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*(subject to editorial corrections)**

IN HER MAJESTY'S COURT OF APPEAL IN NORTHERN IRELAND

THE QUEEN

-v-

SEAN HACKETT

Before: Morgan LCJ, Girvan LJ and Coghlin LJ

MORGAN LCJ (giving the judgment of the court)

[1] This is an appeal by Sean Hackett against concurrent life sentences with a minimum tariff of 10 years imposed on 29 April 2014 by Stephens J at Dungannon Crown Court. The appellant was tried for the murder of Aloysius Hackett on 4 January 2013 but on 6 March 2014 was convicted by unanimous jury verdict of manslaughter on the ground of diminished responsibility. He was also found guilty of two counts of possession of a firearm and ammunition with intent. Mr Gallagher QC and Mr Fahy appeared for the appellant and Mr Murphy QC and Mr Reid for the prosecution. We are grateful to all counsel for their helpful oral and written submissions.

Background

[2] The appellant is now a 21 year old man and was 18 years old at the time of the offences. In the summer of 2012 he developed emotional difficulties as a result of his exclusion from the Tyrone minor football team and the break-up of his relationship with his girlfriend. In or about September 2012 he started having thoughts that he should kill one of his parents. He explained that the thoughts just arrived in his mind one day all of a sudden and out of the blue. As a result on Sunday 28 October 2012 he attempted to strangle his mother. He got a cable off the TV in his brother's room and took it out to the garage. He left the cable there and then persuaded his mother to go to the garage. At this stage he put the cable around her neck, she screamed and he then desisted. He told his mother that he was not happy with his life and that he wanted her up in heaven. She kept asking why and he said "If you were up there things would be better for me down here".

[3] After this incident his parents insisted that he seek medical advice and, accompanied by his mother, he saw his General Practitioner on 29 October 2012. After that GP's

appointment he attended one session of counselling again accompanied by his mother. He did not take up another appointment nor did he go to another counsellor identified by his GP. He did not return to his GP and did not share with anyone that he was continuing to plan to kill one or other of his parents. Approximately two weeks after the incident his family concluded that everything had returned to normal although the appellant remained somewhat withdrawn.

[4] On 24 December 2012 the appellant obtained a rifle and ammunition from a friend and used it for practice. On 4 January 2013 he worked as usual from 7 am until 2 pm in Augher and returned home. When he got home he loaded the rifle and stood behind the car at the back of the house trying to plan out killing his mother whilst waiting for her to return from work. At 3.00 pm his mother arrived home. The appellant crouched behind a wall but could not bring himself to kill his mother. She went into the house and had a shower. The appellant brought the gun into the house.

[5] Shortly thereafter the appellant went into Augher to socialise. He appeared his usual pleasant self. He returned home about 6.30 pm and met up with his parents. His mother left almost immediately to go to Omagh. He tried to build himself up to shoot his father at this stage but could not do it. At 7.00 pm his father left the family home to attend a GAA meeting. Whilst his father was away at the meeting he went into Augher and returned home. He got the rifle and a handful of cartridges. He waited outside, crouched behind his brother's car. He felt powerful and thought that "it was good to end it". He was excited about what he was going to do. He heard his father's car arriving and heard him getting out of the car and his footsteps. As his father went to get the key out of the flowerpot the appellant stood up and shot him. He fired three times and in order to do this had to load each bullet individually as there was no magazine. His father did not die instantly. The blood trail left by the deceased established that he moved some 26 feet after the first shot was fired.

[6] After killing his father he walked around the house and returned to the scene, apparently to check that what had happened was real. He put the gun into the boot of the car and picked up two of the three cartridge cases. At approximately 11.30 pm he went to a neighbour's home and told them "Daddy's dead". He was described as very distressed and white. He initially gave a false account to the police and said that he had found his father after he had died. He lied about not having the keys of the Peugeot car which he had been driving. He suggested that there had been a burglary which his father had disturbed. Later that evening when the questions continued to build up he told his uncle that he had the keys which the police were looking for and that he was in bother. He was advised to talk to the police. He said "will anybody find out other than the police what happened". He seemed to his uncle to be in a different place from reality. At 5.10 am he told the police that he "did it" and that he "shot him." He also told the police that the gun was in the Peugeot car and that he had the keys in his pocket.

The trial

[7] There was no material dispute about the facts. The trial focussed on the state of mind of the appellant at the time of the offences. Dr Philip Pollock is a consultant forensic clinical psychologist and was engaged on behalf of the appellant. He interviewed the appellant on 20 and 22 November 2013. He considered that the appellant demonstrated clinical indicators of Major Depressive Disorder as a primary diagnosis in the later months of 2012, most

probably since early October 2012. Dr Pollock contended that the appellant's conduct prior to, during and after the killing of his father is best understood using "the explanatory model of chronic catathymic homicide."

