THE EASTERN CARIBBEAN SUPREME COURT
IN THE HIGH COURT OF JUSTICE
(CRIMINAL DIVISION)

SAINT LUCIA

CASE NO. SLUHCRD 2009/0122

BETWEEN:

THE QUEEN

Claimant

AND

ANDREW KAGAN RICHARDSON

Defendant

Appearances:

Mr. S. Innocent and Mr. Leslie Prospere for the Defendant
Mrs. Veronica Charles-Clarke, Director of Public Prosecutions, for the Crown

....

2011: June 2, 9 and 24
July 13

....

JUDGMENT ON SENTENCING

[1]. **BENJAMIN, J:** The defendant was charged for the offence of murder contrary to Section 85 (a) of the Criminal Code of Saint Lucia 2004 on an Indictment filed on March 10, 2010. The said Indictment alleged that the defendant, intending to cause death, caused the death of his mother, Dr. Trona Bennett on Tuesday the 13th day of January 2009 at Trouya, Gros Islet. The defendant pleaded not guilty to the charge upon arraignment. Subsequently, on February 2, 2011, the

defendant pleaded not guilty to murder but guilty of manslaughter by reason of diminished responsibility.

[2]. At the sentencing hearing, evidence was received from Drs. Eloy Castrillo and Swamy, both of whom are consultant psychiatrists. In addition, the Court received testimony from Mr. Hilary Herman, Director of the Bordelais Correctional Facility and Mr. Marcus Girard, Executive Director of the National Mental Wellness Centre. For the purposes of the plea taken and also for the purposes of sentencing, reports were furnished: from Dr. Castillo and Dr. Swamy as well as from Dr. Hazel Othello – a consultant psychiatrist; Dr. Glenn Griffin – a clinical and forensic psychologist; and Dr. Denis Edward – a clinical neuropsychologist.

[3]. Submissions were made by learned Counsel on behalf of the defendant and by the Director of Public Prosecutions (the DPP). The defendant is now before the Court for sentencing.

THE FACTS OF THE CASE:

[4]. The facts were presented in written submissions laid over by the DPP and the Defence did not take issue with them. These facts are critical to the nature of the plea as well as to the determination of the proper sentence to be meted out by the Court.

[5]. The deceased is the biological mother of the defendant. His parents are both medical doctors but they had been divorced prior to the date of the incident.

[6]. On the day before the incident, that is, on Monday January 12, 2009, the defendant and his father had a physical altercation. At the time, they lived in the same residence. The Police had cause to intervene and the defendant, at his request, was taken to his mother's house at Trouya in the

quarter of Gros Islet by the Police in the evening. The defendant was given a warning at the request of his father. At the time he was dropped off at his mother's house, he had three bags with his belongings and his mother was not at home.

[7]. The defendant's father spoke with the deceased at about 6:45 a.m. the next morning. However, at noon, he was made aware that the deceased, with whom he shared an office at the Tapion Hospital, had not attended for work. The Police at the Gros Islet Police Station were notified of this fact.

[8]. Police Officers left the station to investigate the report and while driving along the road leading to the deceased's house at Trouya, they met the defendant walking on the road not too distant from the house. He was observed to have what appeared to be blood on his T-shirt and a bleeding cut on right thumb. He was questioned as to the whereabouts of his mother and he offered that she had gone to work. The Police escorted the defendant back to his mother's house where her vehicle was seen parked. The presence of the vehicle was pointed out to the defendant and he replied that she may have returned early. He was asked whether he had seen his mother leave the house and he responded that he had heard the vehicle start and when he left to go to Windjammer, the vehicle was not there.

[9]. The house was forcibly entered through a small window. The deceased was lying on the floor with blood on and near her face. The defendant was thereupon taken into custody.

[10]. There was a security system installed with cameras at the deceased's house. The digital recording was retrieved by a technician and the CCTV footage was viewed. The defendant was seen

walking around the house, struggling with a female adult, dragging a human body from the side to the front of the house and washing the steps with a garden hose.

[11]. At the Gros Islet Police Station, several minor injuries were observed on the body of the defendant. A red substance resembling blood was seen on his yellow t-shirt and on his brown short pants. In the defendant's possession, the Police found a small knife with what appeared to be blood, a cell phone, a wallet and two keys. One of the keys was later found to fit the bottom lock of the front door to the deceased's house.

[12]. A post-mortem examination conducted by the pathologist, Dr. Stephen King, upon the body of the deceased yielded observations of a brown rope tied around the neck and injuries to the face, lower lip, left index finger and left leg. The cause of death was expertly opined to be asphyxia secondary to ligature strangulation. When pronounced dead at the scene, the doctor observed the face and eyes to be blackened and edematous. These injuries were attributed to blunt force trauma applied by a blunt instrument with severe force.

