Neutral Citation Number: [2023] CA (Bda) 16 Crim

Case No: Crim/2022/04

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE SUPREME COURT OF BERMUDA SITTING IN ITS ORIGINAL CRIMINAL JURISDICTION
THE HON. MRS. JUSTICE SUBAIR WILLIAMS
CASE NUMBER 2020: No. 027

Sessions House
Hamilton, Bermuda HM 12
Date: 23/06/2023

Before:

THE PRESIDENT, SIR CHRISTOPHER CLARKE
JUSTICE OF APPEAL SIR ANTHONY SMELLIE, KCMG
JUSTICE OF APPEAL DAME ELIZABETH GLOSTER, DBE

- -

Between:

TYSHAUN BROWN

Appellant

-and-

HIS MAJESTY THE KING

Respondent

Elizabeth I. Christopher, Christopher's Barristers & Attorneys, for the Appellant
Cindy E. Clarke, Director of Public Prosecutions, for the Respondent

Hearing date(s): 22 March 2023

- -

APPROVED JUDGMENT

SMELLIE JA:

1. On an indictment charging him with offences in the alternative of murder and manslaughter in respect of the tragic killing of his father, the Appellant, on 16 March 2022, entered a plea of guilty to manslaughter. His plea was accepted by the Crown.

2. On 6 April 2022, after having heard submissions on behalf of both the Appellant and the Crown, Subair Williams J, in a detailed judgment, imposed upon the Appellant a sentence of life imprisonment, with a requirement that the Appellant serves no less than 12 years before eligibility for parole (time spent in custody to be taken into consideration).

3. Leave to appeal against sentence was granted the Appellant on 16 June 2022 and on 22 March 2023, his appeal was heard. This is the Judgment.

4. As Subair Williams J noted, the facts of the case are dreadful and heart-wrenching. At about 11:30 pm on the night of the killing, 7 July 2020, the Appellant telephoned his sister and daughter of the deceased, Ms Shauntorri Franks, and informed her that "*I'm going to kill Daddy*". The Appellant was then with his father Mr Amon Brown, in his father's car, parked outside the home of the Appellant's mother, Ms Margaret Moore, where they had gotten into a heated argument. From her end of the telephone call, Ms Franks could overhear the ensuing dispute. She remonstrated with the Appellant, warning him to "*just walk away*". He did not, instead persisting in the argument as the two left the car and he followed his father onto the porch of his mother's residence where the incident turned violent.

5. Throughout the ordeal, Ms Franks remained on the telephone. In her Victim Impact Statement, she explained that she could hear her brother and father "*fighting in the background*". There came a point where the Appellant handed his telephone to his mother and directed her to talk to his sister. Having taken the phone, Ms Moore urged Ms Frank to rush to her home, which she did, by then in the company of her grand-mother and aunt.

6. In the meantime, Ms Moore called 911 to report the unfolding incident to the police. Unsurprisingly, the 911 Report contains a notation that Ms Moore was "*distraught to the point of hysteria, making it difficult for the 911 operator to understand the exact address of the location of the disturbance*." Ms Moore managed however, to report that her son was armed with a knife.

7. Later, in her witness statement, she said that at around 11:30pm, the Appellant had been returned to her home (where he lived with herself and other younger siblings) by his father. She overheard the ensuing argument between them outside and Mr Brown Snr saying "*let's go talk to your Mom about what is happening*." She then went outside by which time both men had already arrived upon the porch. She recalls the Appellant saying to his father that his father's ex-wife, Dawn, didn't like him (the Appellant) or his mother (Ms Moore) because they couldn't go to the house to see him. She expressed agreement with the Appellant, saying this was true because Dawn never really liked her or the Appellant and when he was younger he was not able to go and see his father because of Dawn. Ms Moore said the two continued arguing and the Appellant started crying, saying his father was lying "*cause Dawn never liked us at all*". The Appellant then said "*Nobody's*

going to disrespect [my] Moma" as he punched his father, knocking him to the ground where he continued to strike him as he was lying on the ground.

8. From the prosecution's summary of facts, it appears that driven by his rage, the Appellant had then gone to a neighbouring property, where, from an outside location, he managed to retrieve a knife. He then rushed back to the porch area of his mother's home where he stabbed his father repeatedly. Amon Brown, by then beaten and stabbed, had managed to muster the energy to try to run away from the Appellant, but to no avail. The Appellant chased after him until he was confronted by a concerned neighbour, whom the Appellant, upon recognising him, also menaced with the knife: "*Mr , I will "effing" [fucking] kill you"*.

