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Judgment: approved by the Court for handing down | *Delivered:* **8/1/2008**
*(subject to editorial corrections)**

IN THE CROWN COURT IN NORTHERN IRELAND

DUNGANNON CROWN COURT
(sitting at Belfast)

_____

THE QUEEN

v

ARTHUR FRANCIS MURRAY

_____

HART J

[1] Although copies of this judgment will be provided to the press and other media, B was the victim of an offence of rape, and therefore by virtue of s.1 of the Sexual Offences (Amendment) Act, 2004 nothing must be published which would identify her as a victim of that offence. I appreciate that in the particular circumstances this case this may be difficult, but that is a requirement that must be complied with in reports of this case and publication of any parts of this judgment.

[2] On the morning of his trial the defendant asked to be rearraigned and pleaded guilty to the following offences:

(1) He pleaded not guilty to the murder of A, but guilty to manslaughter of him. This plea was made on the basis of his diminished responsibility at the time of the unlawful killing of A and was accepted by the prosecution.

(2) He pleaded not guilty to the attempted murder of B, but guilty to causing her grievous bodily harm with intent to injure, contrary to s. 18 of the Offences Against the Person Act 1861. This plea was also accepted by the prosecution.

(3) He pleaded guilty to the charge of rape of B.

[3] A was 76, and his sister B was 67 at the time of these offences.

[4] These offences came to light when B phoned her brother C at 10.45 am on Sunday 19 December 2004. Her voice sounded very low, shaky and frightened. She told her brother that someone had tried to kill her during the night, had beaten her up badly and had tossed her downstairs. She was unable to tell C where A was. She wanted C's wife D to come over to her house.

[5] D went there immediately whilst her husband phoned the police. She was unable to gain entrance to the house straightaway, but a number of men who were nearby effected entrance to the house shortly afterwards. When D looked into the hall she saw a number of things that indicated that something was seriously wrong –

(1) B's slipper was lying at the bottom of the stairs.

(2) The mat at the foot of the stairs was soaking and coloured red, and it was subsequently realised that it was soaked in blood.

(3) There were bloody footprints leading into the kitchen. The scene is shown in the photographs in album SO882/04.

[6] D was able to see her sister-in-law lying on a chaise longue in the kitchen. She went in and asked her what had happened, B replied that a man had "Near killed me. He beat me and kicked me. He threw me down the stairs". Having spoken to her sister-in-law D then went upstairs and found A dead in bed. When she returned downstairs she spoke to her sister-in-law again who said:

> "He put his hand over my mouth. He tried to smother me. He put his hand over my mouth. He near killed me. He was a big strong brute."

[7] The post mortem report by Professor Crane concluded that the causes of death were twofold. One, findings consistent with suffocation, and two, coronary atheroma and hypertension. Professor Crane found signs of slight injuries to A's face. Professor Crane considered the causes of death in the following extracts from his report.

> "Injuries such as these could have occurred if a hand or an object had been placed firmly over the face and could have resulted in obstruction to the mouth and nose. Interference with breathing in such circumstances could have induced a serious degree of asphyxia thereby resulting in death.

> Asphyxia caused in this way may not be associated with any diagnostic signs but in this case a few pinhead-sized congestive haemorrhages (petechial haemorrhages) had formed in the lining of the eyelids and in the lining of the upper lip. Petechial haemorrhages whilst not proof of asphyxia would tend to support the diagnosis, albeit that they may be found in deaths occurring in other circumstances. The interpretation of the relatively minor injuries to the face in this case is problematical but, taking everything into account, would be consistent with suffocation caused by obstruction of the mouth and nose.
>
> The autopsy also revealed evidence of underlying heart disease, the severity of which could possibly have precipitated a heart attack at any time. The heart was enlarged, probably due to a raised blood pressure, and there was moderate to severe degenerative narrowing of the main coronary arteries. There can be little doubt that heart disease of this severity would undoubtedly have made this man more susceptible to the effects of suffocation or attempted suffocation both in terms of stress associated with the event as well as the direct effects of airway obstruction. Under these circumstances it would not be unreasonable to incriminate the heart disease as contributing to the fatal outcome."

[8] Shirley Hewitt, one of the ambulance personnel called to the house, asked B when it had happened, and she replied about 4 o'clock, in other words about 4.00 am. She was also able to say that she had been in the hall, "He pushed me down the stairs", and "He tried to suffocate me and he beat at me".

