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Judgment: approved by the Court for handing down | *Delivered:* **2/12/2008**
*(subject to editorial corrections)**

IN THE CROWN COURT OF NORTHERN IRELAND

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DOWNPATRICK CROWN COURT (SITTING AT BELFAST)

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THE QUEEN

-v-

PAUL McMILLAN

_____

HART J

[1] The defendant is before the court to be sentenced on his plea of guilty to the manslaughter of his brother William Alexander McMillan on 27 April 2007. The defendant was initially charged with the murder of his brother, but after the jury had been sworn to try his case asked to be re-arraigned and pleaded guilty to the manslaughter of his brother on the grounds of diminished responsibility. In the light of the comprehensive medical and psychiatric evidence that was available this plea was accepted by the prosecution.

[2] The defendant is a 44 year old man who lived at 38 Gray's Park Drive in the Belvoir estate on the outskirts of Belfast with his elder brother William who was 58. It is abundantly clear from the evidence that both the defendant and his brother were heavy drinkers. However his brother's drinking played no part in the events of that day. It is undoubtedly the case that the defendant has been an alcoholic for many years and has suffered from severe alcoholism and depression. In 1997 he was employed in the Prison Service as a prison officer and had been assaulted at work. Later that year he was referred to a community psychiatric nurse and Post Traumatic Stress Disorder was diagnosed. From 2001 onwards there are many entries in his general practitioner's records showing the prescription of sleeping tablets, tranquillisers and anti-depressants.

[3] There are also references to his heavy drinking. In November 2005 those records show that he was drinking up to a litre of spirits a day at times and was attending Carlisle House. He was admitted to hospital having

collapsed in a shop and this collapse was considered due to a seizure due to alcohol. On 9 August 2006 he was seen in Belfast City Hospital where he had been referred by his general practitioner because of delirium tremens and spontaneous bruising. Again it was noted that he was drinking a litre of vodka a day and was hallucinating. There were physical symptoms which confirmed the account of delirium tremens.

[4] Of particular significance was an admission to the Royal Victoria Hospital between 13 and 23 August 2006. Whilst a patient in intensive care he was again hallucinating and fell from a window suffering a right hip fracture as a result. He had been admitted to hospital for a low haemoglobin and alcohol dependency.

[5] It appears that he managed to abstain from alcohol from some time but there were considerable physical problems which seem to have been related to his excessive alcohol consumption. He was admitted to the Royal Victoria Hospital between 13 and 15 February 2007 and his physical problems at that time appear to be have been related to, or at least significantly affected by, his excessive alcohol consumption.

[6] I have been provided with a statement of evidence from Dr James Rutherford who is a general practitioner at the Belvoir Surgery. The defendant became a new patient of the surgery in February 2007 but Dr Rutherford had not seen him before 27 April 2007. On 27 April another brother of the defendant, Gary, came to the surgery and expressed his concern about the defendant's behaviour because he was hallucinating. Dr Rutherford was extremely concerned about what he had been told, and after making a number of enquiries about the appropriate form of treatment, enquiries which involved him attempting to contact Shaftesbury Square Hospital and Knockbracken Hospital, he went with Gary McMillan to the chemist to acquire the necessary medication, and then went to visit the defendant. The defendant, although lucid, smelt of alcohol and described in graphic terms the hallucinations from which he was suffering. Dr Rutherford persuaded him to take the sedative and remained with the defendant and a number of his brothers for some time, but unfortunately the sedative did not appear to have much effect.

[7] The defendant's brothers agreed to stay with the defendant for a further period of time, and Dr Rutherford went back to his surgery and attempted to arrange for the defendant to be admitted to hospital. He then procured a major tranquilliser (Olanzapine) which had been recommended to him by a consultant psychiatrist, and after unsuccessful attempts to contact the emergency CPN team returned to the defendant's home. All of these enquiries had taken longer than anticipated, and by this time the defendant was alone. He appeared calmer and assured Dr Rutherford that he was feeling better and was no longer seeing the animals he had described earlier.

Dr Rutherford gave the defendant an Olanzapine tablet which the defendant took. Dr Rutherford felt very reassured. Later that afternoon he had further telephone conversations with various professionals, and it was recommended to him that the best course was for the defendant to be taken by his brother to the Belfast City Hospital A&E Department where there would be a psychiatrist on site. Dr Rutherford said that he would follow this up and return to the defendant to try and persuade him to agree to this.

[8] Tragically in the interim the defendant stabbed his brother.

[9] Before I proceed to turn to the circumstances surrounding the stabbing I should make it clear that, as this description of Dr Rutherford's efforts demonstrates, and as Mr Adair QC (who appears on behalf of the prosecution with Miss McColgan) stated, he went to enormous lengths to obtain comprehensive and immediate treatment for the defendant that day and is to be commended for doing so.

[10] It would seem that after Dr Rutherford's second visit and administration of the Olanzapine to the defendant the defendant's hallucinations returned. Shortly after 3.00 pm a number of residents in Gray's Park Drive saw the defendant behaving in a bizarre and aggressive way. For example, he approached the car of a Mrs Patton and told her that he was saving her car which was full of people, even though there was no one in the car at the time. He was then seen to go back into his house and very soon afterwards walked up to another car in which Mrs Lisa Gray was sitting. At this time he had a knife in his hand and one of his arms was covered in blood. He went on to say that "I done him he is dead".

[11] When the police were alerted and came to the scene they found the defendant's brother slumped in a chair in the house suffering from severe stab wounds. Although he was taken to hospital it was not possible to prevent his death. The post mortem report from Dr Bentley, the Deputy State Pathologist for Northern Ireland, shows that William McMillan died as a result of stab wounds of the chest and abdomen. There were fourteen stab wounds in all. Two on the neck, seven on the front of the chest, four on the front of the abdomen and one on the left leg. The doctor described the fatal wounds in the following terms:

> "(3) The stab wounds of the chest penetrated the large blood vessel of the chest (thoracic aorta) and one of its major branches (sub clavian artery), and both lungs. Furthermore, three of the stab wounds of the chest passed downwards through the chest cavity, through the diaphragm, into the abdomen, causing injuries of the liver, stomach and pancreas. These stab wounds of the chest would have resulted in

> rapid heavy bleeding and interference with breathing, and on their own would have been fatal within a short period of time.
>
> (4) One of the stab wounds of the front of the abdomen had transected an artery and cut into a sizeable vein. This injury on its own would have been fatal without prompt surgical intervention."

[12] It is clear that the defendant stabbed his brother repeatedly and that the stab wounds brought about his rapid death. The defendant has been examined on his own behalf by Dr Helen Harbinson, a consultant psychiatrist, and by Dr Carol Weir, a consultant clinical psychologist; and on behalf of the prosecution by Dr Fred Browne, also a forensic psychiatrist. Dr Harbinson and Dr Browne describe in considerable detail the defendant's psychiatric and alcoholic history and they agree that at the time of the killing of his brother the defendant was not able to appreciate what he was doing because he was in a state of delirium tremens. He believed that his brother's body had been taken over by aliens, and thus, at the time of the killing, did not appreciate that he was killing his brother. He was in a state of alcohol withdrawal which brought about the acute psychotic state that manifested itself in the form of delirium tremens. Both doctors agree that the defendant was therefore suffering from diminished responsibility at the time, and accordingly the prosecution properly accepted the plea of manslaughter on the grounds of diminished responsibility.

[13] As I explained in R v Murray [2008] NICC 1, 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.
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> 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.
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> 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."

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 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."

[14] In R v Magee [2007] NICA 21 the Court of Appeal observed at [26] that in manslaughter cases

> "… the range of sentence after a not guilty plea should be between 8 and 15 years imprisonment. This is, perforce, the most general of guidelines. Because of the potentially limitless variety of factual situations where manslaughter is committed, it is necessary to recognise that some deviation from this range may be required."

[15] In the present case I accept that the defendant is genuinely remorseful for the terrible consequences that stemmed from his drinking, and, subject to the question of a custody probation order, taking into account the defendant's plea of guilty I consider that the appropriate sentence is one of six years' imprisonment.

[16] The defendant's history of severe alcoholism and depression, and the circumstances of the present offence are such that both Dr Harbinson and Dr Browne expressed concern that there was a risk of further episodes of delirium tremens if the defendant resumes drinking alcohol. As Dr Browne put it at paragraph 12.8 of his report:

> "In Mr McMillan's case the delirium tremens has resolved. In view of his history of severe alcohol dependence and his failure to abstain from alcohol in the past he remains at risk of drinking alcohol again in the future and if he does resume drinking alcohol he is at risk of developing further episodes of delirium tremens."

Dr Harbinson expressed similar concerns in her report.

> "At present he is mentally well. If however he were to abuse alcohol again, there would be a risk he could develop withdrawal symptoms and again become psychotic. The most appropriate disposal would be a Supervision and Treatment Order. He does not require hospital treatment and a Hospital Order would not therefore be appropriate. Absolute discharge would not be advisable as there is an ongoing risk of further similar episodes if he abuses alcohol."

[17] It is essential to attempt to guard against the risk to others of the consequences of similar episodes if the defendant were to again abuse alcohol. Given the unsuccessful efforts that were made in the past to deal with his alcoholism there must be concern that any form of treatment in the future may again be unsuccessful if the defendant resumes his heavy drinking. Following the defendant's plea of guilty the sentence was adjourned to enable an assessment of him to be carried out under the auspices of the medical team at the Shafesbury Square Hospital and I now have the benefit of their suggestions contained in the pre-sentence report prepared by the PBNI.

[18] I propose to merely summarise the principal components of the scheme of treatment proposed by Dr O'Connor of Shaftesbury Square Hospital as described in the pre-sentence report, a scheme which has been endorsed by Dr Harbinson. The foundation of the entire scheme is that the defendant abstains completely from alcohol, because if he were to relapse again, as he has in the past, the risk of re-offending becomes extremely high. To ensure that this does not occur, it is suggested that he take Disulfiram (antebuse). Upon his release he will be subject to follow up by the Hospital

for a period and then transferred to the care of Dr Rutherford. Thereafter he would benefit from, and so should attend, the RATSDRAM programme. If he does not comply with the various elements of the proposed treatment the PBNI have warned the defendant that an application will be made to the court for an immediate warrant for his return to prison.

[19] I consider that the appropriate sentence is to impose a custody probation order with a probation element of three years duration, and to make the probation order conditional upon the defendant following the course of treatment and supervision recommended by the pre-sentence report. Therefore, if the defendant consents, I propose to make a custody probation order for three years' imprisonment to be followed upon release by three years probation subject to two conditions, namely that

(a) the defendant resides in accommodation approved by the PBNI, and
(b) complies with the treatment/management plan as directed by his Supervising Probation Officer.

The sentence would otherwise have been one of six years' imprisonment.

[20] In effect the defendant is being made subject to an order which, provided he co-operates with it offers him the opportunity to overcome his alcoholism and depression, and thereby remove, or at least lessen, the risk to other members of the public of being subjected to an attack of an equally tragic nature as that which led to his brother's death. Should the defendant not comply with the advice and directions he is given, and in particular resume drinking, the probation order can be revoked, and in that event the defendant may take it that he will almost certainly be returned to prison to serve the remainder of the term of six years' imprisonment which would have been the sentence had I not imposed this custody probation order.