Northern Ireland
Legal Quarterly
Summer Vol. 72 No. 2 (2021) 389–396
Commentaries and Notes: DOI: 10.53386/nilq.v72i2.879

R v Westwood (Thomas): diminished responsibility and disposals under the Mental Health Act 1983

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ABSTRACT

This is a commentary on *R v Westwood (Thomas)*, where the Court of Appeal of England and Wales held that the judge had erred in assessing Westwood's 'retained responsibility' as medium to high under the Sentencing Council Guideline for manslaughter by reason of diminished responsibility.[1] Although the sentencing judge concluded that the offending was caused by Westwood's anger, the Court of Appeal found the psychiatric evidence clearly indicated that the most significant factor was Westwood's mental illness and that his anger at the time of the offence was a manifestation of his mental illness. Westwood's responsibility was low, and it was appropriate to impose both a hospital and restriction order.[2]

Keywords: diminished responsibility; extended sentences; hospital orders; manslaughter; mentally disordered offenders; restriction orders; sentencing guidelines.

INTRODUCTION

At the time of writing, *Westwood (Thomas)* is one of the most recent authorities to consider the interpretation and application of the sentencing guideline for manslaughter by reason of diminished responsibility in England and Wales.[3] This case is significant for two interrelated issues: firstly, the judicial assessment of 'retained responsibility' when sentencing manslaughter by reason of diminished responsibility; and, secondly, the importance of a 'penal element' in disposal under the Mental Health Act 1983 (MHA 1983). Notwithstanding the ostensible degree of flexibility afforded under the new sentencing guideline,[4] it will be argued here that the instant case is paradigmatic of sentencing judges continuing to adopt an

1 Sentencing Council, *Manslaughter by Reason of Diminished Responsibility* (2018).

2 MHA 1983, ss 37 and 41.

3 Sentencing Council, *Manslaughter Definitive Guideline* (2018).

4 For further discussion, see M Wasik, 'Reflections on the manslaughter sentencing guidelines' [2019] 4 Criminal Law Review 315–332.

overly mechanistic approach towards sentencing mentally disordered offenders when determining the appropriate disposal under the MHA 1983.[5]

BACKGROUND

Westwood (W) appealed against a 21-year extended prison sentence, comprising a custodial term of 16 years and an extension period of five years. HHJ Lockhart QC also imposed a hospital direction – often referred to as a 'hybrid order'.[6] W also appealed a limitation direction that he should be subject to the special restrictions being imposed following his plea of guilty to manslaughter by reason of diminished responsibility.

W suffered from paranoid schizophrenia and autistic spectrum disorder. Following an argument, W stabbed and killed his mother (S). S suffered 18 areas of sharp force injury to her chest, defensive injuries, and injuries to her heart and one of her lungs. HHJ Lockhart QC heard evidence from two psychiatrists that W was suffering from hallucinations and paranoid delusions which would have impaired his ability to form a rational judgement and exercise self-control. In considering the first step in the sentencing guideline, which required assessment of the degree of responsibility retained by W, HHJ Lockhart QC acknowledged that W's abnormality of mental functioning was grave and longstanding, but considered that a disposal under section 37 (hospital order) authorising the detention of W in hospital for medical treatment with restrictions should be rejected in favour of an order under section 45A. This was strongly influenced by two factors: firstly, his findings that when W killed his mother he was 'angry with her, and as a result of [his] condition, he more readily lost control'; and, secondly, that he had failed to take his medication, knowing this would place her at greater risk. HHJ Lockhart QC concluded that W retained a 'medium to high' level of responsibility for the killing and indicated that a penal element was important in view of his culpability.

THE COURT OF APPEAL DECISION AND COMMENTARY

The issue for the court in the instant case was the same as in *Edwards and others*.[7] The court had to determine whether a hospital order combined with a restriction order under sections 37 and 41 of the MHA 1983 was the appropriate disposal as opposed to whether a sentence

5 See, for example, *R v Fisher* [2019] EWCA Crim 1066; *R v Rendell* [2019] EWCA Crim 621.

6 MHA 1983, s 45A.

7 [2018] EWCA Crim 595; [2018] 4 WLR 64.

of life imprisonment combined with a section 45A order should be imposed. The three crucial questions for the court to determine in the present case were as follows:

1 What was W's 'retained responsibility'?
2 Was W's failure to self-medicate deliberate or part of his condition?
3 What in the public interest was the best disposal available under the MHA 1983?