9. As the events unfolded, another neighbour had called 911 and reported that the Appellant, described as " *a chubby shirtless male*", was outside #9 Cedar Hill banging on the door. When the police arrived at this address, they found the Appellant covered in blood with a knife in his hand. He shouted to the officers: "*yea, you all looking for me, you looking for me. I'm the one who done it, yea, I killed my own daddy bro, I did it, I deserve life*". After his arrest at the scene, the Appellant called out to his mother saying " *Sorry Moma, he deserved it. Take care of my baby, I am sorry*" And to his grand-mother: "*I did it Granny, it's family matters, I did it, yea, I killed my Daddy, he deserved it".*

10. Later, at the Hamilton Police Station, the custody sergeant asked the Appellant if he knew why he was in custody to which he replied; "*I am here for killing my Daddy. I know I'm doing life, I deserve it"*

11. Amon Brown D.O.B 3/6/64, was pronounced dead upon arrival at the King Edward Memorial Hospital during the early morning of 8 July 2020. He had suffered 26 stab wounds inflicted about his face, chest, arms, abdomen, left hand, right thigh and left leg. It was reported that many of the stab wounds penetrated his peritoneal cavity. A single wound penetrated his heart and the listed cause of death was hypovolemic shock, a fatal condition which disables the heart from pumping blood to the rest of the body, onset by severe blood loss.

12. The Appellant was examined by an on-call physician who observed a cut to his right index finger. Acknowledging this injury, the Appellant said: "*I got these injuries from killing my Daddy … I used a kitchen household knife*." The Appellant was admitted to the Mid Atlantic Wellness Institute for assessment on the 9th July and remained there until 13th July 2020. Upon his release he was deemed fit and capable of being interviewed by the police. When interviewed under caution he made no comment to all questions put to him.

13. There was however, an all too predictably sad history to be told, of a fractured and estranged relationship between the Appellant and his father and a further history of psychosis suffered by the Appellant from having experienced the loss of his sister, when they were both young children.

14. It is this history of the Appellant's that informed the Crown's acceptance of his plea to the reduced offence of manslaughter on the basis of diminished responsibility, and which was central to the disposition by way of sentence before Subair Williams J. It is set out in her Judgment, as relied upon both by the Crown and the Defence and as taken from the report of Dr Sebastian Henagulph,

the psychiatrist who attended upon the Appellant during his detention at the Mid-Atlantic Wellness Institute and later, during his remand at the Westgate Correctional Facility. Dr Henagulph also interviewed the Appellant in November 2020, in preparation for the making of his report to the Court.

15. Summarising his understanding from the Appellant's account of the history and circumstances leading to the offence, Dr Henagulph stated in his report [43] –[44]:

> "43. *Mr Brown told me that on the day of the offence he had been at cricket training in Somerset. He reported that he had a beer with his teammates after training. After this his father picked him up with a friend of his father's and they all went for a drink together. He reported consuming two or three cups of Bacardi and rum and Coke and said that his father had a few drinks as well. His father then drove him home.*
>
> *44. He said an argument began between them in the car. Mr Brown said it was "about [his] past – how [his] father's ex-wife didn't like him. And that [his] father wasn't around much". He said that they had similar arguments in the past but they had been verbal not physical. He said that they continued arguing once outside of the car and he remembers punching his father but is not sure why he did so. He said the next thing he remembered was standing over his father with a knife and dropping the knife when the police arrived. He said they arrested him without a struggle and he next remembers being in the police station. He said he told the police doctor about his suicidal ideas which lead to his admission to MWI for further assessment*."

16. 16. On the subject of the Appellant's relationship with his father, Dr Henagulph reported [45-47] and 72-73]:

> "*45. On direct questioning he reported never having been in physical altercation with his father in the past.*
>
> *46. He also spontaneously mentioned, as also documented in his mother's witness statement [(which recounted the breakdown in her own relationship with Amon Brown and the separation of the family)], that he used to pretend that his father had visited him at school when he had not.*
>
> *47. I noted that while recounting the circumstances of the alleged offence, there was little in the way of emotion or tearfulness from Mr Brown, which was in contrast to his description of the circumstances around his sister's death…*
> *…*
> *72. …When asked about his relationship with his father he said it was generally a good and close relationship.*
>
> *73. Overall Mr Brown presented as calm and co-operative on the ward if generally subdued. He reported some difficulties sleeping as he said, for example, on 13th*

> *July 2020, that when he closed his eyes he could see his father's shadow. There were episodes of tearfulness during which he expressed remorse at what had happened but also said he did not know why or exactly what happened."*

17. The circumstances of his sister death became the subject also of Dr Henagulph's assessment. At the time of the tragic incident, the Appellant and his sister were respectively only 8 and 6 years old. They were getting off the school bus hand in hand and were about to cross the road. The Appellant had heeded the bus driver's warning to step back but tragically, his sister did not and was fatally struck by a passing car. Earlier in his report, Dr Henagulph at [4] had noted:

> *"(The Appellant) has a significant history of contact with mental health services as a child and adolescent. This appears to have been subsequent to his experience of a highly traumatic event in which he was present when his younger sister was killed by a car driver. He has had several extended periods of psychological intervention with Child and Adolescent Services between 2004 and 2011. Diagnoses during this time included bereavement reaction, adjustment disorder, oppositional defiant disorder and possible learning disorder with a differential diagnosis of conduct disorder. He has not been prescribed psychiatric medication or required periods of inpatient treatment*"

18. And further, from [9] of his report:

> "*(The Appellant) appears to have had a fairly unremarkable early development apart from the fact his parents were never married or lived together. This seems to have changed following (the) accident on the 8 August 2003 in which his younger half-sister subsequently died. He then appeared to exhibit challenging behaviours including verbal and physical aggression and thoughts of self-harm. At the time he was diagnosed with a (normal) bereavement reaction and engaged in psychotherapy to help him adjust to his loss. After several months of apparent normal function there was again a marked deterioration in behaviour, on this occasion possibly triggered by his mother getting married to a man who was not his father. At this time an adjustment disorder was diagnosed…"*

19. And still further in relation to the impact of his sister's death, at [27]:

> "27. *He said that at the time of her birthday, 26th February, he still finds it emotionally extremely difficult. He said previously he would go drinking alcohol and "get into trouble", whereas more recently he said he would just wake up crying. He reported other times where he has re-experiencing phenomena which he described as like "a replay of the incident". If he looks at old pictures of her then he immediately starts crying. He said he does not share any of this with others in his family. He went on to describe symptoms of avoidance for example, that he would not go on buses, would avoid the area of Cedar Hill where the accident happened and did not like being inside an ambulance [(he had travelled in the ambulance with his sister on the fatal day)]. He did say that these difficulties had been less intense in more recent years.*"

20. Subair Williams J, as recorded at [23] in her Judgment, had been further informed from Dr Henagulph's report that following intensive psychotherapy with Dr De Silva who had been engaged for his intervention by the Child and Adolescent Services between 2004 and 2011, the Appellant had received therapy for diagnoses including bereavement reaction, adjustment disorder, oppositional defiant disorder and possible learning disorder with a differential diagnosis of conduct disorder, the latter as manifest from his challenging behaviour at school, including aggression, violence and suicidal ideation. However, as an adult, the Appellant had never again received any psychiatric or mental health treatment or care, prior to the killing of his father. So, for an approximate 9 year period between April 2011 (when the Appellant was one month shy of 16 years old) and July 2020 (when he was 26 years old), he had bypassed treatment.

21. As the Judge also recorded at [24-25], during that 9 year period, the Appellant had become known to the criminal justice system, having been convicted on 6 August 2015 when he was 19 years old, twice for using offensive language in a public place, the second occasion involving also the offence of violently resisting arrest. For that offence, his sentence was one of a 12 month discharge entailing a condition that he refrained from using drugs and alcohol and that he submit for assessment in respect of his needs for counselling. Some six years thereafter, on 6 June 2019 by then 25 years old, he was convicted for having assaulted a police officer and again violently resisting arrest. Again, he was given the benefit of a conditional discharge which was directed by the Magistrate to run over a 3 year term, to expire on 6 June 2022. When on the 7 July 2020, this offence was committed, the Appellant was thus in breach of that conditional discharge imposed one year earlier.

22. The Judgment continues [25 – 29]:

> "25. *Dr Henagulph discussed the (Appellant's) previous criminal record with him. The Appellant explained that his use of offensive words for his 2013(sic) conviction was committed when he had been drinking heavily. He also connected his criminal behaviour to his trauma from the death of his sister. This was consistent with the submissions made by Counsel in these sentencing proceedings before me. Addressing the 2015 conviction, the (Appellant) told Dr Henagulph that this was again triggered by his grief for his deceased sister as the offence occurred the week end after what would have been her birthday. Also on this occasion, the (Appellant) acknowledged that he had consumed excessive alcohol… Additionally, Dr Henagulph reported that the Appellant informed him that he had been convicted for numerous traffic related offences, one of which arose from an incident in which he was involved while driving impaired by alcohol. The (Appellant) told Dr Henagulph that he thought that he might have been charged with grievous bodily harm on that occasion."*
>
> *Expanding on his alcohol use, the (Appellant) informed Dr Henagulph that since he was 13-14 years old, he consumed alcohol on most occasions and on one occasion attempted or seriously contemplated suicide as he wrapped bungee cords around his neck. Dr Henagulph reported [41]:*

> *"He said when he drank he tended to drink "a lot". He said more recently he had been doing less drinking but still had occasional heavy binges in which he would experience loss of memory. He admitted to occasional cannabis use and that he had recently been using it more frequently as a result of him using less alcohol. He said he would use cannabis whenever he was feeling bad or down and that he had previously used alcohol on these occasions"*
> *27. During his 10 July 2020 interview with Dr Henagulph, the (Appellant) admitted his alcohol use on the night of the killing and said that after his argument with his father he "blacked out".*
> *…*
> *30… Over the course of subsequent visits, the Appellant agreed to take sleeping medication having reported serial nightmares and poor sleeping habits… Dr Henagulph said that the (Appellant) also spoke about "chronic issues related to the death of his sister such as having re-experiencing events at the time of her birthday in February. Dr Henagulph added: "He further explained that around this anniversary he cries and drinks alcohol. He was wondering how he would be able to cope being in prison during this time"*

