APPEAL COURT, HIGH COURT OF JUSTICIARY

[2018] HCJAC 57
HCA/2017/477/XC

Lord Justice General
Lady Clark of Calton
Lord Turnbull

OPINION OF THE COURT

delivered by LORD CARLOWAY, the LORD JUSTICE GENERAL

in

THE REFERENCE FROM THE SCOTTISH CRIMINAL CASES REVIEW COMMISSION

WENDY GRAHAM

Appellant

against

HER MAJESTY'S ADVOCATE

Respondent

Appellant: Allan QC, Gianni; Faculty Services Ltd (for George Mathers & Co, Aberdeen)
Respondent: McSporran QC (sol adv) AD; the Crown Agent

2 October 2018

Introduction

[1] On 15 December 2008, at the High Court in Edinburgh, the appellant was unanimously found guilty of the murder of her partner, namely Mark Thomson, on 4 June 2008 at their flat in Robert Burns Drive, by stabbing him repeatedly with a knife. She was sentenced to life imprisonment, with a punishment part of 11 years. The trial concerned

whether the appellant should be convicted of murder or culpable homicide. Although the appellant advanced a plea of diminished responsibility, this was withdrawn from the jury's consideration by the trial judge. Provocation remained for the jury's consideration, as did whether the appellant had had the requisite intent or level of recklessness for murder. Provocation was rejected. The jury were clearly satisfied that the necessary mental element had been present.

[2] On 30 June 2017, the Scottish Criminal Cases Review Commission referred the case on the basis of new evidence relating to the appellant's psychological state at the time of the killing. The new evidence was said to come primarily from Dawn Harris, who is a chartered psychologist. She had been instructed by the SCCRC. She first saw the appellant in February 2017. Her view, as expressed in her report of 4 March 2017, was that, at the time of the killing, the appellant "would not have had the capacity to think rationally", having been "driven by years ... of abuse and trauma leading her to acting on impulse in a moment of feeling overwhelmed. This could be considered an impairment of mind".

[3] The appeal raises the primary issue of whether the terms of section 106(3)(a) of the Criminal Procedure (Scotland) Act 1995 have been satisfied. The question is whether a miscarriage of justice has occurred, based upon the existence and significance of evidence which was not heard at the original trial; there being a reasonable explanation of why that evidence was not so heard (s 106(3A)). The reference raises a subsidiary question, stemming from *dicta* in *Galbraith* v *HM Advocate* 2002 JC 1, of whether the evidence of a psychologist is capable of demonstrating, contrary to psychiatric opinion, that an accused person suffered from a "mental abnormality" which impaired his ability to determine or control his acts at the material time?

The trial

Background

[4] The deceased was the 42 year old partner of the appellant. He was killed by the appellant on the evening after the appellant's father's funeral. The deceased and the appellant had lived together for about a year and a half. The trial judge reports that, although the deceased had initially been supportive of the appellant, who had significant problems with depression, self-harming, low esteem and drug and alcohol addiction, the relationship deteriorated. There had been intermittent violence, which the judge describes as being "on both sides".

[5] One neighbour and friend, namely Thomas McIntyre, had previously seen bruising on the appellant's chest and arms, which she attributed to the actions of the deceased. At Christmas, Mr McIntyre had seen the deceased with a fresh head wound, which the deceased said had been caused by the appellant hitting him with a broom. He had seen a "slash" through the deceased's tattoo (presumably on his arm, see Mr Duke (*infra*)). Mr McIntyre thought that the appellant's mental health had been deteriorating. She was self-harming. The deceased could become aggressive when he drank alcohol in conjunction with his anti-depressants. Mr McIntyre had advised the deceased to leave the house or someone would get badly hurt.

[6] Another friend, Justin Duke, described the couple as fine, when they were not drinking. Otherwise they would argue all the time. On two or three occasions, he had seen bruising to the appellant's eyes and chest and finger marks on her arms. He had also seen the deceased with black eyes. On one occasion the deceased had shown him a wound to his arm where, he had said, the appellant had stabbed him. At the same time, the deceased had a massive bite mark to his thigh, with an indented teeth mark, which had been inflicted by

the appellant within months of the deceased's death. Mr Duke spoke to the deceased also being aggressive when he drank spirits.

[7] Lloyd Graham, who is the appellant's brother, was asked very little about the appellant's childhood, although he did say that she had been in care at one time. He had been aware of his sister having previously had violent relationships. He had helped the appellant move from squalid conditions to the address which she subsequently shared with the deceased. He had thought that the deceased had been good for the appellant. They were very alike. Mr Graham had driven the appellant to their father's funeral. The appellant had not had a good relationship with her father. They had had little contact until about four weeks before his death. At the funeral, the deceased had said that the appellant liked to beat him up, but Mr Graham had thought that that was a joke. They had left the funeral at about 6.30pm.