[9] B was then taken to hospital and treated for her injuries. During the afternoon she described to Staff Nurse McKeown her recollection of what happened. From this account it appears that she awoke to find a man standing over her who tried to put his hand over her mouth. The man was carrying a screwdriver but she was able to knock it from his hand. She continued to struggle, but was pulled from the bed, trailed to the top of the stairs, and the man then threw her to the bottom of the stairs, where she lay as her attacker went around the house, "wrecking it" in her words. She also said that the man "must be on drugs", and tried to kiss her. Because she

said that the man had "touched her down there", pointing to between her legs, there was suspicion that she had been assaulted sexually as well as physically.

[10] At 5.30 pm that day she was examined by Dr Livingston, a forensic medical officer. In his statement he recorded the account she gave him of the attack upon her and described her injuries.

> "She stated that at approximately 03 00 am that morning of 19/12/04 when she was lying in bed, a male person entered her bedroom, he put his hand over her mouth and nose, caught her by the hair, and began knocking her head against the wall several times. She was then dragged from the bed by her shoulders, and forced to lie on her stomach as he searched the room. She stated that the person told her she would be choked, if she did not give him money. He then told her to go downstairs and look for money. When she got to the stairs, she felt a blow to the back of her head and fell down the stairs. She had a vague recollection of being on the couch in the kitchen, and the person touching her vagina, but when questioned about any sexual penetration of her vagina she could not remember. She thinks she was unconscious until about 10 30 am when she remembered trying to get to the telephone. She did not remember how she got assistance but could remember being taken by ambulance to hospital. She had no relevant medical history, nor was she on any sleeping medication. On examination, B was a frail elderly lady who was obviously quite distressed by her ordeal. There was a laceration to her head which was heavily bandaged. There was extensive fresh bruising around her right eye, below her left eye left cheek bone, to lateral aspect of her left lip, to the right side of her chin and also to the left side of her chin. There was also fresh bruising to both sides of her neck, and extensive small petechial haemorrhages on her neck. On the anterior aspect of her upper cheek there was extensive bruising to both right and left sides, and also bruising to both right and left shoulders posteriorly. On the anterior aspect of her right upper arm there were five areas of fresh bruising of varying sizes to the

> medial aspect, and bruising to the palmar aspect of her right hand. On the posterior aspect of her right arm, there was fresh bruising to the upper aspect, bruising to her right elbow, and bruising over the dorsal aspect of her right hand, second finger and to her third finger. There was also fresh bruising to the right lumbar area of her back, mid lumbar spine, three bruises on her right buttock and one bruise on her left buttock. On the anterior aspect of her right knee were two fresh bruises, and two bruises to the upper, lateral aspect of her right thigh. On the posterior aspect of her left lower leg was a fresh bruise. I also observed fresh blood around and close to the vagina, with a fresh 1.5 cm laceration to the fourchette region of her vagina, at 6 o'clock position. I was unable to pass a vaginal speculum for further examination due to vaginal spasm."

[11] In addition to the injuries described by Dr Livingston, W J I Stirling, a consultant surgeon, states that x-ray examination revealed a fracture of her right clavicle, and of the second and third proximal phalanges of her right hand.

[12] Swabs taken from B for forensic examination revealed that recent intercourse with ejaculation had occurred, and it was later established that the defendant's DNA was on those swabs. From the extensive bloodstaining found in the house it is apparent that she bled freely as a result of the injuries inflicted upon her.

[13] It would appear that she was left alone in the house and some six hours or more elapsed before she recovered sufficiently to telephone her brother and seek help. It is therefore apparent that she was the victim of a brutal physical and sexual attack of the gravest type. She had been awakened from her sleep by an intruder who proceeded to rape her, pull her from her bed and repeatedly strike her against the wall, before throwing her downstairs. As a result she bled profusely, and suffered numerous bruises, a broken collar bone, and fractures to two of her right fingers.

[14] In her statement dated 14 December 2007 B describes the effect this has had upon her life, setting out in considerable detail the day to day consequences of her grief at the loss of her brother, and the loss of companionship that she has suffered as a result of his death; the loss of her independence; and her dependence now upon the staff of the nursing home and her relatives to look after her. I also have the benefit of a lengthy

statement from her sister-in-law D, who now devotes a great deal of her time to providing support and reassurance to her sister-in-law. In this statement she graphically describes the many ways in which these terrible events have affected her sister in law.

[15] It would be an invidious task to attempt to summarise the many ways in which these events have affected B, but the report of her general practitioner graphically encapsulates the effect upon her.