When addressing the first question, Lord Justice Lindblom held that HHJ Lockhart QC fell into 'significant error' in assessing W's retained responsibility as 'medium to high'.[8] The only realistic conclusion on the evidence was that W's retained responsibility at the time of the offence was 'low'.[9] As indicated by the evidence and subsequent psychiatric reports, the factor of most significance in causing W to commit the offence was his mental illness; he was suffering a psychotic episode when he killed S, and his 'anger at the time was not extraneous to his mental illness, but a manifestation of it'.[10]

In relation to the second question regarding medication non-compliance, Lindblom LJ held that there was no evidence that, in the circumstances, it was a culpable omission.[11] The assertion that W had failed to receive medical treatment seemed hard to reconcile with his discharge by mental health services at a time when he was showing signs of mental instability.[12]

In terms of the third question, Lindblom LJ concluded that a penal element in W's sentence was inappropriate.[13] The psychiatric evidence, taken together with the previous medical evidence, gave no confidence that when W's sentence expired the treatment of his mental illness would have been entirely successful, or that his release into the community could be contemplated.[14] On the facts, there was 'a distinct potential disadvantage' to an order under section 45A, namely that if W was returned to prison 'his mental health would be liable to deteriorate, with a risk that he would then refuse treatment'.[15] The joint expert report concluded that there was 'obvious good sense in [W remaining] ... in a secure inpatient unit for the foreseeable future in order to receive the

8 [2020] EWCA Crim 598 [82].
9 Ibid [89].
10 Ibid [82].
11 Ibid [96].
12 Ibid [65] and [87].
13 Ibid [95].
14 Ibid at [100].
15 Ibid [100].

necessary treatment and rehabilitation'.[16] The Court of Appeal stated that if W were made subject to orders under sections 37 and 41 and if he were ever to be discharged from hospital, the arrangements that would then obtain would provide at least as much and probably more protection for the public than the section 45A regime. If sentenced under section 45A, W could not be compelled to accept medical treatment post-release. The process for his recall could prove slower and more cumbersome than that under sections 37 and 41.[17]

Following consideration of the three expert reports, and hearing live evidence from a consultant psychiatrist, the court concluded that the sentence be quashed and orders under sections 37 and 41 of the MHA 1983 substituted.[18]

DEFINITIVE GUIDELINE ON MANSLAUGHTER: DIMINISHED RESPONSIBILITY

The Sentencing Council issued a definitive guideline on manslaughter in 2018.[19] The guideline applies to all offenders aged 18 and older sentenced on or after 1 November 2018, regardless of the date of the offence.[20] The guideline outlines an 11-step approach to determining sentence. The steps that were considered most pertinent in the instant case are considered in further detail below.

Step one: assessing the level of culpability and responsibility retained

Step one of the guideline, which ordinarily requires a consideration of both harm and culpability, requires only a consideration of the offender's 'retained responsibility' (high, medium, or low): the harm of death (viewed as of utmost seriousness) is factored into all relevant starting points and category ranges.[21] In all such cases, the offender will have the required intent for murder, and their retained responsibility is considered to be the most important factor in assessing culpability.[22] While superficially this approach appears attractive, there is little further assistance for the court in deciding into which category the offender falls beyond enjoining the court to have regard to 'the medical

16 Ibid.
17 Ibid [101].
18 Ibid [103].
19 Sentencing Council (n 3 above).
20 Ibid.
21 Ibid.
22 This reflects the leading decisions in *Chambers* (1983) 5 Cr App R (S) 190 and *Wood* [2009] EWCA Crim 651; [2010] 1 Cr App R (S) 2.

evidence and all the relevant information before the court'.[23] As the instant case and numerous appellate authorities have demonstrated, this approach is often 'fraught with difficulty'.[24]

Psychiatric evidence and the assessment of culpability

It is widely acknowledged that the assessment of culpability in mentally disordered defendants has become increasingly difficult for the court and, in some cases, ethically problematic.[25] Hallett raised concerns that judges have, in some instances, shown no reluctance in asking psychiatrists to comment on issues pertaining to culpability.[26] This, Hallett argues, should be 'resisted both because of non-medical factors involved in the determination of culpability and because even if mental disorder were to correlate with concepts of culpability, it is ultimately a matter for the court'.[27] Notwithstanding these concerns, it would appear that, since the implementation of the revised sentencing guideline for diminished responsibility, the courts have taken a firm approach to ensuring that any assessment of culpability/responsibility retained 'is strictly a matter to be weighed by the judge upon his or her view of the circumstances … and the medical evidence which may bear on the question'.[28]

Medication non-compliance

When assessing the level of responsibility retained, the degree to which the offender's actions or omissions contributed to the seriousness of the mental disorder at the time of the offence may be a relevant consideration.[29] In the instant case, the fact that W had not taken his anti-psychotic medication was taken to be a relevant consideration when justifying the 'penal element' during the sentencing hearing.[30] Despite it being a relevant consideration in assessing the culpability of an offender, Loughnan and Wake have previously noted that there may be numerous reasons for an offender's non-compliance with medication; this may include, *inter alia*, the stigma attached

23 Wasik (n 4 above). See also, Sentencing Council, *Consultation Response: Sentencing Guideline – Manslaughter by Diminished Responsibility* (2018) 17–18.

24 Ibid.

25 J Peay, 'Responsibility, culpability and the sentencing of mentally disordered offenders: objectives in conflict' [2016] 3 Criminal Law Review 19.

26 N Hallett, 'To what extent should expert psychiatric witnesses comment on criminal culpability?' (2020) 60(1) Medicine, Science and the Law 67, 72. See also *R v Yusuf* [2018] EWCA Crim 2162; *R v Ozone* [2018] EWCA Crim 1110.