[8] Laura Mair, a friend of the appellant, spoke to the couple being difficult when they drank; the appellant being the loud one. The deceased had admitted to bending the appellant's fingers. The appellant was physically bigger than the deceased. She had seen him with a bandaged finger and thumb after, he said, the appellant had stabbed him. Ms Mair too thought that the deceased had been good to the appellant. She had not seen him being aggressive.

[9] Graham Darling, another neighbour and friend, said that the deceased was a "placid wee guy", although he had seen marks on the appellant on one occasion. The appellant had told him that the deceased was a "nutter" when drinking. Mr Darling's partner, Catherine Hogg, said that, although the appellant had said the deceased was violent, she had seen no signs of that. The deceased was quiet and she had seen no darker side.

The appellant's ingestion of alcohol and drugs

[10] Mr Graham spoke to the appellant leaving the wake, at which time she had had some drink, but was not unduly adversely affected. When he had phoned the appellant at her house at about 8.45pm, she had been "intoxicated", probably as a result of her taking antidepressants "or something like that". She was quite significantly different.

[11] At between 9.00 and 9.30pm the appellant had called round to her friend Laura Burns' house. Mrs Burns said that the appellant had told her that she had had a couple of drinks at the wake "and that was it". She was fine and seemed ok. There was no sign, according to Mrs Burns, that she had taken drink or medication.

[12] After the killing, the appellant had gone to the house of Mr Darling and Miss Hogg. Miss Hogg said that the appellant was gasping and staggering, but walking; distraught, upset and just ranting. When detained by the police at about 0.30am on 5 June, the appellant was, according to the police, not obviously intoxicated. She was withdrawn but fully oriented.

[13] The appellant's own accounts of her alcohol and drug consumption varied. At about 2.45am on 5 June, she told the forensic medical examiner, Dr Alan Grant, that she had drunk four or five cans of lager on the previous day. She took prescribed and illegal diazepam (6 x 5mg and 2 x 10mg respectively), methadone (10mls) and mirtazapine (30mg). Dr Grant, who had been asked to assess the appellant's fitness for interview, reported that, although she smelled of stale alcohol, she was fully oriented.

[14] During her police interview (*infra*), the appellant said she had drunk five or six cans and a Bacardi, together with an antidepressant. She had taken a half gram of amphetamine and two diazepam before the funeral.

[15] At 12.45pm on 5 June the appellant told another FME, Dr Michael Khaim, that, in addition to her prescribed medication, she had been taking amphetamine daily. She normally drank between eight and ten pints of lager per day. On the day of the killing, she had got through six cans. Samples were taken. Diazepam, dihydrocodeine, amphetamine, methadone and mirtazapine were found, but no alcohol. She smelled of stale alcohol but was not under its influence.

[16] The appellant was seen by a speciality registrar forensic psychiatrist, namely Dr Alistair Morris, on 5 June. She told him that she had taken ½ gram of amphetamine and two diazepam tablets. She had drunk 1½ pints of lager and a Bacardi at the funeral and four cans at home. She said that she had been intoxicated at the time of the killing. She had been taking 3gm of amphetamine and 400mg of diazepam per week for the previous two months.

[17] Dr Fionnbar Lenihan, a consultant forensic psychiatrist, saw the appellant on 30 July. He recorded her as drinking two cans by noon, a pint and a Bacardi at the funeral, together with her prescribed diazepam, extra diazepam and a £20 bag of amphetamine. In the three months prior to the killing she had been drinking constantly and consuming £20 of amphetamine per day.

The death and its aftermath

[18] The appellant had phoned Ms Mair at about 7.00pm. She had sounded down, but ok. She had said that she would have preferred being in a "box", instead of her father. About 7.00 or 8.00pm, the deceased was seen going to buy drink for the appellant. A friend, Catherine Gosman, who had been asked by the deceased to phone the appellant, also referred to the appellant as sounding "down".

[19] The deceased had texted Mr Darling at about 9.30pm. Mr Darling had phoned him back. The deceased sounded as if he had been drinking. He had wanted to borrow money. He said that he would send round the appellant, to whom he referred in derogatory terms.

[20] After the appellant had called to visit Mrs Burns (*supra*), she had sent a text to Mrs Burns, as follows:

> "I've had about enough of being so unhappy with [the deceased]. If, he won't leave, hen, I will bread him out, as I know I deserve better. I hate him, hen. I have to get him out of my life once and for all as life is too short, hen. F..k him. I hate him so much. If I can do it. You can too, love. You think how short life is, hen. Go for it. I am weak, but not anymore. He has someone else to feel sorry for him, as it won't be me."

The reference to "bread him out" was taken by Mrs Burns to be a reference to a bread knife. The trial judge understood that the phrase meant that the appellant intended to stab the deceased with a bread knife, perhaps fatally; even if, strangely, the advocate depute did not ultimately found on this at the trial and deleted the libel of previous malice.