> "Prior to the traumatic incident in December 2004, B was living with her brother, she worked as a housewife, drove her car and managed her own affairs with ease. According to the staff in the practice, B was an outgoing person, she would have been light hearted and chatty.
>
> Since the physical assault and rape in December 2004, together with the murder of her brother, B has been withdrawn, low anxious, quietly spoken and distracted. She feels her hearing has deteriorated since the attack – however it is normal on testing. She has suffered from chronic severe abdominal pain which has been thoroughly investigated by surgeons, urologists and gynaecologists and has been found to be of psychosomatic origin. She remains on strong analgesia to keep this pain under control.
>
> She has been assessed by psychiatry who have diagnosed a significant mixed anxiety depressive neurosis as a result of the assault.
>
> In short, B was previously a well, capable, independent woman who lived with her brother, managed the house, drove her car, was on medication for osteoporosis and an irregular heart beat. Since the attack, she is living in a nursing home, unable to drive, on multiple strong medications for anxiety, depression, pain, abdominal complaints and urinary symptoms, none of which have a physical cause. She is highly dependent on family to manage her affairs.
>
> B's life was completely transformed overnight by the attack, she will never return to the independent living or the good health that she

> had. In Dr McCammon's words "To say that she is only a shadow of her former happy, outgoing self is an understatement. She is going to have to live with the pain and memory of what occurred along with the loss of her brother for every day of the rest of her life."

[16] The police investigation into these crimes involved them taking DNA samples from a number of men in the vicinity, one of whom was the defendant. An analysis of his DNA revealed that it matched that of the semen sample recovered from B. A search of his house led to the discovery of two garments, a fleece and a coat. Fibres matching those from the fleece were found on a quilt from A's room, and on the exterior of the kitchen window. Blood matching that of B was found on the coat. This blood took the form of spots of projected blood, predominantly on the front right and sleeve, and, in the opinion of Jason Bennett of FSNI "the distribution of the blood would be consistent with the jacket being close to a source of projected blood". The fibre and DNA evidence therefore provided overwhelming evidence that it was the defendant who entered the house, killed A, and raped and brutally attacked B.

[17] When the police sought to arrest the defendant he was found to be a patient in Craigavon Area Hospital where he had been admitted after a collapse on 21 February 2005.

[18] During interview the defendant denied these offences, saying that he had no recollection of these events. He described how he had been at a Christmas works party organised by an employer for whom he had worked on a part time basis over the previous 2 ½ years. He told the police that he had taken some drink and then gone home, where he went to sleep on two chairs and slept until he awoke next morning.

[19] I have been provided with a number of extremely detailed psychiatric reports on the defendant. These have been prepared by Dr J M Bird, a consultant neuro-psychiatrist at the Frenchay Hospital in Bristol; by Dr R W J Reeves, a consultant forensic psychiatrist of the Priory Hospital in Bristol; and by Dr Christine Kennedy, a consultant forensic psychiatrist employed between the Shannon Clinic Medium Secure Unit and the Northern Trust Community Forensic Team. Dr Kennedy was retained by the prosecution. Dr Bird and Dr Reeves were retained by the defence.

[20] These reports describe the defendant's personal and medical history in very considerable detail and I propose to merely refer to the main features of these accounts. The defendant, who is now 46, was born in Lancashire although both his parents came from Ireland. His parents separated when he was two and thereafter he lived with his mother. He

describes his mother at that time as a violent person who repeatedly hit him and his younger brother for the slightest misdemeanour, using any weapon that came to hand. They lived in straightened financial circumstances. The defendant left school when he was 16 and got married when he was 20. The marriage lasted four years; they had two children with whom he maintained contact as they grew up.

[21] As will be seen when I turn to deal with his record later in this judgment he committed a number of offences in his teenage years and early 20s. As a result he was sentenced to periods of imprisonment, and whilst in prison his father visited him and they re-established relations. After the defendant was released he lived for some time with his father, he found regular work, and by the age of 30 was living in Birmingham. He became friendly with his half sister from his father's other relationship and they worked together in the hotel trade. They decided to come to Northern Ireland because of their family connections with Ireland and in 1997 or 1998 they moved to the Coalisland area. The defendant's father also lived in that area, and the defendant found work there. It appears that he has two half brothers, who also live in Northern Ireland, and another half sister lived in Coventry who died of cancer in February 2004.

[22] The medical records examined by Dr Bird in particular contain a well-documented and substantial psychiatric history starting in March 2001 and continuing after the commission of these offences in December 2004. In March 2001 his general practitioner prescribed an anti-depressant, and on 14 March 2001 he was seen for the first time by a consultant psychiatrist and was admitted to St Luke's Hospital that day because, in Dr Bird's words, he was hearing voices, was paranoid about the suspected presence of others about his house and showed violent outbursts for no good reason. Later at page 9 of his report Dr Bird recorded:

> "He reported a history of violence and of assaults against the Police and other people, he said that these were always alcohol related, but not for several years. He admitted that he had been violent towards his wife when they were married in his early twenties."

