improvement in his symptoms and presentation (including aggression towards others).*"

89. Dr Mirvis then considered the difference in the release mechanisms between the two options open to the court. He says this:

> "*If release was ever proposed into the community this would most likely be considered at a Mental Health Tribunal. If discharged this would typically be conditional. Mr Calocane's illness is likely to be lifelong and require close review of his mental health for subtle signs of relapse, ongoing prescription of psychiatric medication and monitoring of his compliance. Under this arrangement he would be monitored in the community by a mental health team (often a specific community forensic one). In this scenario if Mr Calocane's mental state deteriorated he could be reviewed promptly and recalled to hospital under s 37/41 (almost certainly to a secure mental health hospital).*"

90. We take this to mean that the offender will always present an extremely grave danger to the public if he is ever released. That danger may be mitigated by medication if he is compliant with the treatment regime and if the medication is effective. Although the safeguards described by Dr Mirvis and provided by the mental health team are no doubt effective in managing many cases, the extreme violence perpetrated by this offender makes it very likely that, whichever of the two options had been adopted, he will spend the rest of his life in a secure hospital.

91. This view is supported by Dr McSweeney who says:

> *"This is a chronic and enduring psychotic mental illness. His illness will never be 'cured', and he will require long term, very cautious management with antipsychotic medication and appropriate psychological and supportive interventions (almost certainly for the remainder of his life)….. The strong link between his mental disorder and offending makes the Section 41 Restrictions Order particularly apt for maintaining the protection of the public in the event of his conditional release (which I appreciate may be unlikely) from hospital in the future."*

92. "*Very cautious management*" is, in our view, unlikely to involve this offender ever being managed in the community. Dr McSweeney appears to share this view. In his oral evidence he said that the offender would require treatment in a secure mental hospital for many decades to come and would need to take his medication throughout his life. He did not exclude the possibility of eventual release but made it clear that he would always require "the most intense management and monitoring".

93. In our judgment, the risk caused by any non-compliance with the medication regime or any failure of the medication to control the psychosis is so high that release into the community can properly be assessed as "*very unlikely*". On this approach, it is even harder to label the hospital and restrictions order unduly lenient, since it will have the same effect as the only other available option.

Conclusion

94. This was a sensitive sentencing exercise that was not straightforward. But there was no error, in the approach adopted by the judge. His conclusion that, on the facts of this case, a penal element was unnecessary and the better protection of the public required a hospital and restrictions order, rather than a hybrid order, was one properly open to him. We do not consider it arguable that the resulting sentences were unduly lenient. We refuse leave.

95. It is impossible to read of the circumstances of this offending without the greatest possible sympathy for the victims of these terrible attacks, and their family and friends. The victim impact statements paint a graphic picture of the appalling effects of the offender's conduct. Had the offender not suffered the mental condition he did, the sentencing judge would doubtless have been considering a whole life term. But neither the judge nor this court can ignore the medical evidence as to the offender's condition which led to these dreadful events or the threat to public safety which the offender continues to pose.