IN THE COURT OF APPEAL
CRIMINAL DIVISION

CASE NO 202001859/A1

NCN: [2021] EWCA Crim 2004

Royal Courts of Justice

Strand

London

WC2A 2LL

Tuesday 14 December 2021

LORD JUSTICE HOLROYDE

MR JUSTICE PICKEN

RECORDER OF MANCHESTER

(HIS HONOUR JUDGE DEAN QC)

(Sitting as a Judge of the CACD)

REGINA

V

LUCY OSAYAMEN INNEH

Computer Aided Transcript of Epiq Europe Ltd,

Lower Ground, 18-22 Furnival Street, London EC4A 1JS

Tel No: 020 7404 1400; Email: rcj@epiqglobal.co.uk (Official Shorthand Writers to the Court)

MR D WRIGHT appeared on behalf of the Appellant.

MR T DEVLIN appeared on behalf of the Crown.

J U D G M E N T

1.
LORD JUSTICE HOLROYDE: This appellant (now aged 30) has sadly suffered mental health problems over a number of years. She has a history of hospital admissions after violent or aggressive behaviour and has been diagnosed as having a schizoaffective disorder of a chronic relapsing and remitting nature.

2.
On 19 September 2018 she made an unprovoked attack in the street on a man aged 94, striking him with his own walking stick and inflicting injuries which included fractures of an arm and a finger and cracked ribs. She was charged with an offence of causing grievous bodily harm with intent, contrary to section 18 of the Offences Against the Person Act 1861. At her trial in the Crown Court at Isleworth, the jury found that she had done the act charged but was not guilty by reason of insanity. The trial judge (HHJ Barrie) subsequently made a hospital order, pursuant to section 37 of the Mental Health Act 1983, and ordered that the appellant be subject to the special restrictions set out in section 41 of that Act.

3.
The appellant now appeals against that order by leave of the single judge. Mr Wright, on her behalf, submits that the section 37 order provides sufficient protection for the public and that the section 41 restriction order was wrong in principle or manifestly excessive.

4.
The appellant's mental health problems were first diagnosed following an incident in September 2010, when she bit the faces of her mother and her brother in order, as she said, to rid them of demons. She was treated with antipsychotic medication. In 2013 she was admitted to hospital on four occasions: the first was brought about by her noncompliance with her oral medication, which led to a relapse in her condition; the second followed her threatening to kill the pastor at her church; on her third admission she presented with symptoms of mania and psychosis; and on the fourth, she was transferred to a psychiatric ward from the A & E Department where she had assaulted a doctor. On each of these occasions her condition improved whilst she was in hospital and she was discharged.

5.
Further hospital admissions followed in 2014, after she had caused a fight on a bus; in 2015, when she had stopped taking her medication and assaulted a police officer; and in 2016, after she had seriously assaulted her mother's carer and then punched her mother.

6.
On 17 September 2018 the appellant assaulted a classmate at college who had brushed against her arm. The appellant later told one of the reporting doctors that she struggled with anger management whenever she was touched, stressed out or felt she was being disrespected.

7.

Two days later the appellant attacked the elderly gentleman, claiming that he had touched her breast and that he was a pervert who deserved what he got. On admission to a psychiatric ward she was extremely aggressive, threatening to attack staff and gouge out their eyes. A few days later she lashed out at a member of staff, hitting and scratching him. She was subsequently transferred to a more secure ward.

8.
The judge was assisted by a number of medical reports, some of which had been directed to the issues of fitness to plead and insanity at the time of the offence rather than to the issue of the appropriate disposal. There was no pre-sentence report but none was necessary in view of the detailed medical evidence. Each member of this court has read the reports which were before the judge and an additional report which has been prepared since the hospital order was made.