[23] A diagnosis of moderate depressive illness was made. The defendant was discharged from hospital on 3 April 2001 when he was considered to be much improved, and the records show that he was reviewed by consultant psychiatrists at regular intervals over the next year or so. The next significant entry in his record is a report from the community psychiatric nurse who visited him on a regular basis. The defendant had developed a delusion that he was going to be taken to prison because he had not paid his rates. Dr Bird records that:

> "On the nurse's visit, Mr Murray was prepared for the police and anyone else to come and he was going to resist arrest. He even had a knife waiting to help him to protect himself. The nurse wrote 'I do feel that to visit Arthur on one's own without having a rapport with him would be dangerous, and I only visit when his friend is present. Thankfully, Arthur will not open his door to anyone coming unless Mr O'Neill is present, but I would worry if anyone did persist, what he would actually do. Again his actions would not be resultant from psychotic state but due to an extreme anxiety reaction which in itself could become psychotic." The nurse went on to say "that he felt that Mr Murray had elements which make him dangerous to others".

[24] The defendant continued to be reviewed at regular intervals by various consultant psychiatrists, and on 5 March 2003 one "had concerns that he might show violent outbursts at some stage". Thereafter he was regularly seen by consultant psychiatrists and his anti-depressant and anti-psychotic medication was continued. On 17 January 2005 he was admitted to Craigavon Accident and Emergency Department in an unconscious state having taken an overdose of tablets. He was transferred to ICU and then to St Luke's Hospital. In due course he was released, Dr Bird recording at page 14:

> "The impression was this was an accidental overdose in a person with a history of depression and possible psychiatric features in the past, and schizoid personality traits."

Finally there was a further admission to Craigavon Accident and Emergency Department on 22 February 2005 following the collapse to which I have earlier referred, and he was still a patient in Craigavon Hospital when he was arrested for questioning in relation to these charges.

[25] It is against this background and history that I turn to consider the explanation, if any explanation there can be, as to why the defendant carried out these crimes. In his report of 5 August 2005 Dr Bird concluded that he was suffering from Paranoid Psychosis and Severe Personality Disorder.

> "It is my view, therefore, that at the material time, Mr Murray was likely to have been suffering from such abnormality of mind as to have substantially impaired his mental responsibility for his acts. I consider that his abnormality of mind, Paranoid Psychosis and Severe Personality Disorder, were so different from that of ordinary persons, that any reasonable person would have regarded them as abnormal. At the time in question, I think it unlikely that Mr Murray was able to exercise his will power to control his physical acts in accordance with rational judgement, and I think it likely that, at the material time, he was unable to form such a rational judgement about whether what he was doing was right or wrong. I believe that these abnormalities of the mind were due to the recognised psychiatric disorders of Paranoid Psychosis and Severe Personality Disorder, exacerbated by alcohol. I think that all of these factors were sufficient as substantially to diminish Mr Murray's responsibilities for his acts at the material time. The causes of the underlying illness were clearly inherent causes due to disease of the mind. The alcohol, although obviously not an inherent cause, was only effective in substantially reducing his ability to control his acts in this case because of his underlying psychiatric disorders.
>
> Currently, I regard Mr Murray as fit to plead."

[26] This diagnosis was made upon the basis that the defendant denied that he had been using cannabis on 18 December 2004 (see page 5), although he did admit using cannabis regularly, saying that he used about 1oz a month (see page 4). However, in Dr Reeves' report of 29 September 2007 he gives a somewhat different account of the defendant's cannabis use.

> "He became increasingly depressed and gradually increasing his consumption of cannabis until eventually he was smoking a ¼oz a week. He would have a reefer first thing in the morning, then one or two in the daytime, then three or four in the evening. He said some days he was smoking cannabis all day. The point was it was a

> secret. He never told anyone, even his best friend that he was a daily user of cannabis."

[27] Therefore, whilst the amount of cannabis the defendant admitted taking was the same, he was now saying that on occasions he was smoking cannabis everyday. Dr Reeves also elicited from the defendant that the type of cannabis he was smoking was hashish, and Dr Reeves described the effects of that in the following extract from page 16 of his report.

> "There are various forms of cannabis plant. The drug can either be taken as the dried and chopped up leafy part of the plant and is known by a variety of names including 'blow and weed'. However the plant also produces a resin which comes in sticky balls or slabs and that is known as hashish. However, plant breeders have been breeding other strains of cannabis and that is how 'skunk' has arrived. This plant can grow outside a greenhouse, even in Holland. Furthermore, the product obtained from it is much more intoxicating than the earlier forms of cannabis. A sizeable proportion of cannabis users consume cannabis on a regular, even daily basis, and as a consequence tend to live in a fog. They can lose the sharp appreciation of reality and lethargy sets in (Amotivational syndrome). They can become dull and ponderous in conversation with thoughts tailing away mid stream. Also it can cause paranoia in some people and also it can cause a paranoid psychosis and this may be short lived and there may well be disorientation, fear, delusions and hallucinations."