27 Hallett (n 26 above).

28 *R v Rodi* [2020] EWCA Crim 330 [25].

29 Sentencing Council (n 1 above).

30 *Westwood* (n 8 above) [51].

to 'certain medications, religious beliefs, paranoia, side effects, and depression',[31] which may also contribute to an offender's failure to engage with mental health services.[32] Further, the sentencing court's assertion that W would have recognised the risk in failing to take his prescribed medication would also (potentially) incorrectly assume that he had knowledge of any potential consequences of failing to do so.[33] Although the ruling in *Edwards* rightly acknowledged that failure to medicate may be inextricably linked to an offender's mental illness,[34] it is disappointing that this has not been made explicitly clear in the sentencing guideline.

Step four: determining sentence and disposals under the MHA 1983

In view of the conclusion on 'retained responsibility', the most significant and important part of the court's ruling in the present case[35] related to the range of mental health disposals under the MHA 1983. This consideration is reflected in step four of the sentencing guideline which had been revised to reflect respondents' concerns during the Sentencing Council's consultation on the diminished responsibility sentencing guideline and the ruling in *Edwards and others*.[36] This step requires the sentencing court to engage with the criteria for making a hospital order under section 37 (with or without a restriction order under section 41) and a hospital and limitation direction under section 45A. As an emergence of recent appellate cases has demonstrated, the choice to be made between a custodial sentence, a hospital order, and a hospital and limitation direction can be 'notoriously difficult'.[37]

The court ultimately held that there was 'sound reason for departing from the need to impose a sentence with a "penal element"'.[38] According to Taggart, this reveals how an erroneous assessment of retained responsibility may infect the remainder of the sentence and skew the position the sentencing judge takes on the need for a 'penal element'

31 Arlie Loughnan and Nicola Wake, 'Of blurred boundaries and prior fault: insanity, automatism and intoxication' in Alan Reed, Michael Bohlander, Nicola Wake and Emma Smith (eds), *General Defences in Criminal Law Domestic and Comparative Perspectives* (Ashgate 2014) 131.

32 Thomas Crofts and Nicola Wake 'Diminished responsibility determinations in England and Wales and New South Wales: whose role is it anyway?' (2021) 72(2) Northern Ireland Legal Quarterly 323.

33 *Edwards* (n 7 above) [68].

34 Ibid [34.v].

35 Westwood (n 8 above).

36 *Sentencing* Council (n 23 above) p.19.

37 Wasik (n 4 above).

38 *Westwood* (n 8 above) [103].

and, indeed, the overall disposal of the case.[39] Of course, in cases with defendants suffering from mental disorders, the court will also need to consider the nature of the enduring mental illness, the need for long-term treatment in hospital, the gravity of the offence, and also any finding of 'dangerousness' under the Criminal Justice Act 2003.[40]

Step five: factors that may warrant an adjustment in sentence

In order to remedy the difficulty in step four, there is a novel step five, which requires the court to 'review the sentence as a whole' to see 'whether [it] meets the objectives of punishment, rehabilitation and protection of the public in a fair and proportionate way'.[41] Relevant issues will include 'the psychiatric evidence and the regime on release'.[42] On a strict reading, however, it is difficult to see what extra benefit step five provides. For instance, when assessing 'responsibility retained' at step two, the court is already required to identify whether a combination of the specified aggravating or mitigating factors 'or other relevant factors' should result in any upward or downward adjustment from the sentence. According to Wasik, step five's 'oblique reference' to the 'regime on release' conceals some disagreement in the appellate authorities as to whether a hospital order or a hospital and limitation direction affords greater protection to the public given the different criteria which apply in determining the release of the offender from hospital or from prison and the differences inherent in the supervision arrangements following that release.[43] Further, step four already requires the court to consider 'all sentencing options' before imposing a hospital order, and countless sentencing cases in the past, in addition to the other guidelines here, have warned against 'an overly mechanistic approach to sentencing'.[44] Notwithstanding these difficulties, it is arguable that step five allows 'considerable latitude' for the sentencing judge,[45] who is reminded that diminished responsibility manslaughter cases 'vary considerably on the facts of the offence and the circumstances of the offender'.[46]

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39 J Taggart, 'Sentencing: *R v Westwood (Thomas)*' [2020] 10 Criminal Law Review 973, 976.
40 Ibid.
41 Sentencing Council (n 1 above).
42 Ibid.
43 Wasik (n 4 above).
44 S Walker, 'Sentencing Council's definitive guideline on manslaughter' (2018) CLW/18/30/8.
45 Wasik (n 4 above).
46 Sentencing Council (n 1 above).

CONCLUSION

Although the sentencing guideline represents a positive step in an attempt to achieve greater consistency in manslaughter sentencing,[47] its limitations are becoming increasingly apparent. It is therefore imperative that the Sentencing Council reviews these guidelines in order to prevent a cavalcade of similar cases reaching the appellate courts in the future.

47 To 'regularise practice' as the Sentencing Council put it in the *Manslaughter Guideline Consultation* (2017) 9.