[8] In considering whether the idea that he formed to kill his parents was delusional, quasi-delusional, obsessive or compulsive in quality, Dr Pollock concluded:

> "It is plausible to argue that Mr Hackett developed a singular, encapsulated delusion regarding killing one of his parents in the context of a depressive disorder, although the present assessment finds this contention debatable and insufficiently convincing. It is here contended that Mr Hackett's belief and subsequent plans to kill one of his parents as solution to his problems was more characteristic of over-valued ideation or quasi-delusion that is known to be characteristic of the catathymic process rather than a delusion of truly psychotic quality. Regarding the second phase [of catathymic homicide], the act of killing itself was planned extensively and there is report of instances of experimentation and practice in terms of dry-runs and behavioural try-outs. There is no evidence of an acute, triggering, precipitating event in Mr Hackett's case. The third phase of the process is apparent as regards Mr Hackett's current mental status. Despite Mr Hackett's acknowledgment that he has acted illegally and morally wrongfully, he does not present with a depth of recognition that he has irrevocably changed matters in a drastic, catastrophic manner. He does not accept responsibility for his actions. Mr Hackett declared at interviews that his depression has resolved. …"

[9] In his further report on 14 February 2014 Dr Pollock said that the appellant suffered from a Major Depressive Disorder as a recognised mental condition satisfying part of section 53 of the Coroners and Justice Act 2009. He contended that the abnormality of mental functioning provided a contextual explanation for the appellant's conduct and was a significant contributory factor in causing him to carry out the killing. Repeating his views regarding chronic catathymic homicide, he said the appellant's rational judgment was significantly impaired by virtue of such ideation and its irrational reasoning whereby he developed and acted upon compelling, convincing, quasi-delusional or over-valued ideation. He said there was no evidence to suggest that the appellant's ability to exercise self-control was substantially impaired. According to his own evidence, he exercised decision-making, choice and self-control at different points in time before the killing.

[10] Dr Harbinson, consultant psychiatrist, reported in December 2013 that the appellant was fit to plead. In her report dated February 2014 she stated her opinion that at the time he killed his father the appellant was suffering from an abnormality of mental functioning. Deciding whether this arose from a recognised medical condition was a complex matter. She considered that the appellant's belief that by killing his parents and sending them to heaven

they would be of assistance to him was not rational and could be considered delusional. She considered the possibility of schizophrenia and concluded:

> "The disturbed emotions, subtly changing perceptions and feeling of impending disintegration and altered personal relationships in early schizophrenia are often associated with disturbed and apparently inexplicable behaviour. There can be a long gap between the offence and the emergence of diagnostic symptoms which eventually emerges in prison."

She recommended seeking the opinion of Dr Minne, a consultant psychiatrist in England.

[11] Dr Harbinson provided an addendum report dated 15 March 2014 to comment on dangerousness. She said that in her opinion an argument could be made that at the time he killed his father the appellant was delusional and in a prodromal phase of schizophrenia. He was not at that time demonstrating any active symptoms of major mental illness. She concluded that his mental state would require careful assessment and monitoring and that it would be important to clarify the diagnosis, severity of illness, causation of the violent behaviour, the treatability of his behaviour and the prognosis. She again recommended assessment by Dr Minne.

[12] Dr Browne is a consultant forensic psychiatrist with considerable experience of assessing those suffering from mental disorder who was called by the prosecution. He agreed with Dr Pollock that the killing appeared to conform to the pattern of chronic catathymic homicide but noted that such classification did not clarify the issue of psychiatric diagnosis. He agreed with Dr Harbinson that the appellant had deficits in his personality including narcissistic traits but considered that the appellant did not fulfil the diagnostic criteria for personality disorder or obsessive compulsive disorder. He did not consider that the appellant showed the features required to make a diagnosis of schizophrenia although he recognised the need to be alert to the development of that condition. He did not accept the diagnosis of depressive episode and considered that a diagnosis of adjustment disorder would not account for central features of this case such as the persistent homicidal thoughts, the feelings of control, the excitement, the lack of victim empathy or the subsequent emotional disconnection.

[13] Dr Bownes, consultant forensic psychiatrist, noted in a report dated March 2014 the research on parricide and the difficulty of diagnosis. He concluded that because of the lack of clarity regarding several matters around risk the appellant should be considered as presenting a further risk of serious harm until further assessed. That dangerousness assessment was agreed by Dr Browne and is not in issue in this appeal.