[28] Dr Reeves' conclusion may be seen from the following extracts from pages 28 and 29 of his report.

> "It would seem to me that the evidence suggests an ongoing psychotic condition, either induced by cannabis in which case it would fluctuate or he developed a paranoid schizophrenic illness made worse by the ingestion of cannabis. All along he has been prescribed antipsychotics and antidepressant medication and that medication would counteract, at least in part, the effect of the cannabis.

> Assuming he committed this very serious offence, I think it is of significance that he told me that he had stopped his medication some time before the alleged offence and also said he did not always take his medication. He drank that day and it seems to be probable, assuming he is guilty, that the alcohol induced a temporary worsening of his mental health and he became, for a short time, floridly psychotic. We already know that in the past he had command hallucinations. He claims he cannot remember and yet the DNA evidence apparently is totally conclusive that he must have been there. His loss of memory therefore may be feigned and he is lying or it may be connected with alcohol. Alcohol amnesia is very common. But also patients with acute transient psychotic states who kill and do serious harm may, quite genuinely, not be able to recall what happened and one can interview these prisoners or patients over the years but one is never able to retrieve the actual delusions or hallucinations that were operating at the time of the violence.
>
> No doubt the Court will be going carefully into the question of whether there was any animosity between Mr Murray and A or B. If there was not and the offence seems inexplicable without motivation I think one is left with the conclusion that on the balance of probabilities Mr Murray had tipped over into florid psychosis and his extreme violence flowed from the delusions and hallucinations associated with a psychotic illness. These brief psychotic episodes can be short-lived even though the violence is horrendous and then the person quickly reverts to their normal state."

[29] Dr Kennedy examined the defendant on behalf of the prosecution, and at page 2 of her addendum report of 7 December she concluded that the offences were most likely to have occurred when the defendant was acutely psychotic.

> "The constellation of factors which came together to result in this offence are not entirely clear and may never be known. Why it happened on that particular evening and to those particular victims

> is unknown. We are assuming that this offence is most likely to have occurred when Mr Murray was acutely psychotic, possibly experiencing command hallucinations to kill, and this state largely having arisen as a consequence of non-compliance with prescribed medication and use of illicit drugs. He has longstanding angry feelings and there may be conflicting love/hate feelings towards his mother which were of relevance in this offence also."

[30] The psychiatric evidence is therefore that at the time the defendant committed these crimes he was in a psychotic state, and that is why the prosecution accepted the defendant's plea of not guilty to the murder of A, but guilty to his manslaughter upon the grounds of diminished responsibility. I have referred to the defendant having been treated by a number of psychiatrists, and it is appropriate that I should draw attention to the comments of Dr Reeves.

> "..in my opinion as a forensic psychiatrist now of some 40 years standing, I do not see that there was any warning, assuming Mr Murray is guilty, that this particular tragedy was going to occur and I do not see what could have been done by the caring professionals to have prevented it. My view is that if Mr Murray is being truthful about his cannabis consumption it played a significant part in maintaining an abnormal mental state. He never disclosed it to the professionals caring for him because it was a guilty secret. If they had known and assuming it was true, then I think that they would have comprehended much more clearly the reasons for Mr Murray's on-going paranoid mental state and I am sure would have done their level best to dissuade him from using cannabis."

The defendant's deliberate concealment of his cannabis consumption is a factor of considerable significance when it comes to deciding the extent of his residual responsibility for these crimes, and the sentence that should be imposed, as I will explain later in this judgment.

[31] What then is the risk of the defendant harming someone in the future? This is a complex and difficult question. Dr Bird's view as expressed at page 18 of his report of 5 August 2005 was that the defendant was likely to remain dangerous.

> "I regard Mr Murray as suffering from a severe and lifelong condition now, that of Paranoid Psychosis with Severe Personality Disorder. At the time in question he was apparently taking his medication regularly and he was under fairly close Community Psychiatric review. He had been regarded as dangerous in 2002. I therefore regard his prognosis for recovery from his condition was [presumably this should be "as"] very poor and think that he is likely to remain dangerous as a result of his psychiatric disorder. His present imprisonment does not seem to be making his underlying disorder worse. I would recommend a forensic psychiatry option as to the most appropriate psychiatric disposal. Apart from the use of ongoing medication, I do not consider that any neuropsychiatric treatment is required."

[32] In a brief letter to the defendant's solicitors dated 20 November 2007 he gave a somewhat more qualified opinion as may be seen from those comments.