9.
The authors of all the reports were agreed as to the appellant's diagnosis and as to the relapsing and remitting nature of her illness. They were also agreed as to the need for a section 37 hospital order. Whereas previous hospital admissions had been comparatively short, the appellant had, by the time of the sentencing hearing, been in a medium secure ward for more than 18 months and had for the first time been receiving psychological as well as psychiatric input. The reports described a considerable improvement in her condition. For example, in a report written in May 2019 Dr Mortlock, a consultant forensic psychiatrist who had for a short time been the appellant's responsible clinician, summarised the appellant's history of aggressive behaviour when unwell and her paranoid and persecutory beliefs, but said that she had made considerable progress in hospital and that her mental state was much improved. Dr Mortlock noted however that there had been no clear precipitant for the appellant's relapse in September 2018 and said that further psychological treatment was necessary because without it, there was a high risk of the same pattern of relapse. Dr Mortlock indicated that she would not recommend a section 41 restriction order in this case. Dr Oloduni, a specialty registrar in forensic psychiatry, expressed a similar view.

10.
Similarly, Dr Sahota, a consultant forensic psychiatrist who reported in January and March 2020, described the appellant as having "a moderate to high degree of vulnerability to stress, given the number of relapses leading to psychiatric admission" but noted that she had been engaging well in hospital and had benefited from the psychological intervention. She was self-medicating and had progressed to unescorted as well as escorted leave. Dr Sahota said that discharge would be premature until rehabilitative treatment was complete and there was a continuing risk to her health and to others because of her vulnerability to stress, but he did not think that a section 41 order was necessary. In his opinion, the appellant was manageable under the current treatment plan and would upon being discharged be transferred to a community service "and can be referred to a specialist forensic service if there are concerns about her risk to the public."

11.
Dr Balasubramanian, a specialist trainee in forensic psychiatry, expressed a similar opinion in a report written in June 2020 and in her oral evidence to the judge.

12.
In the light of those reports, Mr Wright submitted to the judge that the appellant had gained clearer insight into the need to maintain her medication, was engaging positively with her care and was remorseful for her actions. The risk of future violence had been greatly reduced by the treatment she

had received and she would be subject to a robust care and risk management plan on discharge. In those circumstances, he submitted, a section 37 order was sufficient.

13.
The judge did not accept that submission. In her sentencing remarks, which if we may say so were of a high standard, she noted that the appellant had been admitted to hospital nine times, with the majority of those admissions being associated with violence, either before or during the admission. The relapses in the appellant's health had occurred very quickly and not all of them had been associated with her noncompliance with medication. In September 2018 the appellant had apparently been compliant with her medication, and it seemed that the appellant's placing herself under pressure and stress by embarking on a college course had been a significant trigger for relapse. For that reason, the judge said, it was not as simple as monitoring the appellant's compliance with her medication: her relapses were more complex, they occurred very quickly and the appellant when unwell posed a significant risk of physical harm both to known adults and to strangers. The appellant's recent progress had been extremely positive and encouraging and the judge acknowledged that none of the medical evidence before her supported the making of a restriction order. But, she said:

"I have to balance against that firstly the gravity of this offending and the level of violence that was used by Ms Inneh in this assault. Secondly, the nature of her illness which, as I said is enduring and relapsing and [remitting]. Thirdly, her history of serious violence when unwell and, fourthly, the complex triggers to the reasons for her relapse, not limited to non-compliance with medication. Fifthly, the speed with which she relapses when unwell and, six, the lack of certainty that she will automatically be discharged under a community treatment order, with a power of recall to a forensic team.

In my judgment, reflecting all of those matters, a restriction order is necessary to protect the public from serious harm and to ensure that her aftercare is supervised by appropriate professionals. The restriction order would have the advantage of ensuring that Ms Inneh’s eventual discharge is scrutinised with care. She would only be released by a Mental Health Review Tribunal, in proceedings in which the Ministry of Justice are a party and upon release she will be supported by a robust aftercare plan, with conditions that she accepts treatment and supervision in the community.

If she failed to adhere to those conditions and/or there were signs of relapse, there is a safeguard of her being recalled immediately to hospital and, in the circumstances of this case, and in having regard to the level of risk, I am satisfied that this level of scrutiny is necessary..."

