



**THE COURT OF APPEAL**  
**CRIMINAL**

**UNAPPROVED**

**NO REDACTION NEEDED**

**Bill Number: CCDP0026/2013**

**Court of Appeal Record No.: 105/2014**

**Neutral Citation No: [2022] IECA 239**

**Birmingham P.**  
**McCarthy J.**  
**Ní Raifeartaigh J.**

**BETWEEN/**

**THE PEOPLE AT THE SUIT OF THE DIRECTOR OF PUBLIC PROSECUTIONS**

**RESPONDENT**

**- AND -**

**SIMON MCGINLEY**

**APPLICANT**

**JUDGMENT of the Court delivered on the 14th day of October 2022 by Ms. Justice**

**Ní Raifeartaigh.**

## **Introduction**

1. This is an application pursuant to s. 2 of the Criminal Procedure Act 1993. The applicant has applied to the court for an order quashing his convictions for murder, burglary and false imprisonment on the ground that a new or newly-discovered fact shows that there has been a miscarriage of justice in relation to them. This arises in circumstances where an expert consultant psychiatrist has provided a report indicating that the applicant currently suffers from paranoid schizophrenia and has set forth certain views as to whether the applicant was in the early stages of this illness at the time of the offence and how it might have interacted with a drug and alcohol dependency on the part of the applicant at the time of the offences.

2. The applicant's trial took place in March/April 2014 in the Central Criminal Court. He was convicted on the 3 April 2014. On the same date, he was sentenced to life imprisonment in respect of the murder, seven years in respect of the burglary, and ten years in respect of false imprisonment, all sentences to run concurrently and to date from the 29 September 2012. He lodged an appeal against conviction, which was rejected by this Court and in that regard, the judgment of the court was delivered on the 21 November 2016 by Birmingham J. (as he then was) [2016] IECA 424. No issue was raised at the trial by the defence as to the applicant's mental health at the time of the offence. No defence of diminished responsibility was raised at the trial nor in the original appeal to this Court. The issue has been raised for the first time in this application.

## **Section 2 of the Criminal Procedure Act 1993**

3. This judgment will at times refer to the application herein as "a s.2 application". S. 2 of the 1993 Act provides as follows:

(1) A person —

(a) who has been convicted of an offence either—

(i) on indictment, or

(ii) after signing a plea of guilty and being sent forward for sentence under section 13(2)(b) of the Criminal Procedure Act, 1967, and

who, after appeal to the Court including an application for leave to appeal, and any subsequent re-trial, stands convicted of an offence to which this paragraph applies, and

(b) who alleges that a new or newly-discovered fact shows that there has been a miscarriage of justice in relation to the conviction or that the sentence imposed is excessive,

may, if no further proceedings are pending in relation to the appeal, apply to the Court for an order quashing the conviction or reviewing the sentence.

(2) An application under *subsection (1)* shall be treated for all purposes as an appeal to the Court against the conviction or sentence.

(3) In *subsection (1)(b)* the reference to a new fact is to a fact known to the convicted person at the time of the trial or appeal proceedings the significance of which was appreciated by him, where he alleges that there is a reasonable explanation for his failure to adduce evidence of that fact.

(4) The reference in *subsection (1)(b)* to a newly-discovered fact is to a fact discovered by or coming to the notice of the convicted person after the relevant appeal proceedings have been finally determined or a fact the significance of which was not appreciated by the convicted person or his advisers during the trial or appeal proceedings.

(5) Where—

(a) after an application by a convicted person under *subsection (1)* and any subsequent re-trial the person stands convicted of an offence, and

(b) the person alleges that a fact discovered by him or coming to his notice after the hearing of the application and any subsequent re-trial or a fact the significance of which was not appreciated by him or his advisers during the hearing of the application and any subsequent re-trial shows that there has been a miscarriage of justice in relation to the conviction, or that the sentence was excessive,

he may apply to the Court for an order quashing the conviction or reviewing the sentence and his application shall be treated as if it were an application under that subsection.”

## **Background**

4. A brief summary of the facts leading to the applicant’s murder conviction was set out in this Court’s judgment dated the 21 November 2016 concerning the original appeal, and we gratefully adopt the summary therein as follows.

5. The background was that on the 19/20 September 2012, the applicant entered the home of Mr. Eugene Gillespie at Old Market Street, Sligo, in the course of a burglary. Mr. Gillespie was 67 years of age and lived alone. The prosecution case as outlined by counsel at the trial was that while Mr. Gillespie was in his home, he was subjected to a serious degree of violence. The evidence was such as would leave the jury to infer that he had been subjected to a violent assault and subjected to repeated blows. The house was ransacked and

indeed one witness described it as being “*like a bomb went off*”. A number of pieces of furniture were broken. The applicant restrained Mr. Gillespie by tying his hands behind his back with a cord that he had found in the house. When the applicant left the house, he left Mr. Gillespie tied up in the house. At around 1.35pm on the 20 September, the applicant rang the emergency services and referred to a house across from the station with a “brown gate”, saying that there was a man tied up in the house. In fact, the house where the accident occurred was red, not brown. There was a house with a brown door or gate opposite the Garda station and the Gardaí called to that house, but of course found nothing untoward there. It was not until 9.20pm on Friday the 21 September that Mr. Gillespie was found tied up in his home. He appeared to be unconscious and was having difficulty breathing. He was brought to the hospital and was found to have experienced a brain bleed and a swollen brain, a skull fracture and a fractured jaw. He had also suffered significant hand injuries arising from the fact that the cord restraining him had constricted the veins. He subsequently died of his injuries.

6. The applicant entered a plea of guilty to manslaughter in the presence of the jury and at trial the only issue was whether the case was one of murder or manslaughter. He was represented at trial by an experienced legal team and they had no criticisms to make of the judge’s charge. Subsequently, he had a different legal team who raised many matters on appeal, all of which were rejected in the judgment of this Court of the 21 November 2016. The issues raised in that original appeal included matters such as how the trial judge dealt with the explanation of intent, s. 4(1) of the Criminal Justice Act 1964, the question of foresight and its relationship to intent, the “natural and probable consequences” presumption, and related matters. As already noted, neither insanity nor diminished responsibility had been raised during the trial and neither of these arose on that appeal.

## **The present application**

7. This application is grounded on the affidavit of Joe Hackett, Solicitor, of Sheridan & Leonard Solicitors, Belfast. Mr. Hackett avers that around the 8 October 2018 he was contacted by the applicant's mother inquiring if he would act for her son. He explains how he received various papers, and how requests were made for various medical notes, and he records that Martin O'Rourke QC/SC was instructed. On the 28 May 2019 a letter of instruction was sent to Professor Kennedy, a Consultant Forensic Psychiatrist at the Central Mental Hospital inquiring if any consultant psychiatrist would examine the applicant and consider the case. On the 2 July 2019, Dr. Stephen Monks accepted instructions. He indicates that in early November 2019, Dr. Monks received two boxes of papers including the original trial papers, Court of Appeal papers and all the medical notes and records in respect of the applicant that could be obtained. Dr. Monks conducted a personal examination of the applicant in mid-January 2020.

8. Mr. Hackett indicates that he received a copy of Dr. Monks' psychiatric report on the 11 June 2020 after which he sought further advices from senior counsel. As a result of this, he sent a number of further questions to Dr. Monks for clarification and received an email on or about the 12 August 2020 with a supplemental report attached, in which Dr. Monks set out his answers to the questions.

9. Mr. Hackett requests the Court to find that there may have been a miscarriage of justice in the applicant's case and to quash the convictions of the applicant on all counts by reason of the contents of the Dr, Monks' reports, which he says amount to a newly discovered fact

as defined by s. 2 of the Criminal Procedure Act 1993 and which if it had been before the jury might have influenced the outcome of the applicant's trial.

**10.** It is a curious feature of this case that diminished responsibility was not mentioned at all by Dr. Monks in his opinion(s), nor in the applicant's written submissions, but that it came to the forefront of the oral submission on appeal where in effect it became the centrepiece of the applicant's submission. In essence, his submission was that there should be a retrial so that the question of whether he was suffering from diminished responsibility could be decided by a jury.

**11.** Section 6 of the Criminal Law (Insanity) Act 2006 provides for what is known as the defence of diminished responsibility, which, if successful, reduces a verdict from murder to manslaughter. It provides:

“(1) Where a person is tried for murder and the jury or, as the case may be, the Special Criminal Court finds that the person—

(a) did the act alleged,

(b) was at the time suffering from a mental disorder, and

(c) the mental disorder was not such as to justify finding him or her not guilty by reason of insanity, but was such as to diminish substantially his or her responsibility for the act,

the jury or court, as the case may be, shall find the person not guilty of that offence but guilty of manslaughter on the ground of diminished responsibility.”

12. Section 1 of the 2006 Act provides that “mental disorder” includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication.

13. Counsel on behalf of the applicant brought to the attention of the Court a number of authorities from England and Wales which have carefully considered the interaction between alcohol/drug ingestion and mental disorder: *R v. Dietschmann* [2003] UKHL 10; *R v. Stewart* [2009] EWCA Crim 593; [2009] 2 Cr. App. R 30; and *R v. Kay (Robert; Joyce (Trevor))* [2017] EWCA Crim 647; [2017] 2 Cr. App. R. 16. For present purposes, we do not deem it necessary to engage in a detailed examination of those authorities. It suffices to say in general terms that careful and nuanced distinctions have been drawn in those authorities for the purpose of both: (1) maintaining the well-established rule that voluntary intoxication cannot in and of itself bluntly provide a defence to criminal conduct; and (2) dealing appropriately with more extreme and complicated situations where a mental disorder is involved, such as where a person’s alcohol/drug consumption has caused brain damage or has become a (medically-recognised) dependency, and/or where there is an interaction between a person’s alcohol/drug addiction and a separate mental disorder such as schizophrenia. The applicant relies upon these authorities together with Dr. Monks’ evidence to argue that the conviction should be set aside so that a jury could properly consider whether the applicant was suffering from a mental disorder (or several of them interacting with each other, namely alcohol/drug dependency, and schizophrenia – in its prodromal phase) at the time of the killing such that his responsibility was substantially impaired.

### **Relevant authorities on applications pursuant to s. 2 of the 1993 Act**

14. There is much Irish authority on the question of when an application may successfully be brought pursuant to s.2 of the 1993 Act: see *The People (DPP) v. Pringle (No. 2)* [1997]



2 I.R. 225, *The People DPP v. Meleady* [1995] 2 I.R. 517, *The People (DPP) v. Meleady & Grogan (No. 3)* [2001] 4 I.R. 16, *The People (DPP) v. Shortt (No. 2)* [2002] 2 I.R. 696, *The People (DPP) v. Wall* [2005] IECCA 140, *DPP v. Hannon* [2009] 4 I.R. 147, *The People (DPP) v. Conmey* [2010] IECCA 105. There are also authorities concerning applications for compensation pursuant to s. 9 of the 1993 Act from some of the above-mentioned applicants, but these are not relevant for present purposes. Of most importance for the present application, however, are two cases which specifically concern applications which are grounded upon expert evidence: *The People (DPP) v. Kelly* [2008] 3 I.R. 697, and *The People (DPP) v. Abdi* [2019] IECA 38, to which we now turn.

**15.** In *DPP v. Kelly*, the appellant had been convicted of murder in respect of an elderly woman. The bodies of the woman and her brother were found in a house which was severely damaged by fire. The pathologist was of the opinion that the elderly man had died of natural causes but that the woman had been suffocated before the fire was set. The original appeal of the appellant was unsuccessful, and he sought to adduce, inter alia, expert evidence in an application pursuant to section 2 of the 1993 Act.

**16.** The Court identified a preliminary issue as to whether there was a ‘new or newly discovered fact’. The appellant relied in his s. 2 application on a number of items;

- (a) Newly commissioned expert reports questioning the pathology evidence given at the original trial by Dr. Harbison, the then-State pathologist on the cause of the woman’s death;
- (b) An expert report on the origin of the fire;
- (c) A report based on CUSUM analysis of the appellant’s inculpatory statement to the Gardai;

- (d) Photographs taken during the post-mortem examination of the victim that had not been disclosed to the defence during the trial; and
- (e) Expert opinion arising from those photographs.

**17.** The Court distinguished between facts properly so-called, on the one hand, and expert evidence on the other. It described other cases brought pursuant to s. 2 as ones where facts properly so-called had been in issue (referring to *Meleady and Grogan*, which involved the non-disclosure of information about the existence of a fingerprint on a window; *Pringle*, in which information came to light about the existence of a conflict between two Gardaí about a bloodstained tissue; *Hannon*, which involved the non-disclosure of notes of a complainant's account of a rape and a Garda report based thereon; *McDonagh*, where a signed statement of a co-accused came to light; and *Shortt*, where there had been non-disclosure of serious allegations raised against principal State witnesses. In each of these cases, what emerged after a trial was a matter of fact, not opinion.

**18.** Kearns J. (as he then was) stated that opinion evidence should not in general be regarded as being capable of constituting a newly discovered fact. First, he said, "*to so interpret opinion evidence would be to give a meaning to the word "fact" which is quite different from its ordinary and natural meaning*". Secondly, he said:-

"[41.] it would have the effect of rendering virtually every conviction, even one upheld by this Court following an appeal, open to later challenge if a further or new expert could be found to offer an opinion which went further than a defence expert had done at trial, or which tended to contradict or undermine experts called on behalf of the prosecution at trial. It would open the door to the introduction of additional

evidence in circumstances which were plainly contra-indicated by this Court in *The People (Director of Public Prosecutions) v Willoughby* [2005] IECCA 4. (Unreported, Court of Criminal Appeal, 18<sup>th</sup> February, 2005).”

**19.** In this regard, he quoted from *Willoughby* as to the factors which are pertinent to the question of whether fresh evidence may be adduced:

“(a) Given that the public interest requires that a defendant bring forward his entire case at trial, exceptional circumstances must be established before the court should allow further evidence to be called. That onus is particularly heavy in the case of expert testimony, having regard to the availability generally of expertise from multiple sources.

(b) The evidence must not have been known at the time of the trial and must be such that it could not reasonably have been known or acquired at the time of the trial.

(c) It must be evidence which is credible and which might have a material and important influence on the result of the case.

(d) The assessment of credibility or materiality must be conducted by reference to the other evidence at the trial and not in isolation.”

**20.** He pointed out that the *Willoughby* principles had been approved by the Supreme Court in *The People (Director of Public Prosecutions) v. O’Regan* [2007] IESC 38, [2007] 3 I.R. 805 and should now be seen as settled law. Kearns J. took the view that it would be “altogether impermissible for this Court to adopt an approach to opinion evidence which both ignores the express terminology of s 2 of the Act of 1993 and also, by implication at least, goes totally against the thrust of the two decisions to which I have just referred.”

**21.** Kearns J. did, however, leave room for exceptional cases in which the evidence would be admitted and the application considered on the merits:-

“[44.] That is not to say that opinion evidence is in all circumstances inadmissible, as the court’s present ruling will make clear. There may be cases where a state of scientific knowledge as of the date of trial may be invalidated or thrown into significant uncertainty by newly developed science. There may also be cases where the opinion of an expert at trial may later be shown to have been tainted by dishonesty, incompetence or bias to such a degree as to render his evidence worthless or unreliable. Once such “facts” are established, expert opinion evidence must clearly then be admissible so that such new “facts” can properly be interpreted.”

**22.** In addition to the above general comments of Kearns J. set out above, it is of interest to note how the court in *Kelly* actually dealt with the various items advanced by the appellant in that case. In the first instance, it accepted that the undisclosed photographs did constitute ‘newly discovered facts’ (and were therefore admissible evidence). However, it was satisfied that they would have been of “*little benefit*” to the defence when they were examined in conjunction with the other evidence (the other photographs, the position of the body, the examination and findings of Dr. Harbison, and the evidence of the two expert witnesses on the appeal, particularly the evidence of Professor Crane). The court was not satisfied that “any further cross- examination of Dr Harbison by reference to the absent photographs would have *thrown any real doubt on his diagnosis of cause of death*” (emphasis added). Thus, having deemed the photographic evidence admissible, as well as the expert evidence founded upon it (that of Professor Crane), the court refused to quash the conviction “on the

merits”, as it were. Secondly, the court turned to the evidence concerning “CUSUM” analysis, on which there had been evidence from two opposing experts. Here, it said that it was “*left in a state of considerable unease*” by the evidence offered by the appellant’s expert (Dr. Farrington) and did not accept that a “*newly discovered fact*” had been established under this heading of appeal at all. Thus, this form of evidence appears to have fallen at the hurdle of admissibility because it was insufficiently reliable or credible.

**23.** The case of *Abdi* is particularly relevant to the present case because it involved a mental disorder and expert evidence. In *Abdi*, Mr. Abdi had beaten his infant son so severely that he died. There was evidence in the case showing that there had been a gradual onset of the appellant making comments of a paranoid nature in the period leading up to the killing. His relationship with his son was good although there was some suggestion that the marriage was breaking down. On being charged with murder and cautioned he said “*I don’t know. Nothing to say. I don’t remember anything. I am not in good stead. I am so upset my son is dead. I am sorry it happened. That’s all.*”

**24.** The defence of insanity was to the forefront in the original trial. In the first trial, in early 2003, Dr. McCaffrey (the defence expert) expressed the view that Mr. Abdi was insane at the time of the killing and Dr. Mohan (the prosecution expert) opposed that view. The jury disagreed, necessitating a second trial. In the second trial later in 2003, there was an additional defence expert, Dr. Washington Burke, and both defence experts offered their opinion the jury that insanity by reason of paranoid schizophrenia was operative at the time of the killing. Dr. Mohan again took the opposite view. Mr. Abdi was convicted of murder with the jury rejecting the defence of insanity. An appeal to the Court of Criminal Appeal was unsuccessful.

**25.** Mr. Abdi spent periods of time in the Central Mental Hospital during his imprisonment. He subsequently made an application, claiming a newly-discovered fact, being the current diagnosis based upon treatment and observation in the Central Mental Hospital. The application to the Court of Appeal resulted in an order for a re-trial. In a significant development since the trial, Dr. Mohan, the prosecution expert who had opposed the insanity verdict, had issued a supplementary report in which he opined that there was now good evidence to support the defence view that the defendant's mental state had started to deteriorate some months prior to the killing, and that it was more likely than not that the appellant was suffering from a mental disorder at the material time. The Court of Appeal ordered a re-trial. At this third trial of the matter in which the insanity verdict was the sole issue, and a special verdict of not guilty by reason of insanity was returned by the jury in December 2019. For present purposes, it is not necessary to examine the subsequent application pursuant to s. 9 for a certificate of miscarriage of justice, which was recently brought to finality by a decision of the Supreme Court (judgment delivered by Charleton J.) on the 30 May 2022 [2022] IESC 24, and which upheld the decision of the trial judge and this Court that a certificate pursuant to s. 9 was warranted.

**26.** In *Abdi*, this Court in the s. 2 application reiterated the point as to the overlap between the principles in such applications and in "fresh evidence" applications, and again referred to the *Willoughby* principles in this regard. This Court on the s. 2 application also discussed the 'exceptionality' principle set out in *Kelly* with regard to expert evidence:-

"[83.] We consider that the circumstances in which the applicant seeks to introduce evidence of the 2013 diagnosis to be exceptional, and the question is: could that

exceptionality perhaps justify a departure from the general rule? Notwithstanding that the circumstances of the present case are exceptional (and we will elaborate below on why we consider it to be so), it cannot be claimed that the opinion that it is sought to introduce is based on any newly developed science. Neither can it be claimed that the original opinion of Dr. Mohan is tainted by dishonesty, incompetence or bias. While the manner in which these two possible exceptions proffered by Kearns J. were presented might, on one view of it, suggest a reluctance by the Court of Criminal Appeal to contemplate, and leave open, the possibility that yet other exceptional circumstances might equally permit an opinion being received as a newly discovered fact, we do not consider that it was the intention of the Court of Criminal Appeal to foreclose on that possibility. It seems to us to be much more likely that their intention was to emphasise that the general rule was to apply in most cases, but that a departure from it could be allowed in circumstances of sufficient exceptionality, which cases are likely to be rare.

[84.] Accordingly, in our view, the two instances identified of exceptional circumstances capable of justifying a departure from the general rule are not to be taken as representing comprehensively the only circumstances in which the general rule might be departed from. Although not stated to be such in express terms, we are satisfied that these were proffered merely as examples or illustrations of circumstances that would be of sufficient exceptionality as to justify a departure, but that there was no foreclosure on the possibility that yet other circumstances could be sufficiently exceptional to also justify a departure”.

**27.** The Court decided that the *Abdi* case fell into the exceptional category, saying:-

“[86.] Counsel for the respondent has argued that there is no new diagnosis nor new opinion. He relies on the fact that the jury in 2010 had before it a diagnosis of schizophrenia, supported by several medical experts called by applicant. Admittedly, the jury also had conflicting evidence from a witness called by the prosecution. However, counsel says, the applicant's fundamental case has not changed. The evidence he adduced was to the effect that he was suffering from schizophrenia. That remains his case. Nothing has changed. He does not rely, fundamentally, on any newly discovered fact. It is still his case that he suffers from schizophrenia, that he was suffering from it at the time of the killing, and that it triggered an irresistible impulse in him that led him to kill his son. In our view, therein lies the weakness in the respondent's position.

[87.] It is simply not the case that the applicant does not seek to place fundamental reliance on the newly discovered facts that he identifies. To suggest otherwise is to deny reality. Time has moved on since the trial and in so far as the appellant has had ongoing mental ill-health issues there has been further opportunity to observe his presentation at length and in depth. In that time, the appellant has manifested further and additional symptomology; there has been a further opportunity to observe his responses to treatment; he has had numerous further hospital admissions to the only dedicated forensic psychiatric facility in the State (namely the Central Mental Hospital); and the doctors now treating him at that facility have changed the diagnosis that was attributed to him at an earlier point by another doctor or doctors at the same hospital. He places fundamental reliance on all of that.



[88.] Moreover, and what renders this case wholly exceptional, quite apart from the documented continuation of the applicant's illness culminating in a change of his diagnosis to one of paranoid schizophrenia by the doctors now treating him at the only dedicated forensic psychiatric facility in the State in the circumstances outlined earlier in this judgment, is that the recent independent review which was commissioned by the respondent, namely that by Dr Quinn, has concluded that prior to the offence the applicant was suffering from significant symptoms of a psychotic mental illness, namely schizophrenia. Clearly Dr Quinn's conclusion, following his said review, is not based on the same evidence as was the expert evidence adduced on behalf of both sides at the trial. It is only based in part on that. Critically, however, it is also based on what has happened in the years since the appellant's conviction, and the placing of the evidence adduced at the trial in the new context provided by that additional information. Accordingly, Dr Quinn's opinion would, it seems to us, also qualify as a newly discovered fact sufficient to engage s.2 of the Act of 1993, although it has not specifically been relied on for that purpose by the appellant. Be that as it may, it is contextual evidence of which we can take account in considering whether by virtue of those newly discovered facts on which the applicant is entitled to rely, and in particular the changed diagnosis, this represents an exceptional case. As we have already indicated, we are satisfied that it is.

[89.] A medical diagnosis is undoubtedly the opinion of the medical person that has arrived at it, but the existence of such an opinion is a fact in itself, as is any promulgation of it and reliance on it. Moreover, a diagnosis does not exist in a vacuum

as the dictionary definition of the term makes clear. “*Diagnosis*” is defined in The Oxford English Dictionary (2nd ed, Vol IV) as:

*“Determination of the nature of a diseased condition; identification of a disease by careful investigation of its symptoms and history; also the opinion (formally stated) resulting from such investigation.”*

A diagnosis cannot easily be divorced from the investigation of the symptoms or history on which it is based. If, as between diagnostic exercises conducted on different occasions, either the manner or extent of investigation was not the same, or the symptoms and history were not the same, then they are different diagnoses, and that would be so even if the eventual conclusion reached was the same in both cases.

[90.] In our view the applicant's psychiatric symptomology, presentation and treatment since he was sentenced are undoubtedly newly discovered facts. Moreover, his current diagnosis of schizophrenia is also a newly discovered fact, because it is not based on an investigation of the same symptoms and history as underpinned the previous diagnoses, be it that of Professor Kennedy's diagnosis of depression and non-psychotic paranoid state, with which Dr. Mohan was in agreement; or that of Dr. Washington-Burke's and Dr. Caffrey's respective diagnoses of paranoid schizophrenia. Moreover, that the applicant's treating doctors now regard his earlier diagnosis made at the same hospital as having been incorrect, is itself a newly discovered fact in our judgment; and the opinion evidence of Dr. Washington-Burke and Dr. Quinn that in the light of the applicant's subsequent psychiatric history, the symptoms and signs with which he had presented before his trial were possibly incorrectly interpreted and wrongly classified as not being psychotic by his former treating doctor, Professor Kennedy, and by Dr. Mohan who independently assessed him, is a newly discovered fact.”

**28.** The Court later expressed its conclusion thus:

“[94.] Returning to the real life circumstances of this case, we are satisfied that the material being relied upon as being newly discovered facts, would, if it had been before the jury at the original trial, have had at least the potential to influence the outcome. The case might have been either prosecuted or defended materially differently. Moreover, the new evidence, if the jury had known of it, might have significantly influenced the jury's view of the reliability of the expert evidence adduced before them, and the weight to be afforded to the different views being advanced. It is entirely possible that it could have led to a radical recalibration by the jury as to how they should view the evidence. We are in no doubt but that it could potentially have precipitated a different verdict, although clearly we cannot go so far as to say that it would necessarily have done so”.

**29.** Thus, the Court accepted that there was newly discovered fact, that it was material, and that it could have led to a different verdict. The conviction of Mr. Abdi was quashed.

**30.** Although it was not referred to in argument before the Court, it may be noted that there has been much discussion in authorities from other jurisdictions on the question of when expert evidence should be admitted in “miscarriage of justice” applications, and when it should lead to the quashing of a conviction and/or retrial. In one of the leading authorities, *R v. Lundy* [2013] UKPC 28, the Privy Council (judgment delivered by Lord Kerr) set out a framework in which issues would be addressed in a particular sequence:

“[120.] The Board considers that the proper basis on which admission of fresh evidence should be decided is by the application of a sequential series of tests. If the evidence is not credible, it should not be admitted. If it is credible, the question then arises whether it is fresh in the sense that it is evidence which could not have been obtained for the trial with reasonable diligence. If the evidence is both credible and fresh, it should generally be admitted unless the court is satisfied at that stage that, if admitted, it would have no effect on the safety of the conviction. If the evidence is credible but not fresh, the court should assess its strength and its potential impact on the safety of the conviction. If it considers that there is a risk of a miscarriage of justice if the evidence is excluded, it should be admitted, notwithstanding that the evidence is not fresh.”

**31.** It is noteworthy that there have been many English authorities on the admissibility of expert evidence to prove a defence of diminished responsibility for the first time on appeal, but none of these were cited to the Court in this application. An important authority in this regard is *R v. Erskine and Williams* [2010] 1 WLR 183, in which the Court of Appeal set out the kind of case that would have to be made by an applicant in such cases:-

“[92.] The court will normally expect the parties to provide a detailed analysis of the facts to assist it in the application of the statutory test, including an analysis of the following: (i) the psychiatric and/or psychological evidence or other information in relation to the appellant's mental state which was available at the time of trial; (ii) the evidence which has become available since the trial, and an explanation why it was not available at trial; (iii) the circumstances in which the appellant sought to raise on the appeal (a) the evidence available at the time of the trial and (b) evidence that has

become available since the trial; (iv) the reason why such evidence or information as was available at the time of the trial was not adduced or relied on at trial. This will ordinarily include details of the advice given, the reasons for the appellant's decision at trial and, subject to paragraph 89 any relevant evidence of the mental condition in the period leading up to and at the time of the trial and its impact on his decision making capacity; (v) the impact of the fresh evidence on the issues argued at trial and whether and the extent to which it involves a re-arguing of issues considered at trial; (vi) the extent to which the opinions of the experts are agreed and where they are not.”

**32.** The reference in the above passage to paragraph 89 of the same judgment is instructive, because paragraph 89 discusses the heavy weight to be placed upon the fact that the person was legally represented at trial and that the legal advisers chose not to raise either fitness to plead or diminished responsibility at that trial:

“[89.] Assuming that the defendant is legally represented (and in cases like these, he will normally be represented by leading and junior counsel, as well as solicitors) his legal representatives are the persons best placed to decide whether to raise the issue of fitness to plead, and indeed to seek medical assistance to resolve the problem. There is a separate and distinct judicial responsibility to oversee the process so that if there is any question of the defendant's fitness to plead, the judge can raise it directly with his legal advisers. Unless there is contemporaneous evidence to suggest that notwithstanding his plea and the apparent satisfaction of his legal advisers and the judge that he was fit to tender it, and participate in the trial, it will be very rare indeed for a later reconstruction, even by distinguished psychiatrists who did not examine the appellant at the time of trial, to persuade the court that notwithstanding the earlier trial

process and the safeguards built into it that the appellant was unfit to plead, or close to being unfit or that his decision to deny the offence and not advance diminished responsibility can properly be explained on this basis.”

33. As the applicant did not address any of these, or other pertinent, authorities, we merely point them out to demonstrate that there is a considerable jurisprudence, in addition to the two Irish authorities referred to above, on the interaction between expert evidence and fresh evidence/miscarriage of justice cases. Even allowing for slight differences in the statutory wording of “miscarriage of justice” regimes in different jurisdictions, there is much useful discussion in such authorities, all of which emphasise the high bar which must be reached before an applicant will succeed in such a case and explain the kind of detailed and specific evidence required to ground a successful application.

34. We will turn now to the specific evidence relied upon by the applicant in the present case.

#### **Dr. Monks’ first report: the 2 June 2020**

35. Dr. Monks explained the condition of schizophrenia in the following terms:

“[166.] Schizophrenia is a chronic psychotic mental illness. Psychotic illness refers to mental illness where an individual’s reality testing, or ability to distinguish what is real from what is not, is compromised. This is most commonly manifest as delusions, hallucinations and disorganised thinking in the acute phase of schizophrenic illness. The illness tends to run a relapsing and remitting and course which can be moderated by treatment with medication. Between episodes of acute schizophrenic psychosis

chronic symptoms of the illness may be more prominent. These include so called negative symptoms and cognitive deficits. The chronic illness is associated with a significant burden of disability with varying degrees of social and occupational impairment”.

**36.** Dr. Monks indicated that he reviewed the clinical records from the Central Mental Hospital, clinical records from the Irish Prison Service, the Book of Evidence, and the transcript of the murder trial. He also confirmed that he interviewed the applicant in Midlands Prison in mid-January 2020.

**37.** Dr. Monks described the family background of the applicant and noted the absence of psychiatric illness or addiction problems generally, although the applicant himself had extensive difficulties with drugs and alcohol. The applicant appears to have attended school until the age of fourteen but to have left school illiterate, and quickly to have become involved in what he described as “robbing, stealing and using drugs”. He only ever had one brief period of employment when he was fifteen years old.

**38.** Dr. Monks then set out a mental health history of the applicant which is extremely detailed and runs to some thirty-seven pages, in which he set out among other things the verbatim notes of attendances by the applicant at various doctors and hospital settings. He noted that the applicant was at that time on the anti-psychotic medication Olanzapine 30mg and described how the applicant talked to him about “the voices” and a particular obsession he had that a member of the HSE had hypnotised him. Further details of these disordered thoughts were set out by Dr. Monks.

**39.** He set out the applicant's drug and alcohol history, noting that he first started drinking at the age of twelve and quickly became a heavy drinker. He also became a daily smoker of cannabis resin and his use was at times up to 15 or 20 joints per day according to the applicant. He also had used ecstasy, cocaine and benzodiazepines at different stages in his life, as well as heroin on and off from 2009.

**40.** The applicant had served previous prison sentences, including one in 2005 for a stabbing assault and another for a stabbing assault in 2006.

**41.** The applicant told Dr. Monks that in the year leading up to the index offences he was drinking up to fifteen to twenty 500ml-cans of beer a day, and vodka and whiskey; while smoking up to 20 cannabis joints a day as well as using cocaine and ecstasy; and was using large amounts of diazepam on a daily basis. He said that the robbery had not been planned, but that he had taken Valium and cannabis and all he could remember was going through the back door of the house and that the victim fell on top of a chair. He said that he gave the man a few punches and he hit the ground very heavily, he tied the man up using his shoe laces, and took money from his house. He said that he took €55.00 and a handful of change and phoned the Gardaí the following day to tell them that there was a man tied up at the address. He said that he subsequently handed himself into the Gardaí when he saw that the man had died. He said that he did not intentionally kill the man.

**42.** Dr. Monks then set out a number of contemporaneous notes concerning the applicant's condition at different times. The first of these was a psychiatric report dated the 7 February 2011 by a Dr. Qadir in connection with the applicant being assessed at the psychiatric unit of the Sligo/Leitrim Mental Health Service on the 28 January 2011. He reported being



depressed and being stressed with poor sleep but “denied any unusual thoughts, perceptual abnormalities or thoughts of harming himself or others”. Dr. Qadir concluded that the applicant was presenting with a “mild depressive episode with predominant anxiety symptoms”. This was some eighteen months before the murder of Mr. Gillespie.

**43.** The next set of notes were from a GP, Dr. Jane Dorman between August 2011 and March 2012. Of the various notes made by him, there is one on the 7 September 2011 when the applicant is reported as having said that he “hears voices that people will be after him” and “says he is paranoid looking after... not eating properly always afraid”. There was also a note on the 23 of November 2011 where the applicant was reported as saying that he “has heard voices in head”. There is another on the 30 January 2012 where it records that the applicant was charged with “burglary, possession of knife, GBH and drunk and disorderly” and “feels the need to carry the knife - feels paranoid”. This pre-dates the murder of Mr. Gillespie by approximately eight and a half months.

**44.** The next set of documents reviewed by Dr. Monks post-dated the murder and included a letter of the 25 October 2012 by Dr. Mary Maguire, Consultant Psychiatrist at Castlerea Prison addressed to Dr. Conor O’Neill, Consultant Forensic Psychiatrist at Cloverhill Prison where she was requesting a forensic assessment in respect of the applicant but noted that “he has not displayed any evidence of major psychiatric illness since committal”.

**45.** There was a letter dated the 18 November 2015 from Dr. Frank Kelly, Consultant Forensic Psychiatrist, who was requesting GP records and noting that the applicant had been referred by the prison GP complaining of “persecutory auditory hallucinations”. Dr. Kelly’s

“initial impression at that time was that these were pseudo hallucinations and did not represent psychotic illness”.

46. Dr. Monks made reference to a letter dated the 8 May 2017 by a barrister to the Governor of Castlereagh Prison in which concern was expressed about the applicant’s mental state because the latter had presented on the 4 May 2017 as “distressed, paranoid and incoherent”, and the barrister thought that he needed psychiatric admission to hospital.

47. Dr. Monks referred to a letter by Professor Harry Kennedy on the 6 July 2017 in which Professor Kennedy “decided to change his antipsychotic treatment and keep him under review”; a letter of the 13 July 2017 again from Professor Kennedy in which there is a reference to the applicant being on Olanzapine 10mg at night and a letter dated the 13 October 2017 in which there is reference to the applicant taking medication.

48. Dr. Monks notes that the first formal diagnosis of schizophrenia appears to come in a letter from Professor Kennedy dated the 21 November 2017, some five years after the murder of Mr. Gillespie. Professor Kennedy says, “the correct diagnosis is schizophrenia with a drug related exacerbation, now much improved”.

49. There is then a reference to a letter by Dr. Monks himself dated the 7 March 2018, in which he says the following:

“[48.] Mr. McGinley is a life-sentenced prisoner who has acquired a diagnosis of schizophrenia whilst serving his sentence. He presents with chronic delusional ideas that he is possessed and controlled by an HSE psychologist operating from outside the

prison. His symptoms remain despite treatment with olanzapine. Drug use may be complicating the clinical picture and he has tested positive for cannabis.

[...]

[50.] I am currently switching his antipsychotic from olanzapine to Amisulpride in the hope of ameliorating his active psychotic symptoms. Given that he is a first presentation of schizophrenia in prison I have put him on the waiting list for an admission to the CMH although this is non-urgent and is unlikely to come to pass in the near future because of a lack of availability of admission beds.”

**50.** A letter of Dr. Paul O’Connell dated the 20 July 2018 noted that his overall impression was that the applicant suffers from paranoid schizophrenia, having been very thought-disordered during interview and the doctor having reviewed his extensive medical records.

**51.** The next set of documents reviewed by Dr. Monks were records from the Prison Healthcare Management System from October 2005 to September 2019. Various incidents of violence were noted as well as several requests to see a psychiatrist from 2008 (for example the 4 November 2008 and the 12 January 2009). In 2009 and 2010, there are several references to the applicant being seen by an addiction counsellor.

**52.** Importantly, when the applicant was committed on the 30 September 2012 after the murder of Mr. Gillespie, he was seen by the prison doctor, Dr. Siklosi, who noted that he was “depressed not suicidal and taking an anti-depressant? (sic) Seroquel” and was placed in the high support unit for observation and was to see the psychiatrist the next day. Dr.

Monks notes that Seroquel is an antipsychotic medication and is not licensed as an antidepressant medication. He was seen again on the 1 October 2012, at which point Dr. Siklosi noted him to be feeling better and not suicidal but wanting to see a psychiatrist. He was seen by Dr. Maguire, Consultant Psychiatrist. He told Dr. Maguire that he took a load of tablets and lots of drink to celebrate his birthday and then entered an old house to get money to buy tablets “for a comedown”. He “appeared tearful and restless but denied any suicidal thoughts or psychotic symptoms”. Over the next few days he was noted to be crying a lot, feeling depressed and of low mood. By the 15 October he told Dr. Maguire that he felt very guilty about the offence and was sorry that it happened. He said he had saved up certain tablets and took them to celebrate his birthday. He denied any history of psychiatric illness or attendance at psychiatric clinics or hospitals. He was “pleasant and coherent and expressed himself clearly” and “no psychotic symptoms were elicited, and he said he had never experienced such [symptoms]”. On the 25 October, he was noted by a nurse as tearful and tired looking, “states hearing voices but not sure what the voices were saying”.

**53.** On the 22 November 2012 he was seen by Dr. Maguire who did not find mental illness who was of the opinion that there was “no need for psychiatric medication”.

**54.** In a crucial section of his report, Dr. Monks then went on to discuss the applicant’s mental state at the time of the index offence in the following terms:

“[163.] Although *it is possible* that Mr McGinley was suffering from a schizophrenic psychosis around the time of the index offence *it is difficult to establish any causal nexus between mental illness and his behaviour at the material time*. It appears that his actions at the time of the killing [of] Mr. Gillespie were motivated by a robbery.

In Mr McGinley's various accounts of going about this robbery there is nothing to suggest that his mental capacities were diminished as a result of mental illness. It appears he was intoxicated with alcohol and benzodiazepines.

[164.] He described a series of goal directed behaviour related to the episode. He incapacitated the owner of the house. He took measures to conceal his actions by using socks over his hands and burning his clothes afterwards. The following day he phoned (sic) the Gardaí anonymously to inform them there was a man tied up in a house opposite the Garda barracks.

[165.] There is little evidence to support the presence of active symptoms of psychotic illness in the days after the assault. A detailed report by Dr. Tchun-Ugbawa from 28.9.2012 noted that Mr McGinley was intoxicated but did not present with mental illness. From committal to prison on 30.9.2012 up to November 2012 the prison psychiatrist was of the view that he did not present with any psychiatric illness. Although there are reports of his hearing voices was (sic) in October 2012 this is insufficient to conclude with certainty that he was suffering from active symptoms of a mental illness at the time of the assault. Even if he was suffering from active symptoms of mental illness at the time it doesn't appear that they had any direct, obvious or specific effect on his behaviour". (Emphasis added)

### **The second report/letter of Dr. Monks: the 11 August 2020**

**55.** As already described, the report was the subject of advices from senior counsel and the applicant's solicitor raised seven questions with Dr. Monks. By letter dated the 11 August 2020, Dr. Monks gave the answers to those questions in the following terms: -

**Question 1:** “Is there sufficient evidence to conclude that on the balance of probabilities the Defendant was suffering from alcohol/drug dependency syndrome at the time of the killing?”

Answer: “Yes. It is more likely than not that he would have fulfilled the criteria for alcohol, benzodiazepine and cannabis dependence.”

**Question 2:** “Is it probable that the Defendant committed the killing whilst suffering a psychosis?”

Answer: “There is documentation in his GP records of psychotic symptoms in the form of auditory hallucinations and paranoia between September 2011 and March 2012. He was treated with antipsychotic medication quetiapine 400mg. This is a modest dose and from the GP records it appears to have attenuated his symptoms at least at when he was reviewed in March 2012. Thereafter he continued to abuse drugs and alcohol and his continued compliance with antipsychotic treatment is unknown. It was noted in October 2012 following his committal to prison that he was hearing voices.

It is very likely that Mr McGinley was intoxicated at the time at of this index offence. It is also probable that he was experiencing psychosis however there is no contemporaneous documentation of psychotic symptoms in the time immediate to the index offence. It would therefore be difficult to comment on the degree and severity of any psychosis present at the time.”

**Question 3.** “Is it probable that at the time a drug/alcohol-induced psychosis may have merged with/into a schizophrenic psychosis?”

Answer: “The relationship between drug use and schizophrenia is complex. There are a number of illicit drugs, like cannabis, which in their own right can cause psychotic symptoms which resemble schizophrenia. Where these episodes of psychotic symptoms are transient and self-limiting they are sometimes referred to as a drug-induced psychosis. It is often the case that a drug-induced psychosis is a prelude to a subsequent diagnosis of schizophrenia.

Now that Mr McGinley has an established diagnosis of schizophrenia it is reasonable to assume that past episodes of psychosis and psychotic symptoms, from September 2011 onwards, were part of his schizophrenic illness. Drug and alcohol dependence would have complicated the course and presentation of his illness and may have exacerbated his psychotic symptoms.

**Question 4:** “The report states at para. [155.]- “it is possible that Mr McGinley’s presentation of symptoms meant the diagnostic threshold for schizophrenia around that time but [it] is difficult to establish this with certainty for several reasons”. Is it “probable” that the symptoms met the diagnostic threshold for schizophrenia around that time?”

Answer: “With hindsight the description of symptoms recorded in his GP records would be sufficient to diagnose schizophrenia. That is auditory hallucinations and persecutory delusions lasting more than one month.

Schizophrenia is a chronic relapsing psychotic mental illness. That means that over the life long course of the illness there tends to be periods of acute exacerbations of

active symptoms of psychosis and periods of quiescence or remission of symptoms. The course and presentation can be moderated with antipsychotic medication. Acute episodes are more likely to occur in the context of risk factors like non-compliance with medication, substance abuse and stress.

Thus, once the diagnosis of schizophrenia is established, the question would be whether the illness is in remission or whether there were active symptoms. In other words, *with hindsight I think it is likely that he would have met the diagnostic criteria for schizophrenia in the year before the offences. What is much more difficult to establish is the degree to which he was experiencing active symptoms. I did not see any clinical records for the time period between March 2012 and September 2012. This may be because he was not engaged with any services.*”

**Question 5:** “Does the prodromal phase of schizophrenia constitute a “mental disorder”?”

Answer: “Yes. The mental signs and symptoms of the prodromal phase of schizophrenia are debilitating and would appropriately be described as representing a mental disability or mental illness. In my view prodromal schizophrenia would come under the definition of mental disorder as defined in section 1 of the Criminal Law (Insanity) Act 2006. ... the inference I would draw from the GP records, in the context of the wider clinical picture, is that the hallucinations and delusions were probably present for most of the time for more than a month.



**Question 6:** “If the killing was perpetrated under the influence of a mental disorder such as schizophrenia what evidence relating to the commission of the offence which you normally expect to find? Does the absence of available evidence of any causal nexus between mental illness and his behaviour at the material time exclude its existence?...”

Answer: “While it doesn’t appear that Mr McGinley’s decision making processes at the time of the robbery and assault on Eugene Gillespie were specifically influenced by delusions or hallucinations, *active psychotic illness may have impaired his reasoning, judgment and behaviour (for example impulsivity and aggression) in a more general sense.* This would have relevance in addressing the question of whether Mr McGinley intended to cause serious injury to Mr Gillespie.

Clearly, intoxication would also have had a significantly negative effect on his ability to reason and judge but it is somewhat arbitrary to try to estimate the relative contributions of intoxication and mental disorder in terms of how much impairment could be attributed to a psychotic mind versus an intoxicated mind. In this regard, mental disorder and intoxication might be considered somewhat inextricable.”

**Question 7:** “Is it likely that the Defendant’s complex mental illness was undiagnosed by the custody doctor who examined him? (It went undiagnosed until 2017)”

Answer: “... It would be easy to miss psychotic symptoms under these circumstances on a one off mental state examination. The doctor’s main objective was to assess his fitness to be interviewed by Gardaí”.

**56.** The notes for various months in 2013 refer to various observations and low mood/depression but there is no reference to psychotic states or hallucination and in August 2013 he is noted as expressing remorse for the offence to the addiction counsellor (but with no suggestion of any connection with hearing voices). In October and November, he is noted among other things as having flashbacks to the offence and there are references to anxiety. In December 2013 he appeared to have taken some illicit substance and was transferred to the General Hospital and on his return appeared “delusional and paranoid”. It is noted that Olanzapine was initiated by Dr. Maguire on the 16 December 2013 but that it was “not being prescribed as an antipsychotic medication”. There are various continuing entries about various altercations low mood, taking illicit drugs and the like.

**57.** In November 2015, some three years after the offence, a nursing note records him as giving an account of a voice in his head giving him various commands. There is a further reference to his reporting the hearing of voices when alone in his cell and that he “reported previous auditory hallucinations while in custody aged 21 and reported experience (sic) the same outside prison”. On the 17 November 2015 he was reviewed by Dr. Frank Kelly, Consultant Psychiatrist and that he had been referred by the prison GP complaining of “persecutory auditory hallucinations”. Dr. Kelly concluded that there was “no evidence of psychotic symptoms” and “describing pseudo aud hallucinations, from subjective space in the head, secondary to internal conflict regarding index offence”.

**58.** By February 2016 he is reporting to a psychiatric nurse that he was continuing to hear voices in his head which taunt him about the offence. Again, he describes voices in his head to the same psychiatric nurse in March 2016. In April 2016 the impression of the psychiatric

nurse is that there is a possible “emergence of delusional beliefs which appear psychotic in nature”. There are further references to paranoid thoughts throughout the remainder of 2016 and 2017. By May 2017 he is reporting that the HSE psychologist is communicating with him and carrying his child. He is seen by Professor Kennedy in July 2017 who notes that he is “actively deluded about ‘hypnotisers’”. In July 2017 he is thought disordered and has delusional beliefs about his bones being frozen. Thereafter there are many references to his being deluded and thought disordered. Many of the subsequent notes give details of the particular delusions from which he is suffering at that time.

**59.** Dr. Monks also reviewed the statements on the Book of Evidence. He noted that on the 28 September 2012 at around 10pm, the applicant had asked to speak to Garda Pauline McDonagh as he wished to confess to the incident which had led to the death of Mr. Gillespie. She took him to an interview room and he was “crying and extremely distressed”. She said that he was intoxicated and difficult at times to understand him and he said things such as “Pauline what will I do. I’ll not lie about this. Oh God the man is dead”. She said that she was concerned about his medical condition because he had made reference to drinking cans and taking Valium. The applicant was examined by a Garda doctor at 11.50pm that night, who told Garda McDonagh that the applicant had told her “I meant to rob the man not kill him”. Garda McDonagh also said that it was her opinion he was not in a fit state to be interviewed. He was examined by Dr. Ugbawa at 2.30am on the 29 September and was deemed unfit for interview for a period of six hours. Dr. Ugbawa said that the applicant was very co-operative and appeared distressed and tearful and kept saying that he did not mean to kill him and that he “only went to rob him and something went wrong” and that “taking a life is wrong”. He told her that he had taken six to eight cans of beer, thirty Diazepam 10mg tablets and Seroquel when he had come out of prison because he had a lot of anger inside.

He said he had a psychiatric admission to St. Columba's two years before. He said he had smoked "half a quart of hash, which would be his normal amount for the day". She found him to be intoxicated and so advised the Gardaí.

**60.** Dr. Monks reviewed the memoranda of Garda interviews with the applicant. In an interview on the 29 September 2012 at 11.07 he gave an account of what had happened. He said he went drinking on his own and took some "Japanese D 10s" and went drinking with others. He signed on at the Garda station and then went into the house of the deceased after 10.00pm. He hit the man and he fell and he tied up the victim's hands. He did not mean for the man to die. He took about €60 worth of coins from the house which he subsequently spent on "weed and tablets". He burned the clothes that he was wearing that night. He left until the next day to ring the Gardaí. He said that he was "fucked up on drink and Valium". There were further interviews during which he was upset and gave some details which are not of relevance to the present application.

**61.** Dr. Monks noted that no mental state defence was relied on by the applicant at the time of the original trial. The following are relevant excerpts from the report of Dr. Monks:

"[152.] Mr McGinley has a diagnosis of paranoid schizophrenia. The evolution of his schizophrenic illness has been characterised by an insidious onset of mental symptoms over a number of years prior to the florid onset of psychosis in 2015. He was finally diagnosed with schizophrenia in 2017 but had presented intermittently with psychotic symptoms for many years.

[153.] In 2011 he was assessed by the Sligo Leitrim Mental Health Services and diagnosed with depression and anxiety for which he was prescribed antidepressant and benzodiazepine (Valium type) medication. He continued to present with depression and anxiety to his GP but by September 2011 he was reporting hearing voices which persisted and in November his GP prescribed the antipsychotic medication Quetiapine 200mg. He continued to feel paranoid into January 2012 and the dose of Quetiapine was increased to 400mg. By March 2012 the GP noted that Mr McGinley was feeling better and continued the prescription of antipsychotic medication.

[154.] I did not have sight of any records of GP attendances in the months from March 2012 to September 2012 but it would appear that he continued to receive a prescription for Seroquel which was documented on his committal to prison on 30<sup>th</sup> September 2012 following the index offence. Psychiatric assessment in prison noted that he did not display any symptoms of a major psychiatric illness and he initially remained on Seroquel 400mg nocte. However, in October 2012 it was observed by a prison nurse officer that Mr McGinley was hearing voices. His antipsychotic medication was withdrawn in November 2012 as the prison psychiatrist did not feel he had a mental illness at that time.

[155.] *The available records thus suggest that Mr McGinley was experiencing psychotic symptoms in the form of paranoia and auditory hallucinations in the time leading up to the index offence and following committal to prison. It is possible that Mr McGinley's presentation of symptoms met the diagnostic threshold for schizophrenia around that time but is difficult to establish this with certainty for several reasons. Firstly, there is little detail about the frequency, intensity and duration*

of these symptoms. Secondly, treatment with an antipsychotic medication (although not explicitly for schizophrenia at that time) may have attenuated any active symptoms. Thirdly, the presentation of these psychotic symptoms may have been attributable in part to heavy and persistent consumption of drugs and alcohol.

[156.] *At the very least it can be said that Mr McGinley was in a prodromal phase of schizophrenia from late 2011. The prodrome is the period between the appearance of initial symptoms and the full development of illness. Typically, in the natural history of schizophrenia the prodrome can last a number of years. During this time individuals commonly experience nonspecific clinical symptoms, such as depression, anxiety symptoms, and some impairment of social and occupational functioning. This is often followed by the emergence of attenuated psychotic symptoms (hallucination and delusions) which closer to the onset of frank schizophrenic illness will become more frequent, intense and enduring.*

[157.] In 2013 Mr McGinley was experiencing symptoms of post traumatic stress in the form of mood disturbance, anxiety symptoms, panic attacks and flashbacks to the index offence. [There are then references to the medications with which he was treated]. He continued to experience intermittent mood and psychotic symptoms over 2014 into 2015 and received treatment with antidepressant and antipsychotic medication.

[158.] *In November 2015 his psychotic symptoms became more pronounced and it is reasonable to assume this heralded the full onset of schizophrenia although he did not receive this diagnosis at the time. He began to report more persistent and distressing*

auditory hallucinations and persecutory delusions that his food and drink were being poisoned.

[159.] In early 2016, although he continued to experience psychotic symptoms, he weaned himself off antipsychotic medication. By April 2016 he was reporting somewhat bizarre somatic delusions ... Antipsychotic medication was reintroduced by the prison GP in July 2016.

[160.] In 2017 he first reported auditory hallucinations of a psychologist and was diagnosed with a drug induced psychosis. His psychotic symptoms persisted and were resistant to treatment with medication. *It was first formerly noted that his diagnosis was schizophrenia in November 2017.* Since that time he has presented with persistent psychotic symptoms manifest as auditory hallucinations and bizarre persecutory delusions to an HSE psychologist, as described above in the body of this report.

[161.] Mr McGinley has a significant history of alcohol and drug abuse. The relationship between drug use and schizophrenia is complex. There are a number of illicit drugs, like cannabis, which in their own right can cause psychotic symptoms which resemble schizophrenia. Where these episodes of psychotic symptoms are transient and self-limiting they are sometimes referred to as a drug induced psychosis. It is often the case that a drug-induced psychosis is a prelude to the development of schizophrenia.

[162.] Mr McGinley was diagnosed with a drug-induced psychosis in 2017. Many individuals who receive a diagnosis [of] drug-induced psychosis are later re-diagnosed

with schizophrenia. This is the case for Mr McGinley whose psychotic symptoms have endured for sustained periods in the absence of alcohol or drug use. The diagnosis of drug-induced psychosis has been superseded by a diagnosis of schizophrenia.”

(Emphasis added).

## **Discussion and Decision**

**62.** We start by stating what this case is *not* about. First, this is not a case about newly discovered *medical records*. No case is made that the applicant’s legal advisers could not reasonably have known about or obtained the records of his mental state or mental illness at the time of the trial and/or appeal, to the extent that such records existed. If they had sought the medical records that existed at that time, particularly for the purpose of instructing a psychiatric expert, no doubt they would have received them. They did not; and the case is not advanced on the basis that these records were not available to them at the time or that they have only recently been “discovered”.

**63.** Secondly, no case is made, either, that the information about the applicant’s alcohol and drug dependency was not and/or could not have reasonably been known at the trial. His drug and alcohol use was well-known at the time of his trial. It now features in the argument primarily in the context of arguments about the *interaction* between those matters and the progression of his schizophrenia in later years, i.e. after the trial and appeal.



**64.** Instead, the case is primarily based upon the development of the applicant's mental illness subsequent to the trial. Therefore the central plank of his case stems from events *after* the trial and appeal; more specifically, the development of the applicant's schizophrenia during this period, and what this can or might tell us about his mental state/illness at the time of the killing, in what one might loosely call a "look-back" exercise. It has this feature in common with the *Abdi* case. Both Mr. Abdi and the applicant suffer from schizophrenia, and the illness of each progressed through different stages, from earlier, milder stages to a stage involving greater severity/more manifest symptoms. The applicant in the present case, as in the *Abdi* case, seeks to persuade the Court that the post-trial (and post-appeal) development of his mental illness can assist with what is effectively a retrospective diagnosis of the level of mental illness at the time of the killing. In *Abdi*, the prosecution expert changed his mind about whether the applicant was suffering from insanity at the killing because of how Mr. Abdi continued to deteriorate post-trial (and appeal). The applicant in the present case is seeking to engage in a broadly similar exercise; to persuade the Court, on the basis of Dr. Monks' report, that the later manifestation of the applicant's schizophrenia tells us something useful (to put it at its most general) about his mental state/illness at the time of the killing.

**65.** There may well arise some exceptional cases where information which arises subsequent to a trial unequivocally shows that the person was suffering from a relevant medical or psychiatric condition at the time of the offence, which was unknown at the time of trial. By way of illustration, let us imagine a hypothetical case where a man of previously unblemished record and no history of assault kills another man in a sudden and unexplained outburst of anger and violence. Let us imagine that at the time of trial and appeal, there is nothing whatsoever to suggest that he has any physical or mental illness, but years later, it

emerges that all along he had a brain tumour which was pressing on a particular part of his brain such that the doctors now agree that it is “*highly likely* that it was the primary reason for his actions at the time of the killing”. In principle, such information might successfully ground an application pursuant to s. 2. However, in general, attempts to persuade the Court with expert evidence that a retrospective diagnosis can be made such that the conviction should be quashed must be treated with considerable caution, and such cases will be exceptional.

**66.** The case of *Abdi* was itself an exceptional one. The applicant seeks to draw certain parallels between his case and that of Mr. Abdi. But there are a number of obvious differences between the present case and that of *Abdi*. For example, no issue was raised at the applicant’s trial on the question of either insanity or diminished responsibility whereas in *Abdi* the defence of insanity was of central importance at trial, with a number of experts giving evidence before the jury, albeit that they disagreed with each other. However, it must have been obvious to the legal advisers that mental illness on the part of their client was something that had to be dealt with. Secondly, by the time of the application pursuant to s. 2 of the 1993 Act, a number of experts were in agreement that Mr. Abdi fulfilled the criteria for insanity at the time of the killing, including the prosecution expert who had given evidence to the contrary at the trial. The evidence was unequivocal on all sides: the test for insanity under the 2006 Act was explicitly addressed by the experts and said by them to have been fulfilled. In the present case, there is only one expert involved and his views are much less definitive (about which more will be said below).

**67.** Thirdly, it was always quite clear that the purpose of the expert evidence in *Abdi*, both at trial and on appeal, was to establish the defence of insanity. The purpose of adducing the

expert evidence in the present case is much less clear. Is it to support a potential defence of diminished responsibility? Or to strengthen the case that was made at trial (i.e. that the applicant lacked the requisite intent for murder)? Or both in the alternative? Dr. Monks does not explicitly mention insanity or diminished responsibility in either of his reports, presumably because he was never explicitly asked about them. He never offers any formal view on either of the defences set out in the 2006 Act, both of which contain ingredients over and above the necessary ingredient of ‘mental disorder’, although he did of course discuss the concept of ‘mental disorder’ itself (being a necessary but not sufficient condition for the defence under s. 6). Counsel’s written submissions on this appeal did not mention diminished responsibility at all, and yet English authorities on diminished responsibility were laid before the Court and diminished responsibility came very much to the forefront of counsel’s submissions at the oral hearing of the appeal.

**68.** It should be immediately added that Dr. Monks, who is employed by the Central Mental Hospital, is a highly reputable expert. There is no question of his credibility, reliability or expertise being in issue, nor is there any question about his area of expertise being a recognised science (unlike, for example, the evidence of Dr. Farrington on the “CUSUM” technique in the *Kelly* case). The difficulties lie elsewhere, in the detail of his report, to which we now turn.

**69.** Dr. Monks’ initial report said that it was “*possible*” that the applicant was suffering from a schizophrenic episode around the time of the offence, but added “*it is difficult to establish any causal nexus between mental illness and his behaviour at the material time*”. Dr. Monks described a series of what he described as “*goal-directed behaviours*” on the part of the applicant in the context of the robbery, including (a) incapacitating the victim;

(b) concealing his actions by putting socks over his hands; (c) burning his clothes; (d) phoning the Gardaí to tell them there was a man tied up. Thus, Dr. Monks was both putting the likelihood of the applicant having been having a schizophrenic episode around the time of offence at a low level (“*possible*”) and putting a significant question-mark around whether any such episode was *causally* connected with the offences committed.

**70.** Dr. Monks referenced the applicant’s own account of the events and noted that “*there is nothing to suggest that his mental capacities were diminished as a result of mental illness*”. He points out that there was “*little evidence to support the presence of active symptoms of psychotic illness in the days after the assault*”, referring to the medical entries after the applicant’s committal to prison.

**71.** The applicant’s case therefore rests essentially on the second report and letter of Dr. Monks. This arose out of seven further questions which were posed to him by way of follow-up on the advice of counsel (according to Mr. Hackett’s affidavit). These answers do, however, need to be read in light of Dr. Monks’ first report, from which he did not resile.

**72.** It is rather unusual to see an expert witness being probed in detail in the way he was by his own legal advisers with what, at times, are borderline in terms of the leading nature of the questions. For example, Question 2 was: “Is it *probable* that the defendant committed the killing whilst suffering a psychosis?” (emphasis added). This question was posed, despite the fact that Dr. Monks had already assessed this as a “*possibility*” in this first report. It will be recalled that this question was posed on behalf of the applicant to his own expert i.e. not a situation where cross-examination would normally be permitted.

**73.** Another question (question 6) asked, inter alia: *“If the killing was perpetrated under the influence of a mental disorder such as schizophrenia what evidence relating to the commission of the offence which you normally expect to find? Does the absence of available evidence have any causal nexus between mental illness and his behaviour at the material time exclude its existence?”* Again, the appropriateness of such probing might be questioned in light of the fact that Dr. Monks had already said in his first report: *“it is difficult to establish any causal nexus between mental illness and his behaviour at the material time. It appears that his actions at the time of the killing [of] Mr. Gillespie were motivated by a robbery”*.

**74.** But even if we leave those concerns aside, let us take the evidence of Dr. Monks at its height. It might be summarised thus:

- (1) The prodromal phase of schizophrenia constitutes a mental disorder within the meaning of s. 1 of the 2006 Act;
- (2) With hindsight, the description of the applicant’s GP records would be sufficient to diagnose schizophrenia around the time of the offence;
- (3) The applicant fulfilled the criteria for alcohol, benzodiazepine and cannabis dependency (which may be in and of itself a “mental disorder”);
- (4) The applicant’s drug and alcohol dependency would have complicated the course and presentation of his illness and may have exacerbated his psychotic symptoms;
- (5) He was likely intoxicated at the time of the offence;
- (6) He was possibly/probably experiencing psychosis at the time of the offence (first report says ‘possible’; the second report/letter says ‘probable’).

- (7) It would be difficult to comment on the degree and severity of any such psychosis at the time of the killing.
- (8) The causal nexus between the mental disorder(s) and the killing is questionable/speculative.

**75.** The answer given by Dr. Monks to Question 6 in particular bears repetition and careful consideration. In answer to a question about the causal nexus between mental illness and offending, he said (as we have already set out above):-

“While it doesn’t appear that Mr McGinley’s decision making processes at the time of the robbery and assault on Eugene Gillespie were specifically influenced by delusions or hallucinations, active psychotic illness *may have* impaired his reasoning, judgement and behaviour (for example impulsivity and aggression) in a more general sense. This would have relevance in addressing the question of whether Mr McGinley intended to cause serious injury to Mr. Gillespie.

Clearly, intoxication would also have had a significantly negative effect on his ability to reason and judge but it is *somewhat arbitrary to try to estimate the relative contributions of intoxication and mental disorder* in terms of how much impairment could be attributed to a psychotic mind versus an intoxicated mind. In this regard, mental disorder and intoxication might be considered somewhat inextricable.”

(Emphasis added.)

**76.** A criminal lawyer must always be alive to the distinction between ‘voluntary’ and ‘involuntary’ intoxication as it is highly relevant to culpability. It seems unlikely that Dr. Monks is making that distinction as carefully as a lawyer would, and so the use of the word ‘intoxication’ in his reports must be treated with some caution, as it is not clear in what sense he is using the term. It is one thing to become voluntarily intoxicated and thereby aggravate one’s own psychotic symptoms; it is another to be in the grip of an intoxicant dependency which leads to drinking/drug-taking and which aggravates psychotic symptoms. This distinction is carefully maintained in the English authorities on diminished responsibility which were cited to the Court by the applicant. Dr. Monks’ reports, understandably, do not indicate whether the intoxication he is speculating about is voluntary or involuntary in the legal sense.

**77.** Also, given that Dr. Monks was extremely reluctant to ascribe any *causal nexus* between the applicant’s mental disorder(s) (even taking that mental disorder at its height in terms of the retrospective diagnosis) and the offending in question, pointing out that the behaviour appeared goal-oriented and that it was difficult to assess the degree to which any psychosis was active at the time of the killing. Dr. Monks’ evidence falls far short of the “substantial” part of the “substantial impairment” test for diminished responsibility in s. 6 of the 2006 Act.

**78.** The evidence of Dr. Monks must also be considered, not in isolation, but in the context of the overall circumstances of the case. The following points are of relevance. First of all, we are dealing with a (suggested) retrospective diagnosis made some eight years after the killing, in circumstances where, the records show, the first formal diagnosis of schizophrenia by the experts was not made until five years after the killing.

**79.** Secondly, the applicant's interactions with his legal advisers at the time of trial did not raise any alarm bells that he might have been suffering from a mental disorder at the time of the offence. It will be borne in mind that his legal advisers would have interacted with him before the trial, during the trial, and up until the conclusion of the original appeal. There has been no suggestion of incompetence or negligence of counsel. No one appears to have thought it necessary even to seek his medical records (or if they did, the Court has not been told of it), nor was mental disorder raised in any shape or form, even in the lesser form of diminished responsibility. As the court noted in *R v. Erskine and Williams*, mentioned earlier, it will be very rare indeed for a later reconstruction, even by distinguished psychiatrists who did not examine the applicant at the time of trial, to persuade the court that notwithstanding the earlier trial process and the safeguards built into it, a defence of diminished responsibility which was not raised at all should now be considered to be a reason for quashing the conviction and ordering a retrial.

**80.** Nor did any alarm bells go off on the part of the doctor interacting with the applicant in the Garda station upon his arrest, nor on the part of the persons interacting with him upon his committal to prison after his detention in Garda custody concluded.

**81.** There is also the nature of the offence itself to be considered. Again, perhaps the facts of *Abdi* are useful by way of contrast. Mr. Abdi's killing of his infant son could not in any way be described as goal-oriented behaviour. In contrast, on the face of it, the applicant in this case had a rational purpose, albeit an unlawful one, in committing the offence of burglary, namely personal gain. Also, he took various steps to conceal his involvement in the offence, which as Dr. Monks noted, was also "goal-oriented" behaviour.



**82.** Another point is that the applicant himself did not report to the Gardaí during interview anything that would be suggestive of mental disorder being a factor in the killing. This of course is not dispositive, but it is of some relevance to the Court when it is considering the overall matrix within which Dr. Monks' opinions are to be assessed.

**83.** In light of all of the above circumstances, and even taking the contents of Dr. Monks' reports at their height in favour of the applicant, we are satisfied that the evidence falls far short of what would be required for a successful application pursuant to s. 2 of the 1993 Act and we conclude that the application should be rejected.

**84.** We therefore refuse the application.