[13]. Buccal swabs were taken from the defendant and the deceased for comparison with various items of clothing from the defendant, samples taken from the body of the deceased and samples taken from items from the crime scene and the crime scene itself. DNA analysis was done by a forensic scientist from the Forensic Science Laboratory in the United Kingdom. In summary, the conclusions were that the blood samples found could have come from the defendant there being a match to his complete DNA profile. Blood found on swabs taken from the defendant's jersey and pants were concluded to have possibly come from the deceased as the same matched the DNA profile of the deceased.

[14]. In an interview conducted by the Police Investigator with the defendant in the presence of his lawyer, the defendant was formally charged and cautioned, at which time he again elected not to say anything.

PLEA OF DIMINISHED RESPONSIBILITY

[15]. The defence of diminished responsibility was raised ahead of the plea in the defence statement in reliance upon the support of the psychiatric reports by Dr. R. G. Swamy, Dr. Hazel Othello and Dr. Glen Griffin. These reports are dated subsequent to the date of the offence. However, Dr. Swamy's report of January 20, 2009 made reference to and provided a psychological history of the defendant when seen in the years 2000 and 2003.

[16]. The Crown relied upon its own expert and obtained reports from Dr. Eloy Azanza Castillo and Dr. Dennis Edwards. These reports were commissioned after the date of the offence and were sought for the purpose of ascertaining the mental status of the defendant prior to and at the time of the commission of the offence.

[17]. The defence of diminished responsibility is set out in section 90 of the Criminal Code of Saint Lucia 2004. The said section reads:

1. *"If a person kills or is a party to a killing of another person, he or she shall not be convicted of murder if he or she was suffering from such mental disorder (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by deceased or injury) as substantially impaired his or her mental responsibility for his or her acts in doing or being a party to the killing.*

2. *On a charge of murder, it is for the defence to prove that the person charged by virtue of this section not liable to be convicted of murder.*

3. *A person who, but for this section would be liable to be convicted of murder, is liable to be convicted of manslaughter.*

4. *The fact that one party to a killing is by virtue of this section not liable to be convicted of murder shall not affect the question whether the killing amounted to murder in the case of any other party to the killing."*

The purport of the section is that where diminished responsibility is proved, the defendant is liable to be convicted of manslaughter and not of murder.

[18]. The Crown stated its justification for the acceptance of the plea by reference to the following passage in Archbold 2009, para. 19-88(a):-

> *"Where on an indictment for murder the medical evidence plainly points to substantially diminished responsibility, it is proper to accept a plea of guilty of manslaughter based on that ground."*

This learning is based on Section 2 (2) of the Homicide Act, 1957 (UK) which is in substantially similar terms and is supported by a dictum in **R.v. Cox (M)** 52 Cr.Ap.R.130, CA. This approach was adopted by Hariprashad –Charles, J in **The Queen v. Germain Sebastian BVIHCR2006/0004 (BVI)** in relation to Section 148 of the Criminal Code of the Laws of the Virgin Islands.

[19]. Given the wording of section 90 of the Criminal Code, medical evidence would invariably be required to successfully support a defence of diminished responsibility. The evidential burden rests with the defence and must be established on a balance of probabilities by showing that it was more probable than not that the defendant was suffering from such abnormality of mind as to substantially impair his mental responsibility for this acts and omissions in doing the killing. The Court of Criminal Appeal in the judgment of Lord Parker, CJ. R.v. Byrne [1960] 2 Q.B 396 at p.403 interpreted "abnormality of mind" in the following authoritative statement:

> ***"Abnormality of mind"****...... means a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters, and the ability to form a rational judgment whether an act is right or wrong, but also the ability to exercise will-power to control physical acts in accordance with that rational judgment. The expression 'mental responsibility for his acts' points to consideration of the extent to which the accused's mind is answerable for his physical acts, which must include a consideration of the extent of his ability to exercise will-power to control his physical acts."*

[20]. Having determined that the defendant was suffering from one of the causes of abnormality of mind as set out in Section 90 (1), the factual question remains as to whether the abnormality of mind was such as to substantially impair the defendant's mental responsibility for his acts in doing the killing. The test for substantial impairment was set out in the case of **R.v. Lloyd [1967]** 1 Q. B. 175 at p.181 in the following explanation:

"Substantial does not mean total, that is to say the mental responsibility need not be totally impaired, so to speak, destroyed altogether. At the other end of the scale substantial does not mean trivial or minimal. It is something in between......"

At trial, this would be a question for the jury to be decided on as a balance of probabilities. The jury would be advised and be expected to approach the matter from a common sense perspective.

[21]. It can be taken that the Crown applied the law having regard to the evidence provided by the various expert reports in its acceptance of the plea of guilty to manslaughter by way of diminished responsibility. The said reports are synopsized and the salient features relevant to the plea and to sentencing highlighted. In sum, the reports of the psychiatrists, Dr. Castillo, Dr. Swamy and Dr. Othello concluded that the mental capacity of the defendant was diminished at the time of the killing given the existence of depression, schizotypal personality disorder and episodes of psychosis. The clinical psychologist, Dr. Griffin, detected the presence of personality disorder. Dr. Dennis Edwards' conclusions were somewhat conservative and cautious in that, while he did not eliminate the existence of a mental health disorder, he attributed the defendant's actions in killing his mother to a hysterical rage reaction and a difficulty of impulse control more than to the consequences of personality disorder.