> "I have been asked to consider the risk that Mr Murray would re-offend in a similar manner. Taking into account Mr Murray's history, the fact that his exact state of mind is unknowable at the time of the offences, his age and the length of time he has now been in jail, without any evidence of disturbed behavior, it is my considered opinion that, if he were to remain on his prescribed medication and under ongoing and close psychiatric review, the risk of him re-offending in a similar manner is low."

[33] Under the heading "Dangerousness" Dr Reeves in his report of 20 September 2007 addressed the issue in this way.

> "**DANGEROUSNESS**
>
> "If the Court accepts that Mr Murray had an abnormality of mind at the time of the offence and that abnormality of mind was an acute psychotic illness, then this presents grave and difficult problems for those responsible for assessing dangerousness in the years to come. It may be

> likely, of course if Mr Murray is found guilty and there is a prison sentence, that he will have an episode of psychosis sufficient to warrant his transfer to a psychiatric hospital. Apart from that I think there is a very high risk of serious self harm. Even if those two things do not happen it is almost impossible to say with certainty when a person who has committed a serious offence during a brief psychotic episode will ever be safe to live again in the community."

[34] Dr Kennedy dealt with the risk of re-offending in a second addendum report of 7 December 2007.

> "It is impossible to predict the future and specifically whether Mr Murray would, given the opportunity, kill and rape again. The statistical likelihood of such an event happening would be very low. The issue is not so much whether such an event could happen but whether it can be prevented by risk management strategies."

She referred to his history of violence and of alcohol and substance abuse, his significant personality problem in the past, and his failure in the past to entirely comply with recommendations made by his supervising psychiatrist. She continued:

> "These historical factors serve to increase Mr Murray's risk of future violence above the general population threshold. It therefore must be accepted that he will always present a certain level of residual risk irrespective of intervention. The focus therefore has to be on future risk management strategies."

She also commented that his insight into his mental health was poor, and referred to his denying the presence of symptomatology, and not admitting to using cannabis. She noted that he was unable to see any possible link between his cannabis use and the onset of his mental health difficulties, concluding:

> "This suggests to me that he does not fully appreciate how essential it is that he has his medication, complies with his treatment and is

> proactive in obtaining it should it not be made available for him."

[35] Having referred to "his solitary nature and lack of extensive social networks", after the passage already quoted at [29] above, she concluded:

> "I think that the risk of Mr Murray re-offending in a similar manner will only be considered low for as long as he is in a very controlled environment subject to high levels of supervision, abstinence from substances and with a stable mental state. I believe he will need stringent testing out through phased reintroduction of increasing stresses before he could be considered suitable for highly supervised community care. If he receives a discretionary life sentence for example, I would envisage that his longer-term management would be a joint process between Probation and Community Forensic Mental Health Team Staff. Mental Health input would probably need to be life long unless there were new developments.
>
> Following sentence, should his mental state deteriorate or should there be a requirement to assess his need for medication and detail his mental state in its absence, this could be done by transfer to a bed at Shannon Clinic (Belfast Medium Secure Unit)."

[36] At this point it is appropriate that I should refer to the defendant's criminal record. It is a significant record comprising some 28 offences in all, with his first conviction being on 13 December 1997 when he was 15 and his last on 7 September 1990 when he was 28, that is 14 years before the present offences. Of particular significance are the following convictions.

(i) His first conviction on 13 December 1977 was for possession of an offensive weapon in a public place, for which he received a supervision order for two years.

(ii) On 9 November 1978 he was convicted of aggravated burglary and received a sentence of three months in a detention centre.

(iii) On 18 February 1981 at Leicester Crown Court he received sentences totaling three months imprisonment on two charges of assault occasioning actual bodily harm.

(iv) On 4 June 1981 he received total sentences of two and a half years imprisonment, of which two years represented the sentence for an offence of wounding contrary to Section 20 of the Offences Against the Person Act 1861. At that time he was just 19.

(v) His next conviction was on 3 January 1984 when he received a sentence of three years imprisonment for robbery. He was then 21.

(vi) On 21 September 1988 he received sentences of three months imprisonment for a number of offences including two assaults on the police.

All these offences were of a violent nature.

[37] The leading authority on sentencing in cases of manslaughter on the grounds of diminished responsibility is R v Chambers (1983) 5 Cr. App. R. (S) 190 where Leonard J described the approach to be adopted as follows.

> "In diminished responsibility cases there are various courses open to a judge. His choice of the right course will depend on the state of the evidence and the material before him. If the psychiatric reports recommend and justify it, and there are no contrary indications, he will make a hospital order. Where a hospital order is not recommended, or is not appropriate, and the defendant constitutes a danger to the public for an unpredictable period of time, the right sentence will, in all probability, be one of life imprisonment.
>
> In cases where the evidence indicates that the accused's responsibility for his acts was so grossly impaired that his degree of responsibility for them was minimal, then a lenient course will be open to the judge. Provided there is no danger of repetition of violence, it will usually be possible to make such an order as will give the accused his freedom possibly with some supervision.
>
> There will however be cases in which there is no proper basis for a hospital order; but in which the accused's degree of responsibility is not minimal. In such cases the judge should pass a determinate

> sentence of imprisonment, the length of which will depend on two factors: his assessment of the degree of the accused's responsibility and his view as to the period of time, if any, for which the accused will continue to be a danger to the public."