23. The Judgment then turned to a summary of Dr Henagulph's diagnostic conclusions, as set out below:

> "*...Dr Henagulph opined [5-6]:*
>
> > *5. I am of the opinion that the major contributing factors to (the Appellant's) behaviour at the relevant time were mental disorders specifically associated with stress, exacerbated by alcohol.*
> >
> > *6. I am of the opinion that the above factors constitute an abnormality of mind and, as a direct consequence of abnormality, (the Appellant) should be considered for a partial defence of diminished responsibility…*
>
> *7. Although I have stated above that, in my opinion, (the Appellant) does not suffer from a severe and enduring mental illness I am of the opinion that he suffers from a combination of sub-threshold disorders which likely combine to reduce his culpability for the offence…*
>
> *18. As to the nature of (the Appellant's) mental state at the material time, I have noted I could find no evidence of a severe and enduring mental disorder such as schizophrenia, bipolar disorder or severe depression.*
>
> *19. I am of the opinion however, that he was suffering with what would come under the general subcategory of the World Health Organisation's International Classification of Diseases, Version 11 (ICD-11) chapter 6 – Mental, behavioural or neurodevelopmental disorders, namely that of "disorders specifically associated with stress." These are mental disorders directly related to exposure to a stressful or traumatic event. The identifiable traumatic stressor is a necessary but not*

sufficient causal factor … Under this heading and of particular relevance to (the Appellant's) case are post-truamatic stress disorders (PTSD, code 6B40), and prolonged grief disorder (PGD, code 6B42).

20. PTSD may develop from an exposure to an extremely threatening or horrific event or a series of events. There are three main areas which characterize the fully developed disorder: these include 1) re-experiencing the traumatic event in the form of vivid memories, flashbacks or nightmares, 2) avoidance of thoughts or memories of the event(s), and 3) persistent perceptions of heightened current threats, for example hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

21. PGD is a disturbance which, following the death of a partner , parent, child or other person close to the bereaved, there is a persistent and pervasive grief response characterized by longing for the deceased or persistent preoccupation with the deceased, accompanied by intense emotional pain such as sadness, guilt, anger, denial, blame along with difficulty accepting the death, feeling one has lost part of oneself, an inability to experience positive mood, feeling of emotional numbness, and associated difficulty engaging with social or other activities. The response persists for an atypically long period, usually more than six months, and exceeds the expected social cultural and religious norms for the individual's culture and context.

22. In my opinion (the Appellant) does not fully meet the criteria for a clinical diagnosis of PTSD. He clearly experienced a highly traumatic event when he was 10 (sic) years old which impacted upon his behaviour and functioning when a child and adolescent, resulting in several periods of psychological treatment. As far as current symptomology, he did report to me continuing re-experiencing events in the form of vivid flashbacks to the event, particularly around the time of his sister's birthday. He also described avoidance phenomena in the form of avoiding the area where the accident happened and not getting into ambulances (this also appears to have possibly precipitated the offence for which he was convicted in June 2019). However, I was unable to elicit or observe during my numerous encounters with with (the Appellant) substantial evidence of hypervigilance or an enhanced startle reaction. Although he did report some disturbances in sleep I did not judge these to be of a threshold warranting this limb of diagnosis, at best I would judge him to (be) experiencing PTSD of a mild degree of severity at the present time.

23. In my opinion a more clinically appropriate diagnosis would be that of PGD. This appears to have developed following the death of his sister, due to him being a witness of the accident as well as the prolonged nature of the court case, possibly further complicated by the fact there appears to have been a civil claim for psychiatric injury… This would have contributed to the period during which closure would normally have occurred. He told me of continuing episodes of

emotional pain leading to tearfulness triggered by reminders of his sister including photographs of her and also at the time of her birthday; I note that even discussing the accident with me while in prison resulted in an episode of tearfulness. I also note a general preoccupation with the event by the family in general which would have further prolonged this condition. While difficult to quantify, a review of available psychological instruments indicates that (the Appellant) would, at the present time, be unlikely to score above the mild to moderate range, although in previous years would have likely experienced this disorder from a moderate to severe degree.

24. As to the role of alcohol in the alleged (offence), while I believe it was a contributing factor an enabler of an emotional state in which the defendant began to experience emotional pain related to his sister's death and this was further exacerbated by him arguing with his father about his perceived feelings of abandonment by his father when younger it was not in my opinion a major factor in the offence..