[21] According to Mr Darling, it was between ten minutes and an hour after his telephone call with the deceased that the appellant appeared at his (and Miss Hogg's) door covered in blood and saying that she had killed the deceased. She asked for help. She was wearing rubber gloves. Miss Hogg confirmed this. Darien Fish had been in the house at the time and took the appellant to a bathroom to wash up. He and Miss Hogg went with the appellant back to her flat. The deceased was lying inside the front door. The appellant had a can of beer in her hand. She had said something along the lines of the deceased having taken her phone and having had enough of domestic abuse. When Miss Hogg had taken the appellant into the livingroom, she had gone into the kitchen and asked "what have I done?" She had emptied a mop bucket of mixed blood and water into the sink. A bloodstained mop had been in the hall. Miss Hogg's impression was that the appellant had not "realised the

situation". The appellant had told her that she had stabbed the deceased when he had tried to stop her getting out of the door. He had not let her use the phone. Her fingers had been bent back. The appellant said that she had stabbed the deceased three times with a knife, which she pointed out in a block in the kitchen. She showed the knife to Miss Hogg, having initially picked out one which was too small. She selected the largest and said that she had washed it and put it back. The appellant was drinking and not coherent.

[22] The paramedics arrived at about 11.30pm. The deceased showed no signs of life. On the journey to the police station (some time after her detention at about 00.30am) the appellant spoke of the deceased becoming aggressive, hitting her and starting to break her fingers. She said that she had gone berserk; "flipped her lid". She had said it had been self-defence. Although she had initially appeared coherent, she became withdrawn but more agitated in the police van. She had calmed down before reaching the police station.

[23] The deceased had sustained ten stab wounds to his face, torso and arms, but mostly to his legs. He died from a wound to his thigh, which had severed an artery. This had nicked the femur, suggesting a blow of moderate to severe force. The evidence suggested that the appellant may have spent some time clearing up before eventually going to summon help.

The psychiatrists

[24] The Crown adduced the two forensic psychiatrists. Dr Lenihan, the consultant at the Royal Edinburgh's Orchard Clinic, expressed the view that "the most prominent mental disorder present" was dependence on alcohol and benzodiazepines. The appellant had previously been diagnosed with an "emotionally unstable personality disorder" (EUPD). Dr Lenihan considered this diagnosis to have been reasonable, with the caveat that the

appellant's heavy drinking would have obscured the picture. The "most prominent thing going on with" the appellant at the time of the killing was her "very substantial consumption of alcohol and drugs". In relation to diminished responsibility, he said:

> "... the main effect on [the appellant's] mental state at the time of the index offence, was ... intoxication with alcohol and illicit drugs. ... [I]t would be extremely difficult to tease apart the contribution of personality and ... the very prominent effects of alcohol and drugs would ... outweigh any effects from the personality."

[25] Dr Morris, the specialist registrar, also at the Royal Edinburgh, reported that the appellant had told him that she had heard voices saying, "Stab him. Stab him", but only after she had begun to do just that. She had told him that there had been a "long history of being the subject of domestic violence". A "clear history of alcoholism and poly-drug dependence" was noted. Dr Morris considered that, at the time of the killing, the appellant was "intoxicated with drugs and alcohol" and that this would "outweigh any possible evidence of mental disorder". The voices were an artefact of amphetamine abuse. Dr Morris did not agree that an EUPD had been present. Symptoms which might have been attributable to that disorder could have been explained by the appellant's drug and alcohol problems.

The police interview and later actings

[26] In her interview with the police, the appellant explained that, while the deceased had gone for more drink, she had taken her dogs out. Back at the flat, the deceased had become aggressive. A scuffle had ensued. He had pulled the landline out of its socket. He broke her finger. She tried to run out. He started hitting her. She ran into the kitchen and got a knife. The deceased had tried to take it from her. The knife fell to the floor, but she had picked it up again. She started using it; she flipped. She did not seem as if she was in

control of her mind. She had had five abusive partners. She had not aimed for his heart, but at his arms and legs. She had stabbed him four times with a knife from the kitchen set. On being charged, the appellant said that she had not meant to murder the deceased and was not admitting to murder.

[27] Subsequently, the appellant wrote to a number of the witnesses encouraging them to say things that were calculated to assist her defence. The recipients included the deceased's sister, who was asked if she had understood that the deceased had been jealous and controlling. The witness said that she had not been aware of the deceased having any serious mental health issues. Mr Duke was asked to be a witness to the appellant's injuries and to the deceased using her as a punch bag and breaking her fingers; matters of which he was not aware. Ms Mair had been written to and asked to stand by the appellant. The trial judge observed that this conduct, coupled with the delay in seeking help for the deceased and attempting to clean the flat and the knife, would have entitled the jury to regard the appellant as devious and calculating.

