**Neutral Citation no. [2007] NICC 16** | *Ref:* **MORF5854**

*Judgment: approved by the Court for handing down* | *Delivered:* **31/05/07**

*(subject to editorial corrections)**

**IN THE CROWN COURT SITTING IN NORTHERN IRELAND**

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**THE QUEEN**

**-v-**

**SEAMUS LYTTLE**

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**MORGAN J**

[1] The defendant was charged with the murder of his mother. He pleaded guilty to manslaughter on the grounds of diminished responsibility. In light of the agreed medical evidence that plea was accepted.

[2] The defendant is now 36 years old. In October 2005 he was living with his mother in Belfast. Although other members of the family had resided in the family home all by that time had moved out. Both the defendant and his mother abused alcohol and the defendant also abused drugs. Their living conditions were described as squalid. The police were regularly called to the home as a result of reports of domestic incidents in which each of them from time to time were complainants. On 20 October 2005 a referral of the deceased was made to women's aid and an appointment was arranged for 10 a.m. on 25 October 2005. On 24 October 2005 police were called to the home as a result of a further complaint and the defendant at that stage agreed to leave the home. He returned some hours thereafter.

[3] The deceased did not attend the appointment at 10 a.m. on 25 October 2005 and a close neighbour has no recollection of seeing the deceased after 25 October 2005. It seems likely that the deceased was killed at or about this time. She clearly received a ferocious beating suffering multiple fractures of the jaw, neck, ribs, right cheekbone and collar bone. This assault appears to have occurred in the downstairs area of the family home. The precise events leading to this attack are still not clear but it appears that the defendant had consumed excessive quantities of alcohol at the time that he launched the attack upon his mother. Sometime thereafter the defendant dressed his mother in his jeans and other clothes and carried her up 2 floors to his bed where he put a quilt over her. He continued to reside in the house over the next few days. A neighbour became concerned that she had not seen the deceased. On 30 October 2005 the defendant told the neighbour what he had

done. He brought her in to see the body and police were called shortly thereafter and he was arrested. At interview he admitted that he was responsible for the injuries inflicted on his mother.

[4] The defendant has lived an utterly chaotic life. He was taken into care as a child apparently because of his mother's social habits and dependency on alcohol. He was the victim of sexual victimisation by older boys when he was eight years old. He consumed alcohol and illicit psychoactive substances from an early age. He has a long criminal record for offences of robbery, dishonesty, assault and driving offences often associated with substance abuse. Both Dr Bownes and Dr Browne consider that he suffers from paranoid schizophrenia, harmful use of alcohol and drugs, particularly cannabis, and dissocial personality disorder. He has a long psychiatric history including compulsory admissions to hospital.

[5] The defendant was first seen by Dr Bownes at the psychiatric unit in the prison in 1997 because of his agitated and aggressive behaviour. He gave a history of abuse of illegal drugs over a five-year period and excessive alcohol consumption. The clinical picture was consistent with acute psychotic illness and he was transferred for further assessment and treatment under the Mental Health Order. He was next seen in prison in July 1998 regarding paranoid ideation and bizarre thoughts, including ideas that his own thoughts were being interfered with, and auditory hallucinations. A diagnosis of paranoid schizophrenia was made and he was again transferred as a detained patient under the Mental Health Order. During that detention it was noted that he displayed lack of insight into his condition, failure to comply consistently with advice and treatment and a tendency to aggressive behaviour when drinking alcohol or using illegal drugs. In June 1999 it was noted that he had not been attending for his regular injections. He had a history of auditory hallucinations for several months and admitted hitting his mother during an argument after drinking 8 pints of beer. In January 2000 he was readmitted to the psychiatric unit at the prison with a history of abuse of alcohol and illegal drugs. He was treated with antipsychotic medication and transferred to a hospital unit on 7 April 2000. Because of his aggressive behaviour towards staff after consumption of alcohol provided to him by visitors he had to be returned to prison on 17 April 2000. He was readmitted to the hospital unit in the prison on 12 October 2000 because of a deterioration in his mood. He remained there until he was discharged from the prison on 9 January 2001. Although he appeared to comply with his medication for some months thereafter by January 2002 there were concerns that he was hitting his mother and not taking medication. He was readmitted to prison in May 2002 and admitted that he had not taken his medication for a while because of its unpleasant side-effects. He was treated in the health-care centre of the prison and commenced his medication again on 29 July 2002. He was discharged from prison on 25 April 2003 but was readmitted on 7 August 2003 when he had become agitated and unsettled again. He had once again stopped taking