[22]. Given the reports of the experts which included his mental health history as helpfully provided by Dr. Swamy, there was ample material for the Crown to exercise its authority to accept the plea and this Court concurs in the approach taken.

EXPERT REPORTS

(a) PRIOR TO THE OFFENCE

[23]. Dr. R. G. Swamy is a psychiatrist presently employed as a consultant in private practice and at the St. Jude's Hospital. His specialist training in psychiatry dates back to 1995 in India. He has worked as a consultant in that specialized field in St. Lucia since 1997 at the Golden Hope Hospital, the St. Jude's Hospital and at the Bordelais Correctional Facility. Of the experts, Dr. Swamy is the only one who saw the defendant prior to the commission of the offence in January 13, 2009. His report of January 20, 2009 was supplemented and clarified by his viva voce testimony at the sentencing hearing. He first saw the defendant when he was brought to St. Jude's Hospital by his father on May 17, 2000. The defendant then presented a history of decreased self-confidence, decreased sleep, hopelessness and anger outbursts. These were identified as symptoms of depression. In addition, the defendant had a history of alcohol and marijuana consumption. The diagnosis made at the time was moderate depressive disorder with cannabis abuse. The defendant was then prescribed anti-depressant medication. At a follow-up visit on May 24, 2000, the defendant said he felt better but he still suffered from decreased self-confidence and negative, cognitions, that is to say, feeling of hopelessness, worthlessness and helplessness. On his third visit on May 31, 2000, the defendant showed increased self-confidence, a change from negative to positive cognitions and thus general improvement.

[24]. On June 8, 2000, the visit to Dr. Swamy recorded decreased marijuana consumption. The fifth visit was on June 29, 2000 and this was a psychotherapy session to teach coping skills, assertive training and relaxation techniques. Thereafter, there was a substantial hiatus until a visit on April 29, 2003. The defendant gave a history of relapse with the resurfacing of depressive features

coupled with alcohol and cannabis abuse. Medication was prescribed and psychotherapy recommended. There were no further visits to Dr. Swamy.

[25]. However, Dr. Swamy saw the defendant at the Bordelais Correctional Facility and at Tapion Hospital since the date of the offence. The defendant was placed on a low dose of anti-psychotic medication.

[26]. Dr. Swamy noted that with the visits during 2000 he had established a rapport with the defendant. He also indicated that one has to first treat the depression before addressing the alcohol and cannabis use. Having seen the defendant, he is the opinion that the defendant can improve with treatment inclusive of psychotherapy.

[27]. **(b) POST-OFFENCE REPORTS**

The defendant was seen and examined by Dr. Hazell Othello on January 15 and January 27, 2009. In her written report of March 16, 2009, Dr. Othello detailed the defendant's personal history gleaned from interviews with the defendant's father, and his former cohabiting companion, the defendant's younger sister and the defendant himself. The defendant's psychiatric history was also chronicled with the additional input of a report by Dr. Edgecombe following a psychiatric evaluation on October 25, 2005.

[28]. Dr. Othello observed that during the two days of examination the defendant was calm and his facial expression showed no or little emotion: The defendant complained of feeling depressed, of difficulty sleeping and restlessness. He also spoke of being easily distracted and prone to day-

dreaming. However, he denied being hallucinatory and Dr. Othello detected no delusions. His judgment was found to be intact and there was no impairment of his cognitive functions. In the course of the interviews, the defendant admitted to harbouring suicidal thoughts approximately two weeks prior to the offence.

[29]. In response to indirect questioning about the events surrounding his mother's death, the defendant told the doctor that he had slept under his mother's house. He remembered thinking about how to kill her and hearing voices "supporting" him; he was, however, certain that the voices did not command or instruct him to kill his mother. He also said that he was planning to commit suicide.

[30]. Dr. Othello diagnosed the defendant as suffering from schizotypal personality disorder. She wrote:

> "He felt depressed at times and abused drugs and alcohol in an attempt to cope with his feeling of inadequacy and his interpersonal and academic difficulties. He also had psychotic episodes during which he would experience auditory hallucinations and paranoid delusions with religiose overtones and would exhibit obviously bizarre behaviour. During the months and weeks preceding the murder of Dr. Trona Bennett, he continued to exhibit bizarre behavior." The report further stated that the defendant's "bizarre behavior when psychotic and his apparent careless disregard for social norms and house rules resulted in sanctions against him which only further increased his stress..... His mother's refusal to allow him to stay at her house was in his mind further rejection and alienation. Because of his underlying personality disorder, Andrew Kagan Richardson did not possess the skills required to objectively process in his mind his perceived adversities and formulate a socially acceptable course of action."

[31]. The final opinion of Dr. Othello was that at the time of the offence being committed the defendant "suffered from abnormality of mind (Schizotypal Personality Disorder with episodes of psychosis) which substantially diminished his mental responsibility for his actions."