Appellant's testimony

[28] Some time was spent exploring the appellant's background in her examination-in-chief. She described being brought up in poverty by a mother, who was often admitted to hospital for psychiatric care, and an alcoholic father. She had married at seventeen. The marriage involved weekly physical abuse with the appellant being punched and kicked on the face and body. She suffered from depression. She had married again at twenty seven. This marriage was also abusive. Her husband kicked her from head to toe until she was black and blue. She began to drink excessively and was taking drugs by the age of thirty, having become involved with a heroin addict and alcoholic. She began abusing

amphetamine because, she said, her psychiatrist had stopped her anti-depressants. In 2007 she began living with the deceased. The deceased began hitting her. She did not retaliate "until things got really bad".

[29] The appellant's psychiatric history was explored in some detail. She had first overdosed in 1981. She had been referred to a psychiatrist in 1988 for depression. In 1995 she had been diagnosed with post-natal depression. By 1997 she was being treated for "non-dependent alcohol abuse" and depression. In 2000 she was reporting the physical abuse from her second husband. Overdoses were recorded in 2001 and 2002, when she was taking heroin. She had in-patient psychiatric care in early 2002. Reports of further abuse were made; one being a complaint of mental and physical abuse over a prolonged period of 13 years. Further assaults were noted in 2003, 2004, 2006 and 2007, by which time the appellant had become worried about losing her own temper. She had become anxious about harming her partner. She was admitted to hospital for alcohol detoxification in 2007. She had thought that she was "becoming out of control". In 2008 she made more complaints of violence against her.

[30] The appellant and the deceased had both been drinking before and during the funeral, although the appellant said this only involved half a can of lager, a pint of lager and a Bacardi and coke. The appellant had another half pint of lager when she returned to the house. Later that evening she took amphetamine. She had also taken diazepam, some of which had been prescribed and some had not. Other drugs, including methadone, dihydrocodeine and mirtazapine, were, she accepted, in her system.

[31] The appellant and the deceased had argued for several hours after returning home. This had culminated, according to the appellant, in the deceased pulling her hair, pushing and shoving her, preventing her from leaving the flat, rugby tackling her and holding her in

a head lock. The appellant had broken free and taken a knife from the kitchen. He had seized her hand. The knife had fallen to the floor in the hall. The appellant had picked it up and had stabbed the deceased. When asked what she had been thinking when she did that, she replied, "I don't know". She had not intended to kill him. "If it wasn't going to be him it would have been me and I just ... don't know". When asked "what made you kill him", she replied, "I think that I just snapped, I had enough. I was scared for my own life ... I just think I had enough. I don't know. I was scared for my own life at times."

[32] The trial judge reports that the jury must have rejected this account in whole or in part, or found that it was not sufficient to amount to provocation. On the basis of what she had said at interview, it was put to her in cross-examination that she had known what she had been doing. She replied, "I suppose I did, yes".

Speeches

[33] The advocate depute told the jury that there was no possible basis upon which they could find diminished responsibility established, because there was no evidence:

> "from a suitably qualified man of science or of medicine … that [the appellant] suffered from an abnormality of mind which substantially impaired her ability to control her acts".

That left the issues of provocation and intent/recklessness for the jury's consideration. Self-defence had not been advanced by the appellant.

[34] The defence address to the jury contained repeated, and perhaps unwise, criticisms of the deceased's lack of respect for the appellant and of his general behaviour. It focused in part on diminished responsibility. The appellant's solicitor advocate had referred to the appellant telling the police that she had had enough of men hitting her all her life before submitting that, at the material time, "she finally cracked ... she could take no more, she had

had enough." He founded upon Dr Lenihan diagnosing "a recognised mental disorder called 'Emotionally unstable personality disorder'" identified in ICD (International Classification of Diseases) - 10. He asserted that the appellant's chronic poly-substance abuse coexisted with, and was consequential upon, her EUPD. A characteristic of EUPD was impulsivity. There were outbursts of emotion and an inability to control "behavioural explosions". There was a tendency to quarrelsome behaviour and conflict with others.

[35] The appellant's solicitor advocate said that Dr Morris had explained that the appellant's poly-substance abuse could have been a symptom of, rather than a reason for, her emotional problems. He suggested to the jury that there were other factors in the appellant's history at play, notably a history of deprivation, poverty and abuse. He continued:

> "... in our law, when a person's ability to control ... her behaviour is impaired as a result of some mental abnormality of the type introduced here, then that person may not be fully responsible for the results of ... her behaviour, so that the responsibility for killing can be correspondingly reduced."

Having dealt with diminished responsibility, the solicitor advocate went on to invite the jury to return a verdict of culpable homicide on the alternative basis of provocation, having regard to the appellant's account of being trapped in the house set against previous acts of violence.

Charge

[36] The trial judge gave the jury the standard directions on the definition of murder; explaining the need for either intent or recklessness. He told the jury that, if a person commits a crime after knowingly taking drink or drugs, he or she is just as accountable for his or her actions as a sober person. The trial judge proceeded to deal in some depth with the concept of provocation and its application to the evidence. He explained that, when

assessing the matter, the jury could take into account what had happened to the appellant at the hands of the deceased in the past, as well as what she said happened on the night.