In that case the sentence on a plea of guilty was reduced from ten years imprisonment to eight. Chambers has been referred to with approval on many occasions since as can be seen from the cases collected in Butterworth's Sentencing Practice at Part B1-1. In the present case it is accepted by the psychiatrists that the defendant's psychiatric condition at present is such that a hospital order is not appropriate.

[38] In R v Stubbs (1994) 15 Cr. App. R. (S) Lord Taylor CJ said:

> "It has to be remembered that diminished responsibility does not mean – and this has been said before in this Court – totally extinguished responsibility. It is not a defence which necessarily involves that there is no blame, no culpability deserving of punishment and indeed of custody in the person who has committed the offence."

I consider that the defendant's minimal responsibility, or "residual responsibility" as it has been described, for these crimes is very high, notwithstanding that he was suffering from diminished responsibility at the time. He had been drinking, he had not been taking his medication, he had consumed cannabis and regularly did so, he has previous convictions for offences of violence (albeit a long time ago), and he committed not just one but two distinct crimes of great gravity.

[39] I consider that the danger of the defendant committing further violent offences, even if not of the exact nature of the present charges, cannot be regarded as insignificant. In assessing the danger of the defendant to the public I take into account not only the exceptional violence displayed when these crimes were committed, but I also have regard to crimes of violence he has committed in the past, and the potential for violence which he displayed some years ago when being visited by his community psychiatric nurse. It is clear from Dr Kennedy's assessment, supported to some degree by that of Dr Bird in 2005, that the low risk of re-offending in this way is dependent upon the defendant being subject to high levels of supervision, abstinence from substances such as cannabis and a stable mental state. His concealment of his cannabis consumption from the doctors who treated him in the past, his

lack of insight into the danger of taking cannabis and medication, together with his not taking his medication in the past, has led me to conclude that the risk of further offences of violence will only be reduced to acceptable levels by the most stringent assessment of his condition before he is released from custody, together with a rigorous regime of supervision and mental health care after such release. To adopt a phrase used by Dr Kennedy in her second addendum report of 7 December 2007 the focus when he is considered for release "has to be on future risk management strategies".

[40] How best can this be achieved? It is implicit in the reports of Dr Bird and Dr Reeves, and is the stated view of Dr Kennedy, that the defendant's present state of mental health is such that a hospital order is not appropriate. Mr Orr QC on behalf of the prosecution referred me to the power of the court to impose a longer sentence than would otherwise be appropriate by virtue of the provisions of Article 20(2)(b) of the Criminal Justice (Northern Ireland) Order 1996. However I consider that such a sentence could not provide for the imposition of sufficient safeguards upon the defendant when he was released from prison. Neither in my opinion would a custody probation order, even if otherwise appropriate, adequately provide for such a situation. Nor would an order under Article 26 of the 1996 Order that the defendant be released upon licence upon the expiration of a determinate sentence in respect of the rape charge. Article 26(1)(b)(i) of the 1996 Order permits the court to order that the defendant be released subject to such a licence, having regard to "the need to protect the public from serious harm from him". Whilst there seems to be no reason in principle that such an order could not provide for supervision of the defendant after he was released, including contact with and supervision by mental health professionals, it could not prevent him being released upon the expiration of his sentence even if there were well-grounded concerns at that time that he would not take his medication and abstain from taking cannabis.

[41] I consider that any form of determinate sentence imposed in this case would suffer from that defect, and I regard it as crucial for the protection of the public in the future that when the time comes to consider whether the defendant should be released from custody two objectives can be achieved. The first is that a thorough assessment of his mental state is carried out before he is considered for release, and unless that assessment establishes that it would be safe to release him he will not be released. Secondly, if it is decided that it is safe to release him, steps can then be taken to ensure that upon release he is subject to a rigorous regime of supervision in an environment that ensures that the supervision will, so far as possible, ensure that he takes his medication and abstains from consuming alcohol and illegal substances such as cannabis.

[42] A further option indicated in Chambers, and one I explored with Mr Gallagher QC in the course of the plea which he made on the defendant's behalf, would be to impose a life sentence. In R v. McCandless and others [2004] NI 269 at page 296 the Court of Appeal again approved the principle enunciated in R v. Hodgson.