25. Overall I am of the opinion that the major contributing factors to (the Appellant's) behaviour were a combination of subthreshold/mild PTSD and mild-moderate PGD, exacerbated by intoxication with alcohol. It was these factors which lead to a common emotional verbal argument escalating to an alleged homicide"...

Disposal

28. While I have stated above that I believe the (Appellant) was in either a state of mental disease or suffering from an abnormality of mind at the time, I am not of opinion that his mental disorder is of a nature or degree that would normally warrant hospital treatment, for example under the Mental Health Act 1968.

29. The treatment the (Appellant) requires would, but for the alleged offence, normally be provided on an outpatient basis and would consist of psychological therapy to address the past trauma and grief, as well as comprehensive treatment of his alcohol use in order to facilitate long-term abstinence. Should the (Appellant) receive disposal by way of imprisonment I believe such treatment can be made available in this environment and can be continued on any future release date under conditions of supervision.

Future risk

30. Without suitable treatments, I am of the opinion that there would be a chance of the (Appellant) engaging in similar, although not necessarily fatal, behaviours particularly under the influence of alcohol. Likewise, without intervention, he would remain at an elevated risk of attempting suicide in the future ..."

24. The learned Judge next turned to the analysis of the law applicable to the sentencing for an offence of manslaughter, concluding, as explained at [2] above, that a sentence of life imprisonment (with a minimum term of 12 years imprisonment) should be imposed. She began appropriately by setting out a summary of the statutory framework from the Bermuda Criminal Code Act 1907, noting that sections 297A(1) and 298(1) respectively provides as follows:

> " 297A. *Where a person unlawfully kills or is party to that killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.*
>
> *298(1). Any person who commits the offence of manslaughter is liable to imprisonment for life."*

25. In seeking to determine the appropriate approach to sentencing in this matter, the Judge next turned to an examination of the statutory provisions in the United Kingdom, in particular the Criminal Justice Act 2003 (the "CJA 2003") (both as it applied to offenders convicted prior to and on or after 1 December 2020). She noted at [38] and [39], that effective 1 December 2020, a significant portion of the sentencing provisions of the CJA 2003 had been repealed and replaced by the Sentencing Act 2020 (the "Sentencing Code"), and that under Schedule 19 of the Sentencing Code as read with section 307 thereof, manslaughter now appears as a specified offence carrying a maximum sentence on indictment of imprisonment for life. And further, that pursuant to section 285(1)(b) of the Sentencing Code, section 285 also applies to Schedule 19 offences including manslaughter, requiring the Court to impose a life sentence if the seriousness of the offence justifies it doing so.

26. In seeking to determine whether the seriousness of the instant offence required the imposition of a life sentence, the Judge then noted at [42], that section 225(1) of the CJA 2003 applied to persons [like the Appellant] aged 18 or over who were convicted of a "serious offence" [a defined term including manslaughter], so long as the Court was of the opinion that there was a significant risk of the offender causing serious harm to members of the public, occasioned by the offender's commission of further "specified violent offences." At [43], the Judge noted that, for the purpose of assessing the dangerousness and future risk posed by the offender so as to determine whether, under section 225(1) there was a significant risk of the offender causing serious harm to members of the public occasioned by the commission of further offences, the Court was guided by the criteria outlined under section 229 of the CJA 2003, which required inter alia,(and one might say uncontroversially), the taking into account of all such information about the nature and circumstances of the offence and about the offender as was available to the Court .

27. Crucially, it seems however, to her final disposition in the case, the learned Judge then went on at [44], to note that, where the Court was satisfied that the approach advised by section 225 of the CJA 2003) applied, under section 225(2) of the CJA 2003, it was open to the Court to impose either a life sentence or an indeterminate sentence of imprisonment for public protection. And further, that pursuant to section 225(2)(b) of the CJA 2003, ***the Court was under an obligation*** to impose

a sentence of life imprisonment where it considered that the seriousness of the manslaughter justified a life sentence.

28. The learned Judge next turned to the Sentencing Guidelines currently applicable in the United Kingdom, noting at [45], that sentencing guidelines may provide some assistance to the Court, particularly in cases where the judge has first ruled out the appropriateness of a life sentence. She also noted that both Ms Clarke (Madam DPP) and Ms Christopher (counsel for the Appellant) referred to the sentencing guidelines which specifically apply to manslaughter by reason of diminished responsibility (the "MDR Guidelines") and that the MDR Guidelines refer to section 2 of the UK Homicide Act 1957 which is, in substantial terms, identical to section 297A(1) of the Criminal Code of Bermuda 1907 (above), insofar as it applies to offenders who at the material point were suffering from an abnormality of mind which substantially impaired the offender's mental responsibility for the commission of the offence. This then led at [47] of the Judgment, to the observation that the MDR Guidelines commend a multiple-step approach to determining the appropriate sentence for an offender convicted of manslaughter by reason of diminished responsibility. However, she said that "***the step by step process for determining a fixed period of imprisonment is secondary to the Court's assessment as to whether or not a life sentence ought to be imposed".***

29. I pause here to note that, at the sentencing hearing, both Madam DPP and Ms Christopher had argued for a disposition by way of a fixed period of imprisonment, rather than a life sentence. The DPP advocated for a fixed term sentence ranging between 25 and 35 years. Ms Christopher sought a determinate sentence of between 11- and 15-years imprisonment. In the case of the lower range of the former, eligibility for parole would have arisen after 8 years and 4 months and in the case of the lower range of the latter, after only 3 years and 8 months.