[37] The trial judge had been surprised with the defence approach to diminished responsibility. He advised the jury that there was no basis upon which they could consider diminished responsibility. He explained that the legal test involved:

> "a medically recognised mental abnormality, something far wrong with the accused, which affected the way she acted, and as a result of which her ability to determine and control her behaviour was substantially impaired compared to a normal person."

The judge directed the jury that the appellant's "mental condition at the time of the crime does not reduce her responsibility for her acts."

Prof Thomson

[38] Although the defence had not adduced any medical evidence in support of the diminished responsibility plea, they had obtained a very detailed psychiatric report, dated 6 November 2008, from Prof Lindsay Thomson, who was, and is, the medical director of the State Hospital, Carstairs. This described the appellant's life. The appellant regarded herself as an alcoholic. At the time of the killing, she had said that she was drinking six cans of strong lager and approximately half a litre of Bacardi per day. Prof Thomson reported that the appellant's behaviour was highly suggestive of a personality disorder, notably EUPD. Prof Thomson had considered "battered person syndrome" (BPS); being a reference to any person who, because of constant and severe domestic violence, becomes depressed and unable to take any independent action to escape the abuse. Although it was not a term in use in either of the current international classifications of disease (ICD-10 (*supra*) or DSM (Diagnostic Statistical Manual) - IV), it could nevertheless be considered to be a

psychological condition relevant to diminished responsibility as defined in *Galbraith* v *HM Advocate* (*supra*). The evidence to support its presence, other than the statements of the appellant, was not strong. However, the appellant's extensive use of substances on the day, with likely impairment of her judgment, was the "most relevant factor" in the case. Accordingly, she did not think that the defence would succeed. Prof Thomson encouraged the defence to pursue the plea of provocation, given the appellant's history and circumstances.

[39] In April 2011, Prof Thomson was asked by the appellant's new law agents to re-examine the case in light of quoted passages from a charge to a jury in *HM Advocate* v *McLeod*, 24 October 2002, High Court of Justiciary, Forfar, unreported, (cited in the Scottish Law Commission report (no 195): *Insanity and Diminished Responsibility* (2004) para 3.38, fn 44). The passages were to the effect that it was sufficient that the mental disorder was a substantial, rather than the main or predominant, cause of the appellant's actions; notwithstanding that intoxication was also a factor. In another very detailed report, dated 16 May 2011, Prof Thomson expressed her view that the appellant's "abnormality of mind as caused by emotionally unstable personality disorder and by battered partner syndrome would be a substantial cause of her actions". On that basis, she supported a plea of diminished responsibility.

Further procedure

[40] It was only on 4 October 2012 that the appellant lodged an application for an extension of time to lodge a Note of Appeal. The ground was defective representation. This was based upon the revised view of Prof Thomson; that the EUPD had been a "substantial cause" of the appellant's actions. A report from another psychiatrist, namely Prof Peter

Olley, supported this. On 5 September 2012, Prof Thomson confirmed to agents that she had not consulted with the appellant's legal representatives or been asked if the appellant's mental disorder had "substantially impaired her ability to determine and control her acts." The proposed ground was based on a contention that the appellant's representatives had failed "to investigate fully the issue of diminished responsibility". The application was withdrawn pending the views of the appellant's legal representatives at trial.

[41] A second application for an extension of time was lodged on 30 August 2013. This repeated the defective representation ground. The application was refused on 20 September 2013 ([2013] HCJAC 140) on the basis that: (1) there was no adequate explanation for the delay which had elapsed since the last application; and (2) the appeal did not reach the required standard of probability of success. On 18 October 2013, a few days before the appeal hearing on the application, the appellant's solicitors had received an unsolicited letter from Dr Alex Quinn, psychiatrist, who was involved in the appellant's treatment. He expressed the view that "longitudinal observations" of the appellant suggested that she did indeed have an EUPD. On 24 October 2013, the court ([2013] HCJAC 149) refused the appeal against the decision at first instance. The court noted that the submission from the appellant had been that Prof Thomson had performed a *volte face*. It could therefore hardly be said that there had been defective representation.

The SCCRC reference

Initial Consideration

[42] The SCCRC first considered defective representation; notably, in essence, a failure to call Prof Thomson at the trial. They rejected this on the basis that Prof Thomson had reported that diminished responsibility could be put forward as a defence, albeit that the use

of alcohol and drugs had been the "most relevant factor in the case", even if EUPD had been present. The SCCRC observed that the opinion of a doctor on the availability of a legal defence was not relevant. Prof Thomson's view, in 2008 at least, had been in line with that of Dr Lenihan. Her evidence would not have added substantially to the defence case. Defective representation was dismissed as a potential ground of appeal.