> "[50] The criteria for imposing a sentence of indeterminate length were laid down in *R v Hodgson* (1967) 52 Cr App R 113 and 114, in terms approved and adopted by this court in *R v. McDonald* [1989] NI 54:
>
> > "When the following conditions are satisfied, a sentence of life imprisonment is in our opinion justified: (1) where the offence or offences are in themselves grave enough to require a very long sentence; (2) where it appears from the nature of the offences or from the defendant's history that he is a person of unstable character likely to commit such offences in the future; and (3) where if the offences are committed the consequences to others may be specially injurious, as in the case of sexual offences or crimes of violence."
>
> The application of this test received further explanation in *Attorney-General's Reference (No 32 of 1996) (Whittaker)* [1997] 1 Cr App R (S) 261, where the court emphasized that the two essentials are a crime of sufficient seriousness and good grounds for believing that the offender may remain a serious danger to the public for a period which cannot be estimated at the time of sentencing. In the ordinary way a court will look for specific medical evidence to support the latter proposition, but it may be inferred from the evidence before the court. When the criteria as so understood are so applied, we are satisfied that the judge was quite justified in regarding the present case as one calling for a life sentence. He quite rightly considered other methods of disposition; some were not available to him and others he did not regard as sufficient to deal

> adequately with the case, and he therefore fixed on a life sentence as the one remaining method which would suffice."

[43] I am satisfied that the criteria for imposing a life sentence are justified in this case.

(1) The offences are in themselves grave enough to require a very long sentence.

(2) I am satisfied from the nature of the offences and from the defendant's history that he is a person of unstable character who may remain a serious danger to the public for a period which cannot be estimated at this time.

(3) The nature of the present offences was such, that when one considers the defendant's psychiatric condition and the causes that gave rise to his committing these terrible offences, the consequences to others in the future may be specially injurious.

[44] I am satisfied that the circumstances of the present case are such that only a life sentence can provide an adequate framework where the risk to the public from the defendant can be assessed before a decision is made to release him, and if that assessment shows that it is safe to release him, sufficient safeguards can be imposed to ensure, so far as this can be achieved, that he does not present a risk to the public after he is released. Any form of determinate sentence cannot achieve all of these requirements.

[45] When setting the minimum term to be served by the defendant before he can be considered for release I have to have regard to the aggravating and mitigating factors in this case. I consider that there are only two mitigating factors. The first is that the defendant pleaded guilty, albeit only on the day of the trial, and he is entitled to credit for this. Secondly that he was suffering from diminished responsibility at the time he committed these offences reduces to some degree his culpability for his crimes. However, for the reasons already outlined, his diminished responsibility does not exculpate him from responsibility for these crimes and for the reasons I have given I am satisfied that there is a high degree of residual culpability.

[46] There are a considerable number of aggravating factors.

(1) He broke into the house to commit these crimes and therefore violated the sense of security which B was entitled to enjoy.

(2) He had been drinking.

(3) He had been taking cannabis.

(4) He had not been taking his medication.

(5) The sexual and physical attack upon B was of a particularly grave nature. Not only was she seriously injured, but she had no previous sexual experience.

(6) The consequences of these events have been exceptionally serious for her.

(7) The defendant has previous convictions for offences of violence, albeit that he had not offended for some 14 years.

(8) He committed two distinct offences of great gravity.

[47] When considering the minimum term appropriate to satisfy the requirements of retribution and deterrence having regard to the seriousness of the offence, or of the combination of the offence and one or more offences associated with it, as required by Article 5(2) of the Life Sentences (Northern Ireland) Order 2001, I consider that there should be a consecutive element in the term to take account of the separate crimes perpetrated against both victims. Whilst concurrent sentences are normally imposed where separate offences are considered to be part of the same transaction, that is not an absolute rule. As I have already observed, there were two distinct crimes of great gravity committed by the defendant, and were there not to be a consecutive element to the overall sentence, the result would be that the defendant would not be adequately punished for both crimes. However, I must have regard to the totality of that minimum term so as to ensure that the overall sentence is not disproportionate to the defendant's criminality and his residual responsibility for his crimes.

[48] When fixing the minimum term in a case of this sort it is appropriate to bear in mind that a minimum term equates to a determinate sentence of twice that length, because a minimum term does not entitle the defendant to remission, see R v McCandless at [51]. Thus a minimum term of say 10 years is equivalent to a determinate sentence of 20 years imprisonment.

[49] Having taken all of the various considerations into account I consider that the proper sentence on count one, the charge of manslaughter, and upon count three, the charge of rape, are sentences of life imprisonment with a minimum term of 12 years imprisonment. On count two I impose a sentence of 12 years imprisonment. The sentences will run concurrently, and the minimum term will take account of the time spent by the accused on remand.