[32]. Dr. Glenn A. Elmer Griffin conducted a clinical examination of the defendant on March 14-16, 2009. In addition, he interviewed the defendant's father, his sister, his father's former companion, a friend of the defendant and the helper at his father's house. Meticulous details of these interviews formed part of the clinical psychologist's report. Psychological tests of veracity, neuro psychological tests, intelligence tests, and tests including objective test, self-report measures and tests of pathology were administered.

[33]. The tests concluded that the defendant was fully oriented and co-operated with the examiner with no indication of malingering, exaggeration or false presentation of symptoms. The report further stated:

> *"Neurological screening indicates the absence of any gross organic brain pathology. More specialized neurological and neuropsychological testing would be required to rule out more subtle organic brain pathology. Andrew Richardson's intellectual and memory functioning are in the high average range. Subjectively he is experiencing a high level of depression with suicidal ideation. Objective test results strongly indicate the presence of a personality disorder."*

Dr. Griffin concluded by way of summary of the psychological assessment that the defendant "is suffering from a severe psychiatric disorder of schizotypal personality disorder with pronounced

dependent traits - a severe mental disorder. He also meets the diagnostic criteria for major depression and poly substance dependence." The substances were identified through interview as alcohol, cannabis, tobacco and caffeine. A presumption of mental disorder at the time of the killing was opined, as the defendant was adjudged to lack the mental capacity to know the nature of and weigh alternatives to his behavior.

[34]. In explaining his conclusions, Dr. Griffin wrote in his assessment report:

> *"Schizotypal personality traits are qualitatively similar to the characteristic symptoms of schizophrenia. These data indicate that his mental state and level of functioning had been deteriorating notably over the past three years and that the severity of his disorder increased dramatically in the week prior to the heinous crime. In the hours prior to the crime, he was suffering an acute exacerbation of this mental disorder. The precipitating stressor was perceived parental rejection and abandonment; his pathological dependence resulted in the exacerbation of his disordered schizotypal thinking. The exacerbation was marked by the distinguishing elements of the mental disorder – active violent fantasies, inappropriate affect, paranoia, social alienation, delusional thinking, suicidality and hallucinations. The clinical data indicate that the decompensation precipitated an assault on his father. This acute episode became more severe in the subsequent night time hours during which he reportedly attempted suicide and experienced auditory and visual hallucinations."*

So far as the diagnosis is concerned, Dr. Griffin's conclusion is consistent with that of Dr. Swamy and Dr. Othello.

[35]. Dr. Griffin went on to recommend treatment commencing with extended therapeutic interventions to improve his state of depression and tendency to suicide with targeted psycho-pharmacological medications. In this first report the prognosis was given as guarded.

[36]. The defendant was seen and further assessed by Dr. Griffin one month later in April 2010. The initial diagnosis of schizotypal personality disorder was confirmed. Upon clinical examination, the defendant admitted to having violent fantasies which were non-personal except for his father being sometimes the object of these fantasies. However, on this occasion, the defendant denied having recent auditory or visual hallucinations. Nevertheless, the defendant was yet to recognize the significance of his actions and to formulate a sense of guilt. Dr. Griffin recommended similar treatment with psychotherapy once or twice per week.

[37]. Dr. Dennis Edwards is a neuropsychologist at the Psychology Unit of the University of the West Indies at Mona, Jamaica. He examined the defendant at the request of the Crown, on July 1 – 2, 2010 at the Bordelais Correctional Facility. The resulting report embodied a review of reports, a clinical interview of the defendant and the results of assessment tests. The purpose of the examination was stated to be to ascertain the defendant's mental capacity, current mental capacity as well as the time of the commission of the offence.

[38]. An adaptive behavior assessment by Dr. Edwards revealed that in his general adaptive functioning, the defendant's interpersonal relationships appeared uniformly between the 15 and 18 year old range but fluctuated above this range. Depression and anxiety as well as anti-social and dependent personality tendencies were detected. In addition, there was the harbouring of feelings of ambivalence towards his deceased mother and a possible underlying despising of females.

[39]. From the results of his psychological evaluation of the defendant at the time and upon review of the data provided, Dr. Edwards formed the opinion that there is no compelling basis to proffer that the defendant was mentally unaware of his actions at the time of his mother's death. The report concluded as follows:

> *"(The defendant)" is a highly intelligent young man and has not made any claim of amnesia with respect to his actions in the indexed offence. There was no claim or indication of a substance induced reality break of psychotic type denial as might be plausibly claimed when there is gross impairment in reality testing. On the contrary he was aware of his mother being derisive towards him around the period of the episode. Mr. Richardson also expressed a recall of "might have just snapped" and "didn't know I could do that" which would suggest his prevailing cognitive intellectual orientation to person, place, time and circumstance at the time of his actions. He was further sufficiently oriented and able to supply a falsehood with respect to his mother's whereabouts when asked after his actions."*