[43] The second ground was fresh evidence in the form of Dr Quinn's "longitudinal observations". The SCCRC noted that Prof Thomson, in her report of 16 May 2011, had revised her opinion, whereby the alcohol and drugs abuse was "a relevant" rather than the "most relevant" factor. Both EUPD and BPS would have been a substantial cause of the appellant's actions. In an interview with the SCCRC, Prof Thomson explained that her revised view had been prompted by the appellant's solicitors asking her to address a different test as outlined in the quoted passages from the judge's charge in *HM Advocate* v *McLeod* (*supra*). She said that her view was still "probably" that the appellant's intoxication was the most relevant factor. On this basis, the SCCRC determined that there had been no volte face on the part of Prof Thomson. Her opinion had not altered between 2008 and 2011. Her view did not therefore amount to fresh evidence.

[44] The SCCRC obtained a statement from Dr Lenihan, in which he accepted the accuracy of the EUPD diagnosis, but remained of the view that the main cause of the appellant's behaviour had been intoxication. Dr Morris said that he would not now disagree with the diagnosis of EUPD. The SCCRC reasoned that, in applying the test of fresh evidence, if the defence had contacted Dr Quinn prior to trial, he would have expressed the same view as he presently held. His evidence had been available at the time (although he was apparently not then qualified). There was no reasonable explanation for the failure to lead it. The longitudinal observations were not material, given the gap of six months

between the incident and the trial. This ground was also dismissed as a potential appeal point.

[45] The SCCRC then embarked upon a "further consideration of BPS/Trauma" as a basis for the plea of diminished responsibility. On raising BPS, Drs Morris and Lenihan had said that it was not a condition referred to in ICD-10. This was accepted by Prof Thomson, although she did say that it had been in ICD-9. The United States manual, DSM-V, had a section on "Trauma and Other Stress Related Disorders". She thought that it might be better referred to as a phenomenon rather than a diagnosis. The medical notes, which had confirmed that violence had been used by the deceased, might have prompted Prof Thomson to support a contention that there had been diminished responsibility by reason of BPS.

[46] The SCCRC criticised the absence of greater consideration being given at trial of the extent to which the appellant had been intoxicated at the time of the killing. The police, who had detained the appellant at the locus, had described her as "withdrawn but ... coherent". The SCCRC considered that the ultimate position of the psychiatrists was much weaker than it had been when they had asserted that the EUPD would have been "drowned out" by intoxication.

Dawn Harris

[47] The SCCRC decided to instruct Dawn Harris, a chartered psychologist. Mrs Harris is not medically qualified, having graduated MA in 1990 and obtained master's degrees in social work in 1994 and forensic psychology in 2003. In her extensive *curriculum vitae*, she describes herself as "a registered and practicing (*sic*) Forensic Clinical Psychologist and accredited Psychotherapist". She saw the appellant for the first time on 14 February 2017.

In her report of 4 March 2017, she itemised the information which informed her assessment. Curiously, these papers did not include a transcription of either the appellant's police interview or her testimony at trial. As background, Mrs Harris explained that the ICD tended to be used by psychiatrists to diagnose mental illness, whereas the DSM tended to be used by psychologists to diagnose mental health difficulties. DSM-IV had BPS as a sub-category of PTSD. The more recent DSM-V had a section on "Trauma and Other Stress Related Disorders under which BPS would potentially sit." BPS was too vague and not a diagnostic term. Rather the appellant's behaviour was "better understood from the viewpoint of a traumatised individual".

[48] Mrs Harris wrote:

> "There is now extensive research concluding that trauma such as childhood neglect causes brain abnormalities; these include a constantly activated amygdala leading to increased arousal to threat which can cause potentially aggressive behaviour as the person is easily triggered; a damaged hippocampus, leading to memory impairment especially verbal memory; damage to the left hemisphere leading to problems in effective reading of situations and language processing; difficulties to the cerebellar vermis leading to problems regulating physical activity, attention and emotions, and also problems to the prefrontal cortex causing problems with problem-solving, poor organisation and increased impulsivity."

Mrs Harris referred to the appellant's traumatic childhood, as told to her by the appellant, and described how this would have damaged her neuro, emotional and social development, leading in turn to chaotic relationships as an adult and to "an intense cocktail of fear and anxiety" which would govern her behaviour. Using substances would have helped calm her emotions. Without them, she would: "experience traumatic memories flooding her brain, which become overwhelming".

[49] Mrs Harris considered the appellant to be a "severely traumatised individual who has experienced lifelong complex trauma". Her substance abuse was to "calm her inner state of chaos". According to the account given by the appellant to Mrs Harris, she had had

a "lightbulb moment" just before she attacked the deceased. She had felt that she had become "somewhat different". Because she had not taken as much alcohol or drugs as she normally did, she would not have been as numb as usual. The appellant was "highly dissociative"; that is that she experienced an altered state of consciousness. Mrs Harris expressed the view that, shortly before she killed the deceased, the appellant:

> "was overwhelmed by her traumatic past, remembering her treatment at the hands of various men including her father and [the deceased] and reacted when feeling threatened by the behaviours of [the deceased]. She would not have had the capacity to think rationally, she would have been driven by years, indeed decades, of abuse and trauma, leading to her acting on impulse in a moment of feeling overwhelmed. This could be considered an impairment of mind".