30. The Court nonetheless appeared from the Judgment (at [48-54]) to have considered the step by step process for determining whether or not to impose a fixed term. The Judge noted that "Step One" requires the Court to assess whether the degree of responsibility retained by the offender was high, medium or lower; and that in doing so, the Court should consider whether the offender had voluntarily contributed to the seriousness of the mental disorder, an obvious example being drug or alcohol abuse without any evidence of an attempt by the offender to submit himself to rehabilitation or other identifiable appropriate treatment. "Step Two" was noted as suggesting that the assessment of the degree of responsibility is a useful guide in marking the starting range of sentence, for which the high starting point is 24 years imprisonment for cases involving a single offence of manslaughter resulting in a single fatality. Some of the non-statutory factors which would result in an upward or downward adjustment of these starting points were listed, including, of potential particular relevant to this case, the commission of the offence whilst under the influence of alcohol or drugs. "Step three" requires the Court to consider the dangerousness provisions under section 229 of the CJA 2003 in order to assess whether there is a significant risk to members of the public of serious harm occasioned by the commission of further specified offences which would carry a sentence of life imprisonment. "Step 4" requires the Court to consider disposal under the Mental Health Act. "Step 5" requires the Court to consider whether the sentence should be adjusted to meet the overall sentencing objectives of the Court and the requirement for proportionality. Here relevant factors will include the psychiatric evidence and the

regime on release. "Step 6" and "Step 7" recognise the credit to be given for a guilty plea and any assistance provided to the Crown in the course of an investigation and or prosecution.

31. Finally, in her extensive attempted assimilation of the U.K statutory and sentencing guideline principles, the learned Judge at [56], refers to the Manslaughter Definitive Guideline (ie: that applicable to manslaughter cases in general)(the "MD Guideline"), noting also at [56], that while under the MD Guideline a "*mental disorder or learning disability*" is listed as a factor reducing the seriousness of the offence or reflecting personal mitigation, this is to be contrasted to the MDR Guidelines under which it is a given that the offender's responsibility was diminished by a mental disorder. Concluding: "*Thus, in cases of manslaughter by diminished responsibility, the Court is not concerned with whether there is a presence of a mental disorder but instead the extent to which the offender's responsibility was diminished".*

32. It was that conclusion on a need to determine the extent to which the Appellant's mental responsibility was diminished which, along with the task she initially set herself (at [24-25] above) of determining whether the Appellant remained a threat to the public requiring the imposition of a sentence of life imprisonment, that appears to have most influenced the learned Judge's analysis which followed (at [76] and following).

33. Before turning to that analysis, it is necessary to express this Court's views on the approach to assimilation of the UK statutory provisions and Sentencing Guidelines. While, given the similar statutory footing of the defence of diminished responsibility and discretionary nature of the exercise of sentencing, valuable assistance may be obtained in the absence of local provisions[1]; the process of assimilation must be undertaken with caution and restraint. By way of illustration, while the UK regime now allows for a more structured and nuanced way of arriving at the appropriate sentence, it should be noted, as it is at ***Blackstone's Criminal Practice*** (2021 ed.) B1.40, that "*In a press release published on 31 July 2018 the Sentencing Council said that the guideline on manslaughter by diminished responsibility "ensures comprehensive guidance where previously it was very limited" but that "overall the guideline is unlikely to change sentence levels". The guideline indicates a single level of harm and requires the court to determine the degree of responsibility retained by the offender at the time of the offence (whether high, medium or lower). The guideline requires consideration of the issue of dangerousness at Step 3, consideration of disposals under the Mental Health Act 1983 at Step 4, and a further review at step 5 to see whether "the sentence as a whole meets the objectives of punishment, rehabilitation and protection of the public in a fair and proportionate way; relevant matters at this stage to include are the psychiatric evidence and the regime on release."*

34. The notion of "*a single level of harm*" must be taken in context as a reference to the death of the victim, being the single level of harm committed, once the defence of diminished responsibility is accepted so as to justify reducing the offence from murder. And it is trite that, in the absence of

[1] Part IV of the Criminal Code 1907 provides a statutory statement of the purpose and principles of sentencing and codifies the fundamental principle that a sentence must be proportionate to the gravity of the offence and the degree of culpability of the offender. At section 55, it also declares that imprisonment is to be imposed only after consideration of all alternative sanctions and sets out generic factors for consideration, including many which have come classically to identify aggravating and mitigating circumstances. There are however, no local guidelines for sentencing specifically in cases of manslaughter.

"*such abnormality of mind.. as substantially impaired*" the offender's mental responsibility (in the language of section 297A of the Bermuda Criminal Code Act 1907) or "*abnormality of mental functioning.. arising from a recognized medical condition .. substantially impairing an offender's ability to understand the nature of his conduct*" (in the language of section 2 the Homicide Act 1957 UK as amended by the Coroners and Justice Act (CAJA)2009, section 52), a plea of guilty to manslaughter on the basis of diminished responsibility should not be accepted.

35. If authority for this basic proposition is needed, see again, the discussion at ***Blackstone's*** at B1.18-B1.23. At the latter citation, the following commentary appears:

> "*Lord Hughes in **Golds** ([2016] UKSC 61, [2017] 1 Cr App R 18) at [48] acknowledged the frequency and propriety of accepting a plea to manslaughter in these circumstances [(where there is clear and persuasive evidence of each of the required elements of diminished responsibility)], just as he had previously observed in **Robinson v State (Trinidad and Tobago)** [2015] UKPC 34 at [29] that there are very many cases in practice where it is appropriate to accept a plea, though he also noted that it:*
>
> > *"... remains of great importance that pleas are accepted only in cases where it is proper to do so. Generally that means cases where there is no significant material dispute either of underlying fact or of medical analysis, and moreover it is clear that the defendant's mental responsibility for the killing can properly be described as substantially impaired*".

36. In the present case, that indeed, must have been the basis upon which the plea of diminished responsibility was proffered on behalf of the Appellant, accepted by the Crown and admitted by the Court. This all proceeded upon the basis of Dr Henagulph's medical opinion as presented in his report, and as expressly acknowledged by the learned Judge at [13] of the Judgment, where she states that "*Dr Henagulph (who is) well known to the Courts of this jurisdiction for his expertise, was the (Appellant's) medical officer during his detention at the Mid-Atlantic Wellness Institute after the killing in July 2020."*

37. It is problematic therefore, that in arriving at her conclusion at [84] of the Judgment that the (Appellant) retained a high degree of mental responsibility for the offence, the learned Judge treats his state of intoxication as self-induced while being aware that being intoxicated "*in such close company with his father was more so his dangerous way of permitting his unrestrained emotional state to be unleashed from an abnormal state of mind. The (Appellant) knew all too well on 8 July 2020 that he was filled with a long-lasting and high dose of anger and hurt inside of him and he knew that his excessive alcohol consumption would inevitably lure him into an uncontrolled and violent disposition*".

38. Those conclusions, revolving as they do around the notion of the Appellant's self-induced intoxication, would, it seems to me, come close to negating the basis of his plea and the basis of its proper admission by the Court having regard to Dr Henagulph's opinion. Therein at [24 - 25] (as set out above at [20] , Dr Henagulph stated "*As to the role of alcohol in the alleged (offence), ...it was not in my opinion a major factor in the offence. Overall I am of the opinion that the major*

contributing factors to (the Appellant's) behaviour were a combination of subthreshold/mild PTSD and mild-moderate PGD, exacerbated by intoxication with alcohol."

39. And so, while it will remain legitimate to enquire, as part of the sentencing exercise, as to the extent of an accused's retained mental responsibility for an offence of manslaughter, the analysis should not result in the proper basis of the plea of diminished responsibility itself being doubted.

40. The finding that the Appellant retained a high degree of mental responsibility for the offence also informed the outcome of the Judge's primary enquiry about "dangerousness". She concluded at [86] of the Judgment, that he continued to pose a significant risk of harm to the public, inclusive of his family members. This conclusion was the result of a unilateral interrogation of the Court Audio Record related to the Summary Court proceedings in June 2019. From this the learned Judge gleaned (as recorded at [81] of the Judgment), that the Summary Court had been impressed upon to order a conditional discharge for a term which would enable the Appellant to obtain the treatment he needed (presumably but not expressly stated to be inclusive of alcohol abuse). Having undertaken this exercise of her own motion and without notice to the Appellant (as Ms Christopher understandably complains), the learned Judge nonetheless felt able to conclude not only that the Appellant had failed to comply with his treatment programme but also at [83], that "*Against this background, I am bound to find that the (Appellant) was not only aware of his rehabilitative needs prior to the killing but was plainly aware of the connection between his untreated mental health and alcohol use on one part and his proneness to violent outbursts on the other part*."

41. This was the further analysis which led to the conclusion at [94] that "*only an immediate custodial sentence in the form of life imprisonment is appropriate in this case*". And at [96-97] that *"the (Appellant's) reduced level of mental responsibility arising out of his abnormality of mind (noting that the reduction is on the lower end given the high level of mental responsibility retained) in addition to his guilty plea and expression of remorse are factors which are relevant to my determination of the portion of the sentence he must serve before he is entitled to apply to the Parole Board for release on licence under the Parole Board Act 2001. Having regard to all of the circumstances of the commission of the offence and the character and circumstances of the Accused, I direct that he serve no less than 12 years imprisonment before he may be considered for release on parole.*"

42. While it is a matter for the Court and not the psychiatrist to decide whether an accused continued to pose a risk of harm[2],it is also nonetheless problematic when a judicial assessment is taken about the required length of sentence needed for the delivery of treatment to eliminate or reduce the risk, without having due regard to the medical evidence. Yet that is what appears to have happened here as well. It is clear from Dr Henagulph's report at [29] (set out at [20] above, that the treatment the Appellant requires but for his offence, would normally be provided on an outpatient basis and would consist of psychological therapy to address the past trauma and grief, as well as comprehensive treatment of his alcohol use in order to facilitate long-term abstinence. Should the defendant receive disposal by way of imprisonment he continued, "*I believe such treatment can be made available in this environment (ie: in prison) and con be continued on any future release date under conditions of supervision."*

[2] As emphasized, for instance, by Watkins LJ in ***R v Davis*** (1983) 5 Cr App R (S) 425, and as approved by this Court in ***Cooper v R*** Crim Appeal No 20 of 1990, per DaCosta Ag P, 22 May 1991

43. This advice does not suggest the need for either an indeterminate life sentence or a lengthy minimum period of incarceration of 12 years in order for the delivery of an effective program of treatment. Indeed, nowhere in the learned Judge's analysis does the doctor's advice appear to bear any relationship to her conclusions in that regard. Instead, the minimum term of 12 years appears to be the outcome simply of her subjective sense both of the need for an environment of incarceration and of the period required.

44. There is also a likely unintended outcome which was raised with this Court by Ms Christopher, without demurrer from the DPP. It is that, unlike, as had been the practice when ***Cooper v R*** (above) was determined, and when it was assumed (at p5) that " *the prisoner while in prison (for an indeterminate life sentence) would have his mental and physical treatment carefully considered and if necessary ameliorative treatment would be given to him*", nowadays that is not the case. Under the present regime, the 12 year minimum term would mean that attention would not be turned to the Appellant's treatment until after the expiry of that term. Orders from the Court specifying the program and length of treatment are therefore required properly to engage the process.

45. For all the foregoing reasons, in the end, the learned Judge's assiduous attempt at assimilation of the UK guidelines notwithstanding, her analysis became, in my view, too skewed in favour of deterrence and retribution and away from the equally valid objectives of treatment and rehabilitation. In this way, her sentence of life imprisonment with a minimum term of 12 years imprisonment without eligibility for parole was a disproportionate dispensation. Such a dispensation on the strength of the case law, including ***Cooper v R*** (above) remains appropriate only in exceptional circumstances. As repeated there, (at p4) citing and following ***R v Maun*** (1970) 71 Cr. App Rep 100 (at 101-102) and ***R v Johnson*** (1982) 4 Cr. App R (S) 143; such an exceptional circumstance would likely be where the accused has some mental deficiency and it is impossible to foresee exactly how that deficiency will continue and develop. It is clear from Dr Henagulph's report that this is not such a case.

46. Tragic though the circumstances of this case are, the offending conduct did not rise to the level of seriousness found even in ***Cooper v R*** itself and in many of the other cases cited. In some of those cases the dispensation was, nonetheless, a fixed term of imprisonment with shorter defined minimum terms of incarceration. That, in my view, is the appropriate dispensation here. The Appellant is clearly to be regarded as likely to benefit from treatment. The likelihood of him presenting a threat to the public of similar reoffending must also be heavily discounted. Unlike as the learned Judge found, the deadly attack upon his father was not triggered by any premeditated sense of longstanding enmity or hatred. As his mother testified and as Dr Henagulph opined from his interviews with the Appellant, despite resentment bred from a longstanding feeling of abandonment, the Appellant and his father got along well together. There had been no previous history of violent interaction between them. The tragic killing was truly the result of a state of abnormality of mind in the Appellant triggered primarily by his recognisable medical conditions of PTSD and PGD and such that there was no reason to believe that with suitable treatments, there would be a real risk of the Appellant engaging in similar, although not necessarily fatal, behaviours particularly under the influence of alcohol. As support for this postulation, see Dr Henagulph's report (at [30]) and as set out above at [20].

47. In the result, the appeal against sentence is allowed. We consider that the appropriate sentence should be 20 years imprisonment with eligibility for parole after one-third of the sentence (i.e. 6 years and 8 months) is served and upon the recommendation of the Court that the Appellant receives treatment beginning immediately and continuing while he remains in prison and thereafter, on the out-patient basis, if that is then advised by the attending psychiatrist. It is so ordered.

GLOSTER JA:

48. I agree.

CLARKE P:

49. I, also, agree.