his antipsychotic medication because of its distressing side-effects. He was discharged from the hospital wing on 19 August 2003. In July 2004 he was assessed again in prison when it was considered that he had an exacerbation of his chronic psychotic disorder. There was concern that he had been smoking cannabis. At a Risk Management Strategy Meeting concerning his application for parole on 27 July 2004 it was considered that the defendant presented a serious risk of violent behaviour particularly when abusing alcohol and not taking prescribed medication. It was noted that he had a propensity to drink at home because of his home circumstances and that a return home inevitably heralded alcohol abuse, interference with prescribed medication and a further serious assault. On 3 October 2004 he admitted to drinking alcohol when he was on parole despite having been placed in hostel accommodation and also admitted smoking cannabis once a week. He was released from custody on 17 November 2004.

[6] The defendant was examined by a consultant psychiatrist shortly after his arrest. The psychiatrist noted that he clearly suffered from mental disorder and appeared to be psychotic and paranoid. He refused to take oral antipsychotic medication prescribed by the psychiatrist and spat at least one of the tablets supplied into the sink. On his admission to prison on remand he was unkempt, agitated and vague in manner. The defendant reported that he had been drinking alcohol every day prior to his committal to prison and that he had abused cannabis. He had suffered blackouts during the previous months which were alcohol-related and had not taken any antipsychotic medication since January 2005. Thereafter he was treated within the prison health care facility. I have had the benefit of evidence from Dr Bownes, Dr Browne and Dr Lindsay Thompson, medical director of the State Hospital at Carstairs. All are agreed upon the diagnosis set out in paragraph 4 above. All are agreed that the defendant requires treatment with powerful antipsychotic medication which requires monitoring facilities which are not available within the prison health care system in Northern Ireland. I am advised that there is no mechanism for the transfer of a prisoner on remand to the high security psychiatric facility at Carstairs and as a result a prisoner in the position of the defendant cannot be provided with the medication which the clinicians consider appropriate to the treatment of his condition during his remand. It is clearly in the public interest that prisoners on remand who are suffering from serious psychiatric conditions should receive appropriate medical treatment in order to address those conditions and diminish the extent to which they are a danger to themselves and others. Any administrative obstacles to this course need to be re-examined in order to seek to secure that outcome.

[7] All of the doctors who gave evidence before me agree that as soon as the defendant is sentenced he should be transferred to the State Hospital at Carstairs where in a high security environment he can receive treatment for his condition. It is anticipated that he might remain at Carstairs for around

five years and thereafter be transferred to the medium secure facility at the Shannon Clinic in Northern Ireland. It is not possible to predict how he may benefit from treatment nor can it be said with any confidence when he may safely be released into the community. I consider that the offence to which he has pleaded guilty is clearly a most serious offence. I am further satisfied on the basis of the above material that if he were released into the community he would represent a serious risk of harm to the public. Finally I consider that it is impossible at this stage to predict when it might be safe to release him into the community. Those factors were identified by the Court of Appeal in R v Livie (9 November 1990) and R v Gallagher [2004] NICA 11 as the critical factors in determining whether a determinate or indeterminate sentence was appropriate. I am satisfied that I could not properly protect the public in this case by imposing a determinate sentence of imprisonment.

[8] Against that background Mr Cinnamond QC for the defendant submitted that I should make a hospital order with restriction under the mental health legislation in order to properly meet this case. He started off from the proposition that imprisonment was detrimental to the defendant's prospects of recovery. The history set out above demonstrates that on occasions the defendant has engaged in substance abuse within the prison which has been detrimental to his health. It is also agreed by all of the doctors that the best prospect of recovery for the defendant lies in him receiving expert treatment in a hospital environment. Accordingly it was submitted that any disposal which would expose the defendant to the risk of returning to prison was one which imperilled the prospect of ensuring that the defendant did recover so as to be able to return to the community. Mr Cinnamond pointed out that if a hospital order with restriction was made the defendant would only be released into the community by the mental health review tribunal where it was of the view that the mental illness was resolved or alternatively was at such a level that it was safe for the defendant to be released into the community. He relied on the view of Dr Bownes that one could expect the tribunal to act robustly and he submitted that this gave adequate protection for the public. Finally he relied on the decision of the English Court of Appeal in R v Birch 1 Cr App R (S) 202 where in similar circumstances it found that a hospital order was the appropriate outcome.