14.
The judge therefore imposed the restriction order.

15.
In his submissions to this court, Mr Wright recognises that it was for the judge, not the reporting doctors, to decide whether a section 41 order was necessary. The views of the doctors were nonetheless important because they provided the context in which the judge had to make her decision. None of them said that a restriction order was necessary. Mr Wright emphasises that, in contrast to the earlier occasions when the appellant had been admitted to hospital, she has now gained insight into her condition and has engaged positively with her treatment including the psychological input which has not previously been provided. Mr Wright points to the most recent report, that of Dr Farrell dated 2 August 2021, which, although not before the judge, tends to support the submissions he makes. He further submits that when the appellant is discharged her aftercare

programme will very quickly identify any issues relating to relapse. He adds that the section 41 order has the effect that discharge of the appellant is no longer at the discretion of the responsible clinician, which may be a setback to the appellant's progress.

16.
His core argument is that although the judge rightly considered the various factors which she mentioned in her sentencing remarks, she did so primarily against the background of the appellant's behaviour up to and including the present offence, and failed to give sufficient weight to the progress which has been made over the lengthy period which had elapsed during her in-patient treatment. That treatment, in particular the appellant's engagement in psychotherapy, has helped her to understand her illness and to develop coping strategies, and has strengthened her resolve to maintain her medication.

17.
For the respondent, Mr Devlin points out that the reporting doctors were primarily concerned with the treatment of the appellant rather than with the safety of the public. He reminds the court that there have been in the past occasions when the appellant has simply stopped taking her drugs. He submits that the judge was right not to treat the attack on the elderly gentleman as an isolated incident: it was, he argues, an event in a sequence of incidents of escalating seriousness and sudden violence. Mr Devlin submits that the treatment plan for when the appellant is discharged does not cater for her mental state suddenly and inexplicably worsening as it has done in the past. Moreover, in the account which the appellant gave to Dr Farrell, she said that she had begun to feel paranoid two days before her attack on the elderly gentleman and had missed a dose of her medication. The appellant had however been reluctant to alert professionals to deteriorations in her mental health; lest she be admitted to hospital. Even after everything which has happened in the recent past, the appellant had told Dr Farrell that having to attend a regular clinic for depot medication might interfere with her being able to work, though she expressed her willingness to take oral medication. Mr Devlin submits that the judge was correct to conclude that a section 41 restriction order was necessary to address the continuing risk which the appellant poses to the public.

18.
We have reflected on the written and oral submissions of counsel for which we are grateful.

19.
The appellant has clearly received excellent care during her lengthy period in hospital and has undoubtedly benefited from it. It is however a troubling feature of the case that her past relapses have not always been associated with a failure to comply with her medication. The medical reports indicate, as the judge noted, that stress and pressure seem also to have played a part in at least some of these sudden relapses which have occurred in recent years. There is no doubt that when unwell the appellant has struggled to control her temper and has shown herself capable of causing serious injury to others. The judge therefore had to assess the risk to the public arising, not only from a failure by the appellant to maintain her medication, but also from a sudden relapse associated with a different trigger.

20.
In her careful sentencing remarks the judge identified and weighed all the relevant considerations. The fact that the expert medical evidence did not support a restriction order was an important consideration, which the judge rightly took into account, but it was not decisive. We note moreover that whilst none of the reporting clinicians advised in favour of a restriction order, none made any

comments suggesting that the imposition of such an order would be positively harmful to the appellant's care and rehabilitation.

21.
The imposition of a restriction order does not of course prevent the discharge of the appellant when a Tribunal is satisfied that discharge is appropriate. We hope that the appellant will continue the good progress which she has made. We are however satisfied that the judge was entitled, for the reasons which she gave, to conclude that a section 41 restriction order was necessary for the protection of the public.

22.
Accordingly, this appeal fails and must be dismissed.