> *"While a schizotypal personality disorder does appear plausible in his mental health profile, anti-social and dependent personality disorders are also indicated to be ruled out ...... It is difficult to assume an actual breakdown in Mr. Richardson's consciousness, memory, perception of self or the environment, or sensory and motor behaviour as would obtain in personality disorder dissociation at the time of his actions .... Other self-report also revealed a capacity for deep hurt and angered reaction that is reflected upon only afterwards."*

Dr. Edwards further noted:

> *"It is of significance that (the defendant) is, even currently unable to experience remorse and sadness for his mother's death even as he feels resentment towards himself for being responsible. He exhibits no emotional longing for her having successfully compartmentalized and separated his intellectual and cognitive self and emotional self with respect to his mother."*

[40]. The final conclusion given by Dr. Edwards was that the killing was a result of "a hysterical rage reaction and a difficulty of impulse control, more than would be attributed to the consequences of a personality disorder and a psychotic episode." This guarded interpretation opens the door for diminished responsibility within the meaning of Section 90 of the Criminal Code. As to the present evaluation of the defendant, Dr. Edwards plainly recognized the existence of a real mental health disorder.

[41]. Among his recommendations, Dr. Edwards suggest: a programme of psychotherapy to treat with the defendant's developmental issues of self-esteem and psychosocial adjustment issues as well as the addressing of his peculiar fantasies affect and family relations; continued psychotic monitoring of the defendant's depression and anxieties by mean of psychotherapy and pharmacotherapy upon the advice of a psychiatrist; and vocational and academic exercises to promote self-esteem building and personal growth in preparation for his return to society.

(b) Recent Reports

[42]. The most recent report on the defendant was the joint psychiatric report dated October 1, 2010 by Dr. Eloy Castillo and Dr. Josiah Rambally. This report was furnished at the request of the Court and was produced from seven hours of sessions between the period August 1, 2010 and September 17, 2010 at the Bordelais Correctional Facility. Both doctors observed strange or abnormal behavior by the defendant. On one occasion he was unable to explain his behavior but on a subsequent occasion he told Dr. Castillo that he was having violent fantasies towards his sister.

[43]. Subsequent to the last session, the report concluded that no psychotic features were noted at the time of examination. However, it was concluded that at the time of the offence, the defendant was functioning at a psychotic level. The report recommended that the defendant received comprehensive psychiatric and psychotherapeutical management.

[44]. Dr. Castillo was responsible for attending to inmates at the Bordelais Correctional Facility as consultant psychiatrist. He submitted a further report dated April 4, 2011. The defendant was found to be aware and fully oriented with no memory impairment, delusions and hallucinations. The behaviours of previous sessions were not noticed. The defendant confided that whenever the medication was stopped he would have violent fantasies. Dr. Castillo summarized his prognosis as follows:

> *"I do not rule out that in the future, under certain circumstances, this client could become psychotic and violent again".*

These circumstances he identified as acute stress, some physical conditions and the abuse of drugs, e.g. marijuana, cocaine, amphetamines and alcohol. The report recommended that the defendant be placed under the mental care of a mental health team including a psychotherapist to provide comprehensive psychological and psychiatric care for life with permanent supervision of his compliance to medication. It was strongly cautioned that there ought to be a compulsory prohibition against illegal drugs including alcohol.

[45]. When responding to defence counsel in Court, Dr. Castillo was not prepared to concede to any improvement in the defendant's condition as he explained that the defendant was already on medication but he proffered that the medication has helped the defendant's condition and he is stable. He emphasized the need for the defendant to receive the recommended care as well as the need to ensure compliance with treatment requirements.

PRESENTENCE REPORT

[46]. In compliance with an order of the Court and as required by Section 109 (4) of the Criminal Code, a pre-sentence report was prepared by a Probation Officer to aid the court in sentencing. The personal details contained in the report mirror the family history gleaned and recounted by Dr. Othello, Professor Griffin and Dr. Edwards. The defendant, his father, a friend of the defendant and his family and former co-workers were included in the sources of information.

[47]. The defendant is now thirty-four (34) years of age. He was born in Canada where he was raised until the family moved to Trinidad and eventually to Saint Lucia when the defendant was eleven (11) years old in 1988. He attended St. Mary's College until the age of sixteen (16) years when he returned to Canada to further his secondary education. In 1997, he enrolled in the architectural

department at Florida International University; there he spent a period of ten years and failed to complete the five year programme by one module.

[48]. The defendant was observed by his father to become reclusive during his teenage years although there were no displays of aggression or animosity. He admits to have commenced smoking marijuana in Canada on a regular basis at the age of sixteen (16) and maintained the habit up to the time of the incident. His father said he suspected the drug use but when the defendant was asked he denied it.

[49]. In November 2004, the defendant's parents separated and he went to live with his father. His only sibling, a younger sister was a medical student at the time and she is now a surgeon. Before they separated, the defendant's father observed his increasing reclusion and unusual and bizarre behaviour and took him to see Dr. Swamy. The defendant also began to accuse his family members of not loving him and became less communicative.

[50]. The defendant told the Probation Officer that, at the time he was seeing Dr. Swamy, he was suffering from depression on account of his failure to complete his architectural training. He also admitted that he had sleepless nights and also found it difficult to sleep during the day. Dr. Swamy prescribed Prozac for his depression and medication to combat the sleeplessness. These symptoms were experience while the defendant was striving to complete his architectural degree.

[51]. The defendant resided with his father at Bonne Terre. In 2006, his father began a relationship with a female live-in companion. The defendant resided on the premises in separate accommodation downstairs. He enjoyed access to the main house until the day before the incident when he had a confrontation with his father about the arrangements for access. There followed an altercation that resulted in the defendant physically assaulting his father. It is plain that this incident does not form

part of the charge for which punishment is to be meted out, but the involvement of his father must feature in the assessment of the risk of future re-offending.

[52]. The report suggests that after his parents' separation, the defendant became closer to his father and his sister became closer to her deceased mother. For the present, his sister does not wish to communicate with him.

[53]. The defendant's good friend and his friend's mother, both friends of the family, were interviewed. Both spoke well of the defendant. His friend's mother described the defendant as quiet, very lovely and an introvert. His friend recalled that the defendant had a short attention span and he often drifted off in the middle of a conversation. He also observed the defendant making karate motions and playing imaginary basket-ball. Both persons observed no violence or aggression on the part of the defendant.

[54]. The defendant has only engaged in part-time employment while he was a student. Since October 2005, he has not been employed. His co-workers spoke positively of his quiet temperament and pleasant personality. His officer manager at the architectural firm he last worked with recalled that the defendant had difficulty concentrating. He also observed the defendant executing karate moves. The defendant was eventually dismissed for lack of adequate performance and unpunctuality. Reference was made to an interview with Dr. Edgecombe but this Court would have preferred that this be embodied in a report or provided by oral testimony.

[55]. It was reported that the defendant appeared and conversed normally during the interview. Significantly, while expressing a continued interest in architecture, the defendant desired to write books about sorcery and magic.

THE LAW ON SENTENCING:

(a) Statutory Provisions

[56]. The stipulated penalty for manslaughter is life imprisonment as provided for in Section 93 of the Criminal Code. In this regard, Section 1123 (1) makes it plain that the High Court is empowered to exercise a discretion and sentence on offender to a term less than that prescribed by the Code for an offence. Section 1099 (1) mandates that where the offender is or appears to be mentally disordered, the Court is required to obtain and consider a medical report before passing a custodial sentence other than a sentence mandatorily imposed by law.

[57]. Should the Court be minded to impose a custodial sentence, *section 1097 (2) provides the following guidance for determining the term of sentence:*

"(2) The custodial sentence shall be –

(a) *for any term (not exceeding the permitted maximum) as in the opinion of the Court is commensurate with the seriousness of the offence, or the combination of the offence and other offences associated with the offence; or*

(b) *where the offence is of a violent or sexual nature, for such longer term (not exceeding that maximum) as in the opinion of the Court is necessary to protect the public from serious harm from the offender.*

(3) Where the Court passes a custodial sentence for a term longer than is commensurate with the seriousness of the offence, or the combination of the offence and other offences associated with it, the Court shall –

(a) *state in open Court that it is of opinion that subsection (2) (b) applies and why it is of that opinion; and*

(b) *explain to the offender in open Court and in ordinary language why the sentence is for such a term."*

[58]. Sections 1099 (3) and 1100 (3) of the Criminal Code are directed at the sentencing of offenders with a mental disorder. Section 1099 (3) reads:

"(3) Before passing a custodial sentence other than one fixed by Law on an offender who is or appears to be mentally disordered a Court shall consider –

(a) any information before it which relates to the offender's mental condition (whether given in a medical report, or presentence report or otherwise); and

(b) the likely effect of such a sentence on that condition and on any treatment which may be available for it."

Section 1100 reads so far as relevant:

1. *"Nothing in this Code prevents a Court from mitigating an offender's sentence by taking into account any such matters as, in the opinion of the Court, are relevant in mitigation.*

2. *Without prejudice to the generality of subsection (1), nothing in this Code prevents a Court –*

   (a) from mitigating any penalty included in an offender's sentence by taking into account any other penalty included in that sentence; or

(b) in the case of an offender who is convicted of more than one offence, from mitigation the offender's sentence by applying any rule of law as to the totality of sentences.

3. Nothing in this Code –

(a) requires a Court to pass a custodial sentence, or any particular custodial sentence, on a mentally disordered offender; or

(b) restricts any power which enables a Court to deal with a mentally disordered offender in the manner the Court considers to be most appropriate in all the circumstances." (emphasis added)

[59]. For the purpose of sentencing generally, section 1102 sets out overarching guidelines to be observed by the Court. These include the rehabilitation of the offender as one of the main aims of sentencing and equating the gravity of the punishment to the gravity of the offence.