[9] In order to deal with this submission it is necessary to examine the relevant legislation in this jurisdiction. The definition of mental disorder and related expressions is found in article 3 of the Mental Health (Northern Ireland) Order 1986.

*"Definition of "mental disorder" and related expressions*

**3.** — (1) In this Order—

'mental disorder' means mental illness, mental handicap and any other disorder or disability of mind;
'mental illness' means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons;
'mental handicap' means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning;
'severe mental handicap' means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning;
'severe mental impairment' means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

(2) No person shall be treated under this Order as suffering from mental disorder, or from any form of mental disorder, by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."

This differs from its counterpart in Great Britain in that "personality disorder" is specifically excluded from the definition of mental disorder. In this case the defendant's dissocial personality disorder is of some significance since it is associated with aggressive behaviour and a low tolerance for frustration. If during his stay in Carstairs under a hospital order with restriction the defendant were to apply to a mental health review tribunal for his release the tribunal would be entitled to take into account his personality disorder in determining his mental state and the risk he posed at that time to the community because of the legislative regime in Great Britain. Once he returned to Northern Ireland, however, the tribunal would only have jurisdiction to consider the matters set out in article 3 of the 1986 Order and would not be entitled to take into account the nature of his personality disorder in considering whether he was suffering from mental illness. I accept that it is difficult to separate the aspects of illness by virtue of his paranoid schizophrenia from the aggressive elements of his personality disorder but I take the view that if a hospital order were made there is a risk that the defendant could be released in circumstances where his personality disorder meant that there was some risk to the community. If he is made subject to a

life sentence I accept that if his mental health was to improve but he remained a danger to the community because of his personality disorder he could be returned to prison and that this might have some adverse effect upon his health. There is, however, some respite from that outcome in article 79 (1) (b) of the 1986 Order which permits the tribunal to recommend that a prisoner in such circumstances should be allowed to continue to be detained in hospital.

[10] I have to balance the need to protect the public from serious harm by virtue of the risk that he might be released under the mental health legislation while still a danger against the risk that while subject to a life sentence under the supervision of the Life Sentence Review Commissioners he might be returned to a prison environment and his recovery may thereby be imperilled. I consider that in this case the safety of the public must be secured and the most effective way to do that is by the imposition of a life sentence and that is my order. In order to ensure that his need for a hospital environment is adequately brought to the attention of the Life Sentence Review Commissioners I direct that copies of all of the medical reports submitted for this hearing should be attached to his prison file and I further direct that copies of the transcripts of the medical evidence given on the plea together with these sentencing remarks should be similarly attached. I consider that the Life Sentence Review Commissioners will be sensitive to the public interest in the treatment of the defendant particularly having regard to their composition in article 3(2) of the Life Sentences (Northern Ireland) Order 2001.

> "**3.** — (1) The Secretary of State shall appoint Life Sentence Review Commissioners.
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> (2) The Secretary of State shall so far as reasonably practicable ensure that at any time—
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> (a) at least one of the Commissioners is a person who holds or has held judicial office in any part of the United Kingdom or who is—
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> (i) a member of the Bar of Northern Ireland or solicitor of the Supreme Court of Northern Ireland of at least ten years' standing; or
> (ii) an advocate or solicitor in Scotland of at least ten years' standing; or
> (iii) a person who has a ten year general qualification within the meaning of section 71 of the Courts and Legal Services Act 1990 ;

(b) at least one is a registered medical practitioner who is a psychiatrist;

(c) at least one is a chartered psychologist;

(d) at least one is a person appearing to the Secretary of State to have knowledge and experience of the supervision or aftercare of discharged prisoners; and

(e) at least one is a person appearing to the Secretary of State to have made a study of the causes of delinquency or the treatment of offenders."

[11] Finally I must fix the minimum period of time which must be served before the Life Sentence Review Commissioners may consider your eligibility for release. I take into account that your culpability is reduced by virtue of your illness and that the doctors have not been able to assess the precise extent of your responsibility for the terrible events leading to your mother's death. I also take into account that you accepted some responsibility for your actions at an early stage and that you indicated at an early stage your intention to plead guilty to manslaughter on the basis of diminished responsibility. I fix the minimum period that must be served at 5 years and the period on remand should count towards that period. You must realise, however, that it may be much longer before you are considered suitable for release and if you are released you will be subject to licence conditions, breach of which may lead to your return to custody. This order now enables a Transfer Order to be made to ensure that the defendant can receive appropriate treatment at Carstairs. In light of the evidence which I have heard it is clearly appropriate that the Order should be made as soon as practicable.