Mrs Harris's view was that the appellant's conduct was best understood as being that of a severely traumatised person rather than as a reaction to BPS, which was too vague and too narrow in focus to explain it. At the material time she would not have been able to control her reactions, given the impact of her past traumas.

[50] Mrs Harris was asked by the SCCRC to use the diagnostic tool SCID-D (Structural Clinical Interview for DSM-IV Dissociative Revised). This indicated that the appellant suffered from dissociative amnesia, depersonalisation, derealisation and identity alteration. There was a dissociative identity disorder present. Using ICD-11 criteria, the appellant was said to suffer from a complex post-traumatic stress disorder. Her condition was best described as a "co-morbid presentation of ... [EUPD], Complex PTSD and PTSD with dissociative subtypes". Mrs Harris continued:

> "For people who have been persistently traumatised, life becomes driven by their trauma and they will not respond to situations as people who had not experienced them. In particular, if reliving a trauma, individuals struggle to make sense of what is happening and can become trapped in a life or death situation, in a state of paralyzing fear or blind rage. They will respond as if in imminent danger. They are ruled by parts of the brain responsible for threat responding (the amygdala in the right brain), but the ability to rationalise and be rational is impossible as the part of the brain that could do this for them (prefrontal cortex) has effectively shut down

> and is not working (this has been proven in various neuroscientific studies). Trauma literally freezes thinking. Thus the person is experiencing a range of powerful emotions (fear and terror) and responds as described above. The part of the brain that would normally put things into perspective (the hippocampus) is not developed fully in people who have experienced trauma, and as a result they cannot distinguish between threats from the past and present."

[51] Mrs Harris considered that there had been damage to the appellant's brain, such as would have impacted her ability to control her behaviour. She did not think that the appellant had been inebriated or out of control because of drug use at the time. She had not had enough drink or drugs to have blocked memories/feelings/thoughts from her past. The conclusion was that the appellant:

> "is someone who does not behave, think, or feel the same as someone who has not been traumatised. Her life and behaviours are driven by her traumatic past, meaning the opportunity to be rational and think clearly is very limited for her as she is controlled by emotions, not cognitions. When under stressful situations her coping will not include rational thought, but will be driven by the survival instinct and primitive emotions related to that such as terror or rage, and based on her learning from previous traumatic events. The paradox at the heart of the trauma is that individuals see and feel only their trauma, or they see and feel nothing at all."

Conclusion

[52] The SCCRC determined that, in terms of section 106(3)(a) of the 1995 Act, the post trial opinions of Mrs Harris and others would "clearly" qualify as fresh evidence. In examining the issue of reasonable explanation for the failure to adduce this evidence at trial, the SCCRC assumed that at the time there had been no formal diagnosis of (Complex) PTSD available, since Mrs Harris had relied on the criteria contained in the prospective ICD-11. Similarly, the dissociated sub-type of PTSD became a diagnostic category only when DSM-V was published in 2013. Mrs Harris thought that complex trauma was something that might have occurred to a forensic psychiatrist in 2008. In such circumstances, the SCCRC considered that most of Mrs Harris's evidence would have been available at the time of the

trial. The question which remained was: why had the appellant's representatives not obtained it?

[53] The SCCRC considered that a misunderstanding on the part of the defence, or a misapprehension on the part of Prof Thomson, had produced a situation in which BPS, or "trauma" in the broader sense, had not been extensively canvased pre-trial. This had been a reasonable exercise of professional discretion, but only because it rested upon a mistaken understanding of the factual position. A defence had been available, but had not been put forward.

[54] The SCCRC reasoned that, in the unusual circumstances, this amounted to a reasonable explanation for the failure to obtain and adduce the evidence relating to the effects of trauma. The evidence of Mrs Harris was capable of being regarded as credible and reliable and was material to the critical issue at trial. The SCCRC said that:

> "Mrs Harris' evidence, if it had been available, would have supplied the defence with the alternative explanation that it required to put the diminished responsibility defence. In her reports, she speaks to an abnormality of mind that would in her view have had a serious impact upon the [appellant's] executive functioning. She considers that this would, moreover, have most likely eclipsed the effect of any transient intoxication. While the court in *Galbraith* manifestly did not intend to provide an exhaustive list of conditions, 'the effects of severe trauma' are specified as potentially providing a basis for a diminished responsibility defence. The Commission considers that Mrs Harris' evidence, if it had been led, would have obliged the judge to leave diminished responsibility to the jury."

The SSCRC concluded that:

> "In the final analysis, there is now a body of psychological evidence that might … have led a reasonable jury to the conclusion that the applicant's responsibility for the killing of her partner was diminished. The Commission does not know what the jury at trial would have made of it. It notes, however, that the impact of complex trauma, dissociation and PTSD would appear particularly relevant in a case in which a woman is charged with murdering an apparently abusive partner. On the material available to the Commission the … test [in *Megrahi* v *HM Advocate* 2002 JC 99] appears satisfied."

