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Judgment: approved by the Court for handing down	*Delivered:*	**24/5/2011**
*(subject to editorial corrections)**		

IN THE CROWN COURT IN NORTHERN IRELAND

CRAIGAVON CROWN COURT (SITTING AT BELFAST)

THE QUEEN

-v-

MICHAEL PHILIP McGLEENON

HART J

[1] The defendant has pleaded guilty to the manslaughter of his father Michael Joseph McGleenon (Mr McGleenon Senior) on the grounds of diminished responsibility. He was originally charged with his father's murder, but the prosecution have accepted the plea to manslaughter on the grounds of diminished responsibility, and the defendant is now to be sentenced on that charge.

[2] On 12 November 2009 the police in Lurgan received a 999 call from the defendant reporting that there was an intruder in his home, and that bombs had been placed in the garage of the house. In subsequent calls he reported that his father was dead, and that the defendant was mentally ill and had recently been discharged from a psychiatric unit at Craigavon Hospital. The police went to the scene where they spoke to the defendant, who reported to them that there was a smell of gas in the house and that he had escaped by breaking a landing window. His demeanour appeared detached and vague and both police and neighbours were concerned at the defendant's demeanour. The police forced an entry into the house and discovered the body of his father on the floor of the upstairs bedroom.

[3] It was clear that he had suffered multiple stab wounds. Dr Bentley, the Deputy State Pathologist for Northern Ireland, found that there were nineteen stab wounds of the chest, three of which were on the front left side and sixteen on the back of the chest. Many of these wounds had caused catastrophic injuries to Mr McGleenon Senior's major organs and he died from these injuries. It was apparent that he had tried in vain to defend himself from what must have been a very fierce attack. In addition to the nineteen stab wounds, there were a considerable number of superficial piercing injuries on the right side of the deceased's lower back, suggestive of the light prodding with a knife about the time of death. Dr Bentley's view was it was likely that the injuries to the front of the chest were inflicted first. From this, taken with what Mr Mooney QC (who appears on behalf of the prosecution with Ms Auret) described as "the very harrowing account given to Dr Browne and to the police during

interviews" by the defendant, there can be no doubt that Mr McGleenon Senior was subjected to a very violent and prolonged attack by his son.

[4] The defendant was arrested and taken to the Serious Crime Suite at Antrim PSNI Station. Whilst he was there it became apparent that he might be unfit for interview. He was assessed, and it was decided that he was unfit for interview because of his mental condition. He was then taken to the Shannon Medium Secure Psychiatric Unit at Knockbracken Hospital under the provisions of the Mental Health (Northern Ireland) Order 1986.

[5] It is accepted that at the time he committed these acts the defendant was suffering from a severe mental illness. Mr Barry Macdonald QC (who appears on behalf of the defendant with Mr Moriarty) said that the defendant's family realised that he had not been well for some time and that was why he had been admitted to hospital prior to these tragic events. I have not had the benefit of a victim impact statement from the family, but Mr Macdonald said that all of the family recognise that the defendant was not himself at the time, and they believe that he was not morally responsible for what happened because he was not in control of his mental faculties at the time. He explained that they were more concerned about the defendant receiving appropriate treatment for his condition than receiving punishment.

[6] It is clear from the many very detailed psychiatric reports that have been placed before the court that the defendant suffered from a well-documented and increasingly severe psychiatric condition in recent years. As a teenager his academic progress was adversely affected when he suffered from Hodgkin's Disease at the age of fifteen. He made a full recovery and attended university where he obtained an excellent degree. He and his brother moved to Grenoble in the 1990s, and then to Stuttgart, before spending some time in Paris in 2001. It appears that in or around 2005 the defendant started to develop serious paranoid persecution delusions. He later moved to Munich, and was admitted to a psychiatric unit in Munich University Hospital in July 2008. He returned to live in Northern Ireland in 2008, and the medical records show that on two subsequent occasions he was admitted to a psychiatric unit in Northern Ireland. Not only that, but he was prescribed anti-psychotic medication, and it was noted that on several occasions in October and November 2009 he was not taking his medication. Tragically he committed this offence a few days after his being released from hospital.

[7] I had the benefit of oral evidence from Dr Fred Browne, a consultant forensic psychiatrist, and from Dr McCall who is a consultant forensic psychiatrist at The State Hospital, Carstairs in Lanark in Scotland. I am grateful to both Dr Browne and Dr McCall for the extremely detailed histories which they have given of the development and nature of the defendant's behaviour in recent years. I do not consider it necessary to go into these in any detail, other than to say it is clear that the defendant's condition presents many difficulties from a diagnostic point of view and is far from straightforward. Dr Browne's view is that at the time of the offence, and at the present time, the defendant suffered, and continues to suffer, from a psychotic illness more consistent with paranoid schizophrenia. Dr McCall's view is that he suffers from a psychotic illness which he considers to be affective psychosis. Whilst they differ as to the exact nature of the psychiatric illness from which the defendant

suffers, they are in agreement that it takes the form of a serious mental illness which substantially impaired his responsibility for the killing of his father.

[8] I have not considered it necessary to obtain a pre-sentence report because the defendant's history and psychiatric condition is comprehensively described in the reports and evidence of Dr Browne and Dr McCall in particular, supplemented by the report from Dr Bownes obtained on behalf of the defendant.

[9] The provisions of the Criminal Justice (Northern Ireland) Order 2008 (the 2008 Order) require the court to consider one of three types of sentence in a case of this nature.

(i) a life sentence by virtue of Article 13(2)(b), or

(ii) an extended custodial sentence by virtue of Article 14, or

(iii) an indeterminate custodial sentence by virtue of Article 13(3).

[10] In addition, it is necessary to have regard to the provisions of Article 47 of the Mental Health (Northern Ireland) Order 1986.

[11] Common to each of these four sentencing options is the need to consider whether the accused presents a danger to others by virtue of being a significant risk to members of the public of serious harm in the event that he were to commit offences of the same or a similar nature in the future. However, there are some differences between the requirements of each form of sentencing disposal. The only practical difference between a life sentence and an indeterminate custodial sentence is that a person sentenced to life imprisonment remains subject to being recalled to prison at any time during his natural life if he has been released by the Parole Commissioners after serving the minimum term of imprisonment prescribed by a court. A person sentenced to an indeterminate custodial sentence is also released on licence when it is considered appropriate to do so by the Parole Commissioners, but the distinction between an indeterminate custodial sentence and a life sentence is that a defendant sentenced to an indeterminate custodial sentence has the right to apply to the court to have his licence conditions revoked ten years after release having served the minimum term of imprisonment imposed by the court.

[12] In the present case I do not consider it necessary to consider the possibility of a Hospital Order without restriction because it has not been recommended by Dr Browne or by Dr McCall.

[13] I now turn to consider the criteria for the imposition of a life sentence prescribed by the Court of Appeal in R v Desmond William Gallagher [2004] NICA 11.

(i) The offender has to have been convicted of a very serious offence. This criterion is clearly met in the present case.

(ii) There have to be good grounds for believing that the offender may

remain a serious danger to the public for a period which cannot be reliably estimated at the date of sentence. For reasons which I will set out below I am satisfied that this is the case.

(iii) A life sentence should be reserved for cases where it is likely that there will be further offending of a grave character.

[14] The medical evidence to which I shall refer suggests that it is not possible to say whether the defendant will be fit to be released, and if so when, except that even if the treatment envisaged is successful that treatment is likely to take at least five years from the defendant's transfer to Carstairs. Both Dr McCall and Dr Browne were in agreement that the defendant will be transferred to Carstairs once he has been sentenced. Whilst it is hoped that the treatment will be successful, this cannot be predicted with certainty. The success or otherwise of the treatment will be dependent upon the defendant agreeing to take, or being compulsorily subjected to the administration of, medication. If the defendant is to be released at some time in the future, it is clear that if he does not continue to take his prescribed medication there will be a real risk that he could again develop the persecutory and paranoid beliefs about others which not only led to the tragic events culminating in his father's death, but which it is clear from the psychiatric reports the defendant has developed in relation to other people in the past. If the defendant were to develop such beliefs again then in my opinion he clearly would present a grave risk to the public.

[15] Whilst these factors all point towards a life sentence as being the appropriate sentence, with some hesitation I have concluded that a life sentence is not justified in the present case because it cannot be said that the defendant is "likely" to re-offend if he is ultimately released by the Parole Commissioners. This is because if he is released and continues to take his medication, then any risk to the public is likely to be small because if it were not it is difficult to see him being released at all. It is significant that there is nothing else in the defendant's background to suggest that he would pose a risk of serious harm to the public provided he were to continue to take whatever medication is prescribed for him. Dr McCall's view, with which I agree, is that "there is a good chance that Mr McGleenon will require pharmacological treatment continuously for the rest of his life", and that if he does not continue to take whatever medication may be prescribed for him after his release there is the danger that these risks could re-emerge.

[16] I am satisfied that there is undoubtedly a risk that even if the Carstairs treatment is successful, the defendant might stop taking his medication at some time after his release. Were that to be the case, then his past history suggests that there would be a considerable risk that he could again develop fixated ideas about someone else conspiring against him, or persecuting him as he has so often developed in recent years. In order to protect the public from the consequences of any such fixated ideas, I am satisfied that there will be a continuing need for some form of compulsory medical oversight or continuing review of his medical condition after any release from custody that may be ordered by the Parole Commissioners, and that as such supervision or review cannot be provided by an extended custodial sentence such a sentence would not be a proper disposal in the present case.

[17] All of these considerations lead me to conclude that the proper way of achieving the necessary protection for the public in the future is to impose an indeterminate custodial sentence under Article 13(3)(a) of the 2008 Order.

[18] Such an order requires the court to:

> "specify a period of at least two years as the minimum period … being such period as the court considers appropriate to satisfy the requirements of retribution and deterrence having regard to the seriousness of the offence."

[19] I consider that the defendant should serve a minimum term in the present case because I consider that he bears a substantial degree of responsibility for what happened because of his repeated failure to take his medication. Had he done so in all probability these tragic events would never have occurred. It is well-established that in cases of manslaughter on the grounds of diminished responsibility where a life sentence is imposed that the minimum term should reflect what is referred to as the residual responsibility of a defendant for the events which give rise to his conviction.

[20] I consider that the passages from R v Chambers and R v Stubbs which I set out below are equally applicable to determining what if any minimum term is appropriate in cases where an indeterminate custodial sentence is imposed because the defendant was suffering from diminished responsibility when he committed a killing. In R v Chambers (1983) 5 Cr. App. R. (S) 190 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.'

[21] 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. 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."

[22] Taking into account all of the considerations to which I have referred and the defendant's plea of guilty I impose an indeterminate custodial sentence with a minimum term of five years imprisonment. This will include the time spent on remand. I must emphasise that this does not mean that the defendant will automatically be released after the minimum term has elapsed. On the contrary, he will only be released when the Parole Commissioners are satisfied that it is appropriate to release him in the light of the way in which he responds to the medical treatment which he will receive at Carstairs.

[23] I also wish to take this opportunity to express concern that despite members of the judiciary in Northern Ireland drawing attention to the position on several occasions in recent years, the legislative arrangements necessary to enable remand prisoners to be transferred from Northern Ireland to Carstairs where they need to receive treatment in a high security hospital have not yet been put in place. I associate myself entirely with the comments of Mr Justice Stephens in Warwick [2008] NICC 42 where he pointed to the need for action in this area. Defendants who commit serious crimes because they suffer from grave mental illness do not attract public sympathy, but it is most unsatisfactory that years after the gap in the necessary legislative provisions have been identified steps have not yet been taken to enable remand prisoners to be transferred to institutions such as Carstairs. I hope that the necessary authorities will give this continuing problem the early attention it deserves.