The sentencing remarks

[14] The learned trial judge concluded that he should sentence the appellant on the basis that the jury had accepted the evidence of Dr Pollock. Taking into account the reports of the medical experts and the probation officer and making his own assessment the learned trial judge considered that there was a significant risk that the appellant would commit further specified offences and a significant risk of serious harm to members of the public. He considered that the appellant would constitute a danger to the public for an unpredictable

time. He also considered that this was not a case where the appellant's responsibility for his actions was so grossly impaired that his degree of responsibility was minimal. The appellant calculated and planned the killing and had the ability to exercise self-control. That ability was not impaired. It was his judgement that was impaired. His overall responsibility was, therefore, diminished but remained comparatively high.

[15] He considered that the appellant would constitute a danger to the public for an unpredictable time and that it was, therefore, appropriate to impose a life sentence in relation to each count. He also considered that, given the unpredictable nature of the appellant's mental state, a life sentence was appropriate as protection for the public against the risks posed by the appellant. He further indicated that the determinate sentence for manslaughter and the associated firearms offences would be very long measured in very many years. The three offences clearly called for denunciation reflective of public abhorrence of them. That was also a reason for imposing a life sentence.

[16] The learned trial judge noted that in R v McCandless [2004] NICA 1 the court had approved the proposition that in the case of murder the normal starting point of 12 years could be reduced to 8/9 years where the offender suffered from mental disorder or from a mental disability which lowered the degree of his criminal responsibility for the killing, although not affording a defence of diminished responsibility. Accordingly it was submitted that the starting point should be lower than 8/9 years. The prosecution submitted that because the victim was vulnerable a higher starting point of 15 to 16 years should be adopted. The learned trial judge considered that the appellant's reduced culpability could be reflected by setting a lower starting point of 7 years and then adequately reflecting the aggravating feature of vulnerability always recognising that any aggravating feature was reduced in significance by virtue of diminished responsibility. Alternatively one could take a higher starting point of 15 years making adjustments for aggravating and mitigating factors and then an overall reduction to reflect diminished responsibility. The learned trial judge adopted both approaches as a check on his overall conclusion.

[17] By way of aggravation the judge noted that the killing was planned, that a weapon was used, that the victim was vulnerable, that more than one shot was fired, that the attack was unprovoked, that the appellant sought to cover up his crime *inter alia* by removing two of the cartridge cases, and his indifference. He accepted his youth, his diminished responsibility and his previous good character as mitigating factors. He noted that personal circumstances were of limited effect in serious cases of this nature and that the appellant had not pleaded guilty to the firearms offences. He noted, however, that the appellant had indicated a willingness to plead to the offence of manslaughter and the case was presented to the jury on that basis by his counsel. The learned trial judge accordingly afforded discount in relation to this feature.

[18] In respect of the manslaughter count he imposed a tariff of 10 years and in respect of each count of possession of a firearm and ammunition with intent to endanger life he imposed minimum periods of four years.

The appeal

[19] The main issues identified by the appellant in the original notice of appeal were whether a life sentence was necessary, whether adequate consideration was given to the imposition of an indeterminate custodial sentence, whether a tariff of 10 years reflected the

appellant's culpability, whether the learned trial judge was correct to conclude that the appellant's overall responsibility was comparatively high and whether he was correct to give weight to a number of the aggravating factors, taking into account his diminished responsibility.

[20] Subsequent to the lodgement of the notice of appeal the appellant obtained further reports from Dr Minne, Consultant Psychiatrist and Psychoanalyst, dated 27 February 2015, Dr Samrat Sengupta, Consultant Forensic Psychiatrist, dated 26 February 2015 and Dr Richard Ingram, Consultant Psychiatrist, dated 23 March 2015. The appellant applied pursuant to section 25 of the Criminal Appeal (Northern Ireland) Act 1980 to introduce evidence from Dr Minne and to adduce the reports. The evidence and reports were in support of a diagnosis of delusional disorder and were directed to the nature and severity of the appellant's mental abnormality, the level of his residual culpability, the treatability of his condition, the predictability of the timeframe for such treatment and the appropriateness of a hospital order with restriction. It was agreed that the prosecution could introduce evidence from Dr Browne in rebuttal.

The additional medical evidence

[21] Dr Minne is a consultant psychiatrist and forensic psychotherapist. She has been based in Broadmoor Hospital since 1992 and since 1998 she has worked in the Portman Clinic which is a forensic psychotherapy outpatient clinic attached to Broadmoor hospital for people who have been through prison or high and medium secure units and who are now being treated in the community. She has been a consultant in that speciality since 1998. She considered that the appellant was suffering from a delusional disorder at the time of the killing, that he was still suffering from the disorder, that he would benefit from psychotherapy and possibly medication at a later stage and that his condition was treatable. It was her opinion that a hospital order with restriction was the appropriate disposal in this case.

[22] She said that this was a mental condition which was very difficult to recognise because the person appeared to be completely normal. It was really only when you closely observed the way in which they interacted that it was sometimes possible to detect that there was an emotional cut-off when talking about the terrible offences or events. There was a complete lack of insight but also a sense that the event did not really matter. She was not aware of another case of this type in Northern Ireland but she had seen, assessed and treated cases of this type through Broadmoor hospital.

[23] There were some factors in his life that would have predisposed the appellant to the development of the delusion. It was significant that around the time that he was born there was a family tragedy in which a 16-year-old cousin shot himself. Every birthday coincided with the anniversary of the cousin's death. He also lost his maternal grandfather to whom he was very close just over a year before the attack. He had not been chosen for a particular football team and this was significant given that so much of his self-esteem was actually located in the area. This was a very big blow for him on top of an unresolved bereavement. In addition his close relationship with his girlfriend broke up.

[24] In late August 2012 he started to lose interest in every aspect of his life and in particular his studies, his family, his football and his work. He started to feel that life was no longer worth living. It was around that stage that he developed the delusion that the

solution to his difficulties would be to kill one of his parents and this delusion kept recurring over the coming weeks as he became more withdrawn, more irritable and was not sleeping. Things came to a head at the end of October 2012 when he attacked his mother and he remembers thinking "I just knew I had to do it".

[25] The complete absence of insight and minimisation of what had occurred were pathognomonic for this condition. Dr Minne considered that the shooting of his father was probably influenced by the departure of his three siblings to work or on holiday at the start of the year as a result of which the relationship between the appellant and his parents was intensified. The delusion took over his mind and there was not a sane part left to enable him to pull back as had been the case with his plan to attack his mother. His premorbid state and background were devoid of any factors amounting to dysfunction. She considered it the purest case of delusion disorder that she had come across and believed that the purity had contributed to the difficulties of diagnosis.

[26] Dr Minne considered that the prognosis for the applicant could be good if treatment was provided in a secure psychiatric setting by an experienced and available consultant psychiatrist specialising in psychotherapy. Dr Richard Ingram is a consultant psychiatrist specialising in psychotherapy in the Shannon Clinic, the medium secure facility for those with mental disorders in Northern Ireland. He has produced a report agreeing with the diagnosis by Dr Minne and indicating a willingness to provide the required psychotherapy. Dr Minne considered that if he remained in prison untreated the psychotic part of his mind would remain unchallenged and he would emerge from prison at the same high risk of a recurrence of a violent outburst as he ipresents today. She explained that she had treated half a dozen such patients emerging from Broadmoor hospital on an outpatient basis on average for more than a decade and in some cases expected the treatment to be lifelong. The treatment ensured that the offenders were managed in the community.

[27] Finally she indicated that she presented the case anonymously to her peer supervision group which consisted of several Broadmoor hospital consultant forensic psychiatrists and they unanimously agreed that if they were involved with the case they would have recommended a hospital order with restriction. All agreed that the medium secure conditions available in Northern Ireland were sufficient. Dr Minne said that the appellant had bodily self-control at the time of the offence but that his apparent self-control was completely clouded by his psychotic delusion. She disagreed with Dr Pollock's analysis that this was a compelling, convincing, quasi-delusional overvalued ideation.

[28] If the appellant were transferred to the Shannon Clinic the responsible medical officer in charge of his treatment would be Dr East. He did not give evidence but his report dated 13 March 2015 commenting on the recent medical reports was submitted by agreement. His conclusion was that the appellant was suffering from a delusional disorder at the time of the offence which substantially impaired the appellant's ability to form a rational judgement. He considered, however, that in light of the appellant's report that the delusional beliefs ended with the death of his father he could find no evidence that the beliefs have persisted since and concluded that he therefore suffers from no mental illness. In his report he said that the appellant's illness had been in a state of remission for more than a year. There was only evidence of a single episode of symptoms and he did not believe that the appellant would be liable to detention in hospital for medical treatment on the grounds of the nature of his illness. He did, however, conclude that the appellant presented a specific risk of serious harm to his mother and presents a significant risk of serious harm within the

meaning of the Criminal Justice (Northern Ireland) Order 2008 (the "2008 Order"). Dr East explained that there were 29 secure beds in Northern Ireland and in the absence of mental illness it would be difficult to justify allocating one such bed to the appellant on the basis of a prison transfer order.

[29] Dr Browne still considered that there was uncertainty as to whether the case fulfilled the diagnostic criteria for delusional disorder. He considered that there was an issue as to whether this constituted a delusion or an overvalued idea or destructive urge. He did not consider that there was a significant difference in the treatment of either condition and he agreed that the psychotherapeutic approach would be advantageous and helpful. Both Dr Browne and Dr Minne considered the possibility that the appellant might develop schizophrenia and in those circumstances antipsychotic medication would be useful. Dr Browne noted that the appellant did not appreciate that he needed treatment and did not want medication but he agreed that this may change with time. He agreed that in the absence of psychotherapy there was likely to be an on-going significant risk of serious harm so that it would be preferable to try to address it.

[30] Dr Browne was concerned that if a hospital order with restriction was imposed there was a significant risk that the appellant would be discharged from detention by the Mental Health Review Tribunal ("the Tribunal") on the basis that he did not suffer from a mental disorder. He noted in particular that Dr East at the moment was the responsible medical officer and he was unlikely to support a diagnosis of mental disorder. He said that it was not safe to assume that all the available psychiatric medical evidence including that given to this court would be available to the Tribunal. The current arrangements are that some brief papers are provided to the Tribunal rather than the full set of notes. The medical member has a relatively brief opportunity to look at the clinical notes that are held in the hospital and interview the patient. It was not possible to assume that the details of this judgment would be available to the Tribunal.

[31] If a hospital order were made in a case of this kind dealing with complex psychiatric issues and a danger to the life of members of the public we do not consider that the process set out in the preceding paragraph would be sufficient for the Tribunal to take all relevant issues into account in making the relevant determination. We direct that a copy of this judgment should be sent to the President of the Tribunal to consider whether any amendments to the process need to be incorporated.

Conclusions on the medical evidence

[32] In a complex case of this kind it is unsurprising that the medical evidence remains controversial. No case was advanced on behalf of the appellant at the trial justifying a hospital order with restriction. We have now received evidence from Dr Minne and reports from Dr Sengupta, Dr Ingram and Dr East contending that the appellant suffered from a delusional disorder at the time of the offence. Dr Minne had greater experience of this sort of case than any of the doctors who saw the appellant at the time of the trial. Her conclusion about the diagnosis was peer reviewed and unanimously agreed. Her explanations under cross examination were convincing and impressive. We conclude, therefore, on the balance of probabilities that the appellant suffered from a delusional disorder at the time of the offence and continues to suffer from that disorder.

[33] Dr Minne accepted that the appellant had bodily self-control at the relevant time but said that the apparent self-control was completely clouded by the psychotic delusion. That appears to be consistent with the view of Dr East who concluded that the delusional beliefs substantially impaired the appellant's ability to form a rational judgement. The jury accepted the evidence of Dr Pollock at the trial and his conclusion in his addendum report of 14 February 2014 was that the appellant's rational judgement was significantly impaired by virtue of his ideation and its irrational reasoning whereby he acted upon compelling, convincing, quasi-delusional or overvalued ideation in the context of a major depressive disorder.

[34] The learned trial judge understandably placed some emphasis on the evidence of Dr Pollock that the appellant retained self-control but the additional evidence from Dr Minne and Dr East, supported by the reports from Dr Sengupta and Dr Ingram, indicate that the key to the culpability of the appellant lay in the impairment of his ability to form a rational judgement. In light of the additional evidence we accept that his ability to form such a judgement was significantly impaired and that his culpability was not as high as the evidence before the learned trial judge suggested.

[35] Dr Minne, whose conclusions were supported by Dr Sengupta and Dr Ingram, said that unless the appellant received psychotherapy from a suitably experienced psychotherapist in a secure environment he would remain dangerous. Dr Browne agreed, even on his diagnosis, that psychotherapy of the kind suggested by Dr Minne was desirable and advantageous and that without it he would constitute an on-going risk. Such treatment could effectively only be provided in a secure hospital setting, either under a hospital order or as a result of a prison transfer order. Dr Minne considered the latter second best because of the risk that the appellant would be returned to prison when he was still dangerous.

[36] Dr Minne noted that the appellant was a model prisoner, completely compliant with his regime. She agreed that when the appellant is in the secure environment of the detention regime the delusional disorder can take a back seat and the appellant can appear as if well and not mentally ill. Indeed Dr East, who would be the responsible medical officer in the Shannon Clinic, concluded that he did not now suffer from a mental disorder. Dr East still considered him dangerous, apparently because of matters not connected to any mental illness ,and in this appeared to be at one with Dr Browne who considered that the appellant had a destructive urge. Accordingly both Dr East and Dr Browne considered that there was a real risk that if a hospital order were made in respect of the appellant he could be discharged by a Tribunal on the basis that the appellant was not suffering from a mental disorder when he was still dangerous.

The statutory regime for mental disorder

[37] The court's power to impose a hospital order in respect of an imprisonable offence is found in Article 44 of the Mental Health (Northern Ireland) Order 1986 ("the 1986 Order"). The first condition is that an RQIA approved medical practitioner gives oral evidence that the offender is suffering from mental illness or severe mental impairment of a nature or degree that warrants his detention in hospital for medical treatment and another medical practitioner supports that conclusion. Dr Minne is an RQIA appointed medical practitioner and she is supported by Dr Sengupta and Dr Ingram. Accordingly this condition is met.

[38] The second condition is that the court is of the opinion, having regard to all the circumstances, including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable means of dealing with the case is by means of a hospital order. We have been assisted in the consideration of this condition by the decision of the English Court of Appeal in R v Vowles [2015] EWCA Crim 45. We agree that the court is not circumscribed by the psychiatric opinions and that there must always be sound reasons set out for departing from the usual course of a penal sentence. Lord Thomas suggested four matters that will invariably have to be considered:

> "(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."

[39] It was agreed by all of the doctors that in light of the risk presently posed by the appellant a hospital order, if imposed, would have to be with restriction under Article 47 of the 1986 Order and without limitation of time. A Tribunal's power to discharge a patient who is not restricted is contained in Article 77 of the 1986 Order:

> "77. - (1) Where application is made to the Review Tribunal by or in respect of a patient who is liable to be detained under this Order, the tribunal may in any case direct that the patient be discharged, and shall so direct if-
>
> (a) the tribunal is not satisfied that he is then suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a nature or degree which warrants his detention in hospital for medical treatment; or
>
> (b) the tribunal is not satisfied that his discharge would create a substantial likelihood of serious physical harm to himself or to other persons…"

[40] A restricted patient may apply under Article 78 and is entitled to be discharged absolutely when the conditions in Article 77 (1) (a) or (b) are met and the Tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment. If the latter condition is not met the patient remains subject to the jurisdiction of the Department of Justice.

[41] Dr Browne was concerned about how these conditions might work in practice. There remained conflicting views about the diagnosis and the responsible medical officer in the

Shannon Clinic was of the view that the appellant was not now suffering from any mental illness. If the Tribunal took the view that he was correct it would almost invariably follow that the recall condition would also be satisfied. The appellant would then be entitled to be discharged absolutely while remaining dangerous. Even if one accepted the delusional disorder diagnosis Dr Browne considered that there was also some destructive urge and in this was supported by Dr East who found the appellant dangerous despite finding him mentally well.

[42] The prosecution also raised some concerns about the circumstances in which the test in Article 77 (1) (b) might be satisfied in light of the decision in JR 45 [2011] NIQB 17. At paragraph [13] of that decision McCloskey J held that Article 77 (1) (b) required the Tribunal to be satisfied on the balance of probabilities that there was a real probability of serious physical harm to the patient or some other person. It followed that a real possibility of life-threatening injury to the patient or some other person would not be sufficient to satisfy the test and would lead to the release of a restricted patient unless the Tribunal concluded that it was appropriate for the patient to remain liable to recall for further treatment.

[43] It is apparent from the wording of Article 77 that the statute imposes a burden upon the detaining authority to satisfy the statutory test. Where a statutory test depends upon past or present fact there is no dispute that the Tribunal must be satisfied on the balance of probabilities about that fact. It is also clear from the authorities that the same approach follows in relation to the determination of whether the applicant to the Tribunal is suffering from mental illness. If there is a dispute about that the task of the Tribunal is to resolve the dispute.

[44] The task faced by the Tribunal in Article 77 (1) (b) is different. It is required to make an evaluative judgment and assessment about future events. The judgment is to be made in the context of evaluating risk. At paragraph [35] of R v Vowles the court accepted the submission that the concept of burden of proof was not relevant in risk evaluation. A slightly different approach was taken in R(N) v Mental Health Review Tribunal (Northern Region) [2006] QB 468. The court sought to resolve the difficulty of imposing a standard of proof on an evaluative judgment in this context at paragraph [99]:

> "99. We would accept that the concept of a standard of proof is "not *particularly* helpful" (per Lord Hoffmann, at para 56, in Secretary of State for the Home Department v Rehman , with emphasis added) in relation to such a process. But we would not go so far as to hold that there is no room for its application at all. An opinion on the appropriateness or necessity of continuing detention may in principle be held with different degrees of certainty, and it may be important for the tribunal to know what degree of certainty is called for. Under sections 72 and 73 the tribunal has to be "satisfied" as to the relevant matters. As Lord Lloyd of Berwick observed in In re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 563 , 576 d – g), "is satisfied" is an expression with a range of meanings covering the criminal standard of proof ("satisfied so as to be sure"), through the civil standard

> ("satisfied on a balance of probabilities") to being a synonym for "concludes" or "determines" and therefore having an entirely neutral function. We see no absurdity in a tribunal having some doubt as to the appropriateness or necessity of continuing detention, yet being satisfied on the balance of probabilities that it is appropriate and necessary. Accordingly, as it seems to us, the standard of proof has a potential part to play in the decision-making process even in relation to issues that are the subject of judgment and evaluation. In practice, we would expect the tribunal generally either to form the requisite judgment or not to form it, without needing to have specific regard to any standard of proof. But the standard of proof provides a backdrop to the decision-making process and may have an important role in some cases."

[45] We consider that the approach espoused in JR 45 unduly fetters the evaluative judgement which Article 77 (1) (b) of the 1986 Order requires. That approach is also out of kilter with the case law to which we have referred in the preceding paragraph. When considering this test the Tribunal should examine the nature and extent of the risk and the consequences if the event were to occur. It should then as a matter of judgement assess whether the likelihood of serious physical injury is substantial. Likelihood is not to be interpreted as requiring a probability of serious physical injury. The context is one of risk assessment. Where the risk is of an injury that is very serious or life-threatening a real possibility may well be sufficient to satisfy the test.

Consideration

[46] In light of the conclusions to which we have come on the medical evidence we are satisfied that there is a compelling need for the appellant to receive psychotherapy treatment in relation to his condition. The treatment is likely to be prolonged and can effectively only be delivered within a secure hospital environment by an experienced psychotherapist. The only available such opportunity in Northern Ireland is the Shannon Clinic. In the absence of such treatment the possibilities are either that he will be detained for an indefinite period on the basis that he constitutes a significant risk of serious harm or alternatively that he will be released in circumstances where he actually presents such a risk. If treated the evidence suggests a real possibility that the risk could be managed in the community within a period of 10 years.

[47] The requirement to provide the appellant with the treatment that he needs can only be delivered either by a hospital order with restriction or by a prison transfer order pursuant to Article 53 of the 1986 Order. A prison transfer order can be made by the Department of Justice where it considers it expedient and where the Department is satisfied by written reports from two medical practitioners, one of whom must be RQIA appointed, that the person suffers from mental illness of a nature or degree which warrants his detention in hospital for treatment.

[48] We have indicated at paragraph 34 above that the ability of the appellant to form a rational judgment in relation to the events on the day of the killing was substantially impaired as a result of his delusional disorder and it follows, therefore, that his mental

illness was a significant contributory factor to the offending. The question of his residual responsibility is more difficult. Dr Minne accepted that there was some element of culpability and Dr Browne was of the view that the appellant suffered from a destructive urge. We conclude that the appellant's culpability was low but not minimal and that punishment is not inappropriate.

[49] We are concerned that there remains a degree of uncertainty about the appellant's medical condition and in particular about the assessment of any residual responsibility for the offence beyond the medical diagnosis. The Parole Commissioners would be entitled to take all of those factors into account on the basis of the up-to-date evidence. Because of the uncertainties surrounding the medical picture we are concerned about the risk to the public if the responsibility for the decision on discharge was left with the Tribunal.

[50] The risk to the public should he be discharged by the Tribunal when still dangerous points away from the imposition of a hospital order. We note, however, the evidence from Dr Browne that a prison transfer order was unlikely and the suggestion from Dr East that he would be reluctant to see one of the 29 secure beds in the Shannon Clinic given to someone whom he did not consider mentally ill. We have no power to direct a prison transfer order. The evidence in this case makes it plain, however, that there is a compelling need for this young man to receive appropriate psychotherapy either in the Shannon Clinic or some other suitable location. That compelling need reflects the public interest in dealing with a dangerous offender as well as the appellant's personal needs. To conclude that it was not expedient to provide such treatment would require very weighty countervailing considerations even in the context of limited availability. In those circumstances we have concluded that we should not impose a hospital order but that this case requires the Department to urgently consider the making of a prison transfer order. Both psychiatrists who gave evidence before us were critical of the failure to provide this appellant with any treatment to date.

[51] All parties were agreed that the only appropriate custodial sentences were a life sentence or an indeterminate custodial sentence. In both cases the subsequent release of the prisoner on licence is dependent upon an assessment of dangerousness by the Parole Commissioners. The distinctions between the two are that:

(i) the Parole Board has a power to direct the expiry of the licence where the prisoner has been released on licence for a period of at least 10 years; and

(ii) a whole life sentence cannot be imposed by way of an indeterminate custodial sentence.

The second distinction is not material to the issues in this case.

[52] The approach which the court should take in applying the similar provisions in England and Wales was addressed in R v Kehoe [2008] 1 Cr App R (S) 41 and is helpfully encapsulated in paragraph 17:

> "When, as here, an offender meets the criteria of dangerousness, there is no longer any need to protect the public by passing a sentence of life imprisonment for the public are now properly protected by the imposition of

> the sentence of imprisonment for public protection. In such cases, therefore, the cases decided before the Criminal Justice Act 2003 came into effect no longer offer guidance on when a life sentence should be imposed. We think that now, when the court finds that the defendant satisfies the criteria for dangerousness, a life sentence should be reserved for those cases where the culpability of the offender is particularly high or the offence itself particularly grave."

[53] Lord Judge CJ returned to this issue in R v Wilkinson (Grant) [2009] 1 Cr App R (S) 628 where he said that the crucial difference between a discretionary life sentence and a sentence of imprisonment for public protection arising at the time of sentence is the seriousness of the instant offence as assessed in the overall statutory context. He continued at paragraph [19]:

> "In our judgment it is clear that as a matter of principle the discretionary life sentence under section 225 should continue to be reserved for offences of the utmost gravity. Without being prescriptive, we suggest that the sentence should come into contemplation when the judgment of the court is that the seriousness is such that a life sentence would have what Lord Bingham observed in R v Lichniak [2003] 1 AC 903 would be a 'denunciatory' value, reflective of public abhorrence of the offence, and where, because of its seriousness, the notional determinate sentence would be very long, measured in very many years."

[54] For the reasons we have given, in light of the additional medical evidence, we differ from the learned trial judge's assessment that the overall responsibility of the appellant remained comparatively high. He relied upon the decision in R v Crolly [2011] NICA 58 but since the offence was committed in February 2007 the dangerousness provisions did not apply. He also relied upon R v Wood [2009] EWCA Crim 651. That was a diminished responsibility case where the court imposed a life sentence in respect of an attack with a meat cleaver and lump hammer inflicting 53 injuries on a homosexual victim. The court said that a life sentence should be reserved for those cases where the culpability of the offender was particularly high or the offence itself was particularly grave. Life imprisonment would be rare in such cases, usually reserved for particularly grave cases, where the defendant's responsibility for his actions, although diminished, remained high. We do not consider that these cases provide material support for the imposition of a life sentence in this case.

[55] The next reason provided by the learned trial judge was the power to recall the prisoner when released on licence. That power would be available to the Parole Commissioners if an indeterminate custodial sentence is imposed. Finally, the learned trial judge relied upon R v Wilkinson to which we have referred at paragraph [53] above. That was a case in which the appellant had established a gun factory altering blank firing replica sub-machineguns purchased by him to firearms. It was established from the recovered materials that the firearms had been involved in 51 shootings resulting in 8 fatal shootings

and some 13 instances of injury. Of the 90 replicas bought by the appellant 37 had not been recovered. Unsurprisingly this was treated as an offence of the utmost gravity.

[56] This was a truly shocking offence but the medical evidence that we have accepted shed considerable light upon the circumstances. We do not accept that the appellant's culpability was particularly high and although we have acknowledged the shocking nature of the offence we do not consider that it can be said to be an offence of the utmost gravity having regard to all the circumstances. Accordingly, we consider that the appropriate disposal is an indeterminate custodial sentence.

[57] The learned trial judge imposed a tariff of 10 years being the period of time which the appellant would have to serve before he could be considered for release on licence. As discussed earlier we consider that the new medical evidence indicates that the culpability of the appellant was not as high as assessed by the learned trial judge on the evidence before him. We have derived assistance from the paper on sentencing in cases of manslaughter given by Sir Anthony Hart on 9 March 2011. We note the reference to a number of paranoid schizophrenia cases where the culpability had arisen from the failure to take medication and tariffs of 5 or 6 years had been imposed.

[58] We consider that the culpability of the appellant in this case was more than minimal. We substitute for the period of 10 years imposed by the learned trial judge a period of 7 years before this appellant can be considered for release on licence. Whether or when he may be released on licence will be a matter for the Parole Commissioners who will be best placed to assess the need to ensure the safety of the public.

Conclusion

[59] For the reasons given we allow the appeal. We substitute an indeterminate custodial sentence for each of the life sentences and specify a period of 7 years pursuant to Article 13(3)(b) of the 2008 Order as the period appropriate to satisfy the requirements of retribution and deterrence in respect of the manslaughter conviction. We confirm the tariffs imposed on the firearms offences.