[60]. Both Defence and Prosecution embrace the recommendations of the experts that the defendant is in need of treatment The Crown has urged a custodial sentence to accompany the treatment while the Defence has emphasized the principle of rehabilitation. Both sides are correct and I will go on to further state that the classical principles of retribution, deterrence and prevention play little or no role in the peculiar circumstances of the present case.

[61]. It can be taken from the purport of the statutory provisions on sentencing that:

1. *The Court must obtain and take into account the expert medical reports and the presentence report;*
2. *The offender must be dealt with in the manner the Court deems to be most appropriate in all the circumstances of the case;*
3. *Consideration must be given to the seriousness of the offence;*
4. *Any possibility of the need to protect the public from serious harm by the offender in cases of violent (or sexual) crime must be considered;*
5. *The rehabilitation of the offender is to be treated as a primary objective of sentencing;*
6. *In appropriate cases, the Court can consider a non-custodial sentence;*
7. *The Court must weigh the likely effect of a custodial sentence on the condition of the offender and on the treatment of the offender;*
8. *The seriousness of the punishment must be commensurate with the gravity of the offence; and*
9. *The Court can impose a term longer than is commensurate with the seriousness of the offence including an indeterminate term where the protection of the public from serious harm from the offender is in its opinion required provided that its opinion is so stated in open Court and explained to the offender in ordinary language.*

It is worthy of note that the sentencing function ultimately rests with the Court and must not be directed, though it must be informed, by expert opinions. Each case must be dealt with on its own

individual facts and circumstances as derived from the case itself and the available information on the offender and on his condition.

(b) CASE LAW

The learned DPP and learned Counsel have helpfully furnished several authorities relevant to sentencing in cases of diminished responsibility. Guidelines for cases based on the legislative regime in the United Kingdom, have been pronounced in numerous cases. ***In R.v. Chambers (1983) 5 Cr. App. R. (s) 190***, the Court of Appeal had this to say:

> "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."
>
> 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. 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."

In the case of ***Cardinal Williams v. R.*** – Criminal Appeal No. 10 of 1995 (SVG) the Court of Appeal accepted that the defendant may have suffered from depressive illness and though he had no previous conviction, it was considered that he might have been a threat to the safety of the public. A sentence of ten (10) years for manslaughter on the basis of diminished responsibility was imposed. In ***Edward Toussaint v. R***. – Criminal Appeal No. 5 of 2000 (Antigua and Barbuda), the Court of Appeal substituted a conviction for manslaughter by way of diminished responsibility and imposed a sentence of twenty-five (25) years.

[62]. In Saint Lucia, there is no specific provision for a hospital order. However, by Section 1100 of the Criminal Code, the Court is not only not obliged to impose a custodial sentence but it can deal with the mentally disordered offender "in the manner the Court considers to be most appropriate in all circumstances." My broad reading of this provision is that it must be interpreted as contemplating the committing of the defender to an institution other than the Bordelais Correctional Facility should the case so demand.

INSTITUTIONAL FACILITIES

[63]. At the hearing, both sides recognized this potential interpretation. Evidence was therefore received from the Director of the Bordelais Correctional Facility, Mr. Hilary Herman and from Mr. Marcus Girard the Executive Director of the National Mental Wellness Centre located on the Millennium

Highway. Both gentlemen apprised the Court of the facilities offered and conditions extant at their respective facilities.

[64]. Mr. Herman stated that there are sixty-four (64) inmates to whom psychotropic medication is administered daily. The Ministry of Health is relied upon to provide mental health treatment. Such treatment is supposed to be provided on a weekly basis but in practice visits are typically made every two weeks. The Director commended that the existing facilities are not adequate to meet the requirements of mentally ill inmates as there is no dedicated forensic unit. One of the nine housing units has been allocated for such inmates and it is as secure as the other units. As regards treatment of inmates, the Director iterated that there is no prohibition against private medical practitioners accessing the facility to treat inmates upon request.

[65]. Mr. Marcus Girard is the Executive Director the Mental Wellness Centre which is tasked with rehabilitating patients diagnosed and suffering from mental conditions in the broad sense. Its mandate as a treatment facility is to endeavour to reintegrate individuals treated back into society. There are levels of care reflected in the six (6) Units, the first of which is the Acute Unit for patients of both genders being admitted. This unit has twelve (12) beds but presently houses twenty eight (28) male clients. The total resident population of the facility is in the region of 128 served by a capacity of one hundred and eight (108) beds.

[66]. The Executive Director frankly stated that there are very serious issues of security and he bemoaned the absence of adequate space. He explained that the institution was not built to accommodate persons on remand or under sentence from the Court. In addition, there are staffing issues as there is no social worker, no clinical psychologist and the rehabilitation programme is

understaffed. All in all, the picture painted inspired little confidence in the institution as on option for persons sentenced by the Court.

[67]. This Court is therefore faced with the reality that although empowered to commit a mentally impaired offender to a hospital or other suitable facility other the prison, no such hospital or facility is at present available in Saint Lucia. It follows that where the Court makes a determination that the offender must be confined, the only course open is for that offender to be committed to the Bordelais Correctional Facility.

THE SENTENCE

[68]. The evidence and reports disclose that the defendant was aware of what he did to cause the death of his mother. He was clearly angry at her for not allowing him access to her home overnight. Having regard to the CCTV footage, the defendant struggled with her and was seen using a garden hose to eliminate evidence of the struggle. The deceased was found dressed to go to work. When accosted by the Police, the defendant lied as to his knowledge of her whereabouts on at least two (2) occasions. As such the degree of culpability of the defendant is substantially more than minimal and any punishment must be reflective of such finding. However, the facts of the case do not warrant life imprisonment as in **R.v. Germaine Sebastien –** Case No. 4 of 2006 (Virgin Islands).

[69]. This case throws up many mitigating features. The defendant has no previous convictions and he has pleaded guilty thus obviating a lengthy emotive trial. The defendant is presented as a person of good character by persons interviewed by the Probation Officer. He has spent over two and a half years on remand for which he ought to be given credit provided that this does not conflict with

any need to protect the public. There is of course the defendant's mental illness which operates to mitigate but not to absolve him of responsibility. (See per May, LJ in ***R. v. David John Hempston*** [2006] EWCA Crim. 2869 at para. 41). As to mental illness that falls short of insanity, the Court of Appeal of the Supreme Court of Victoria in **The Queen vs. Leanne Walsh** [1998] NTSC 30 set out five ways in which it is relevant to sentencing, namely:

1) *It may reduce the moral culpability of the offence, as distinct from the prisoner's legal responsibility where that is so, it affects the punishment that is just in all the circumstance and denunciation of the type of conduct in which the offender engages is less likely to be relevant sentencing objective.*
2) *The prisoner's illness may have a bearing on the kind of sentence that is imposed and the conditions in which it should be served.*
3) *A prisoner suffering from a serious psychiatric illness is not an appropriate velude for general deterrence*
4) *Specific deterrence may be more difficult to achieve and is often not work pursuing as such.*
5) *Psychiatric illness may mean that a given sentence will weigh more heavily on the prisoner than it would on a person in normal health.*

[70]. The defendant's abuse of marijuana and alcohol has featured in the reports of all the experts. His habit of marijuana use has been indulged from a young age and for over half of his life. Dr. Swamy noted that there was evidence of improvement from medication in 2000 but that there was a relapse in 2003 when there was a hiatus in his treatment. Dr. Castillo was particularly concerned

that the defendant ought to comply with the medical regimen if medication or psychotherapy are to be effective he sternly warned against the use of illegal drugs and alcohol.

[71]. The incident of January 12, 2009 when the defendant assaulted his own father and the revealing of his ambivalence feelings towards his parents are causes for concern and directly impact the risk to the defendant's family. There is nothing to suggest that, to strangers, the defendant is harmful and likely to become violent. However, there exists the real possibility of harm being visited on his immediate family in the absence of comprehensive and effective treatment for his mental disorder. The defendant is a good candidate for rehabilitation and re-entry into the community provided that treatment is administered and adhered to. In this regard, the Court has given much consideration to an appropriate sentence that would not frustrate the desire of the defendant to resume a life that is as close to normal as treatment would allow. Any orders made by the Court must give the defendant to opportunity to overcome his mental disorder, to address his abuse of illegal drugs and alcohol and to be compliant with any recommended treatment regime. By this means, the identified risk to his family members would be eliminated or substantially reduced.

[72]. An appropriate sentence of nine (9) years imprisonment would satisfy the element of punishment. From this there must be discounted the time spent on remand. In my view the remainder of six years and six months would provide adequate time for treatment to take root and for the defendant to complete the process of rehabilitation. ***(See: Cases of Callachand et al. v. The State (2008) UKPC 49; and Romeo Costa Hill v. The Queen – CCJ Appeal No. 1 of 2010).***

[73]. By virtue of the foregoing reasons taking all the circumstances into account it is ordered as follows:

1) *The defendant is sentenced to six (6) years and 6 months imprisonment at the Bordelais Correctional Facility.*

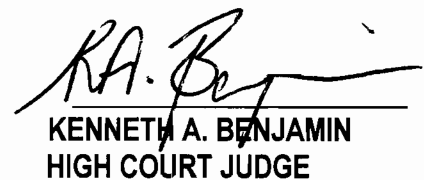
2) *The defendant shall undergo such treatment by way of medication and psychotherapy as recommended by the attending psychiatrist.*

3) *The defendant shall undergo a psychiatric assessment at least once every three months during the period of imprisonment.*

4) *The defendant shall be released on completion of the sentence provided that the Court by order is satisfied that he no longer poses a threat to his family.*

5) *The attending psychiatrist shall issue a report in July of every year as to the responsiveness of the defendant to the treatment ordered.*

The Court is grateful to the Director of Public Prosecutions (DPP) and learned Counsel for the Defendant for the tremendous assistance afforded by the submissions and case law provided.



KENNETH A. BENJAMIN
HIGH COURT JUDGE