The progress of the appeal

[55] A Note of Appeal was lodged on 3 August 2017. The grounds in the Note essentially mirrored the terms of the reference. Indeed, somewhat unhelpfully, they incorporated that reference in its entirety. A revised Note of Appeal was lodged on 3 January 2018. Having recited the fundamental statutory tests, the Note sets out certain propositions of fact. These are that:

> "... at the time of the homicide the appellant suffered a condition then called 'battered person syndrome', a term and concept which is now regarded as somewhat outmoded in light of developed learning on the issue and the more developed emphasis placed on the effects of trauma. The appellant was a severely traumatised individual who had experienced life-long complex trauma and that certain brain abnormalities were most likely present which would impact negatively on her executive functioning. The appellant was highly dissociative which was common in individuals with the appellant's trauma history. ... [T]he appellant was so dissociated that she had no true, integrated understanding of her whole self and life experience. The appellant's level of dissociation was significant to the killing of her partner. The [appellant] had dissociated and 'became someone different' immediately prior to the offence. The appellant's consumption of alcohol was no more than normal, if not less than she would usually take…
>
> That whatever the diagnostic label to be applied, the appellant's actions on the night that she killed her partner were best explained by the extensive history of trauma. The damage to the appellant's brain was so extensive that her behaviours, emotions and thoughts were dominated and driven by a constant need to find safety. This would have impacted the appellant's ability to control her behaviour compared to someone who has not experienced a traumatic past."

The ground continues, along the lines of the narrative in the SCCRC reference.

[56] The Note of Appeal also states:

> "The diagnoses, opinions and observations of the experts instructed by both Crown and defence at the time of the trial would not readily have alerted her legal representatives to a line of enquiry focused on the effects of long term severe trauma on the appellant.
>
> There is a reasonable explanation for the failure to adduce this evidence at the trial as the psychological understanding and diagnosis of this area of human functioning is constantly evolving and developing and, in particular, the diagnostic tool which is utilised in the relevant assessment has only more recently become readily available

> and been fully understood: it was not readily available or fully understood at the time of the trial. Learning in this area has increased and developed in recent years."

The Note sought the substitution of a verdict of culpable homicide for that of murder.

[57] On 18 January 2018, following a Procedural Hearing, the court issued a Note which was intended for the benefit of parties and attempted to identify certain issues that appeared to arise. These related, first, to the witnesses whose testimony might constitute the new evidence at the appeal hearing. The appellant had lodged a list of six witnesses: Dr Quinn; Prof Thomson; Mrs Harris; Ms Murphy; Dr Olley; and Sarah Aitken from the police's Force Information Unit. None of the original trial defence team had been included in the list. The court specifically cautioned that this might present the appellant with a substantial hurdle to surmount, when it came to providing a reasonable explanation for the evidence not being heard at the trial.

[58] Reports from Prof Thomson, Drs Quinn, Lenihen, Morris and Olley, and Mrs Harris and Ms Murphy had been lodged. These were to be taken as constituting part of the evidence in chief of these witnesses. However, the court advised that, if the appellant called any witness, other than Mrs Harris and Ms Murphy, in relation to diminished responsibility, it would require to hear submissions on the relevancy of their testimony, given that any ground of appeal advanced must relate to the reasons given for the SCCRC reference (1995 Act, s 194D(4A) in the absence of leave to do otherwise (*ibid* s (4B)). No application had been made.

[59] The court stated that it would appreciate the citation of authority from other jurisdictions, notably England and Wales, Ireland and the Commonwealth, on the relevance and effect of psychological evidence on the questions of mental abnormality and the

interaction of alcohol and drugs with personality disorders. It pointed parties in the direction of *R* v *Dix* (1982) 74 Cr App R 306 and *R* v *Byrne* [1960] 2 QB 396.

The Evidence

[60] Evidence was led on 4 and 5 September 2018. The appellant first called Prof Thomson, who referred to her pre-trial report of 6 November 2008, which had said that diminished responsibility could be put forward on the grounds of an EUPD but that her view had been qualified because of the appellant's extensive use of substances. She had been surprised not to have heard back from the agents who had instructed the report. She had been contacted by a different firm in 2011 and asked to assess the matter in terms of the quoted passages from the charge in *HM Advocate* v *McLeod* (*supra*). In her report of 16 May 2011, she had focused more on inter-partner violence, relating to trauma. There had been changes to the way in which trauma was thought about. She did not say that there was diminished responsibility; that being outwith the scope of her role. She did say that the appellant's mental abnormality of mind, as caused by an EUPD and BPS, would be relevant to diminished responsibility.

[61] By the time of her report of 18 December 2017, she had become aware of the SCCRC reference and Mrs Harris's reports. Prof Thomson reported that it was a Scottish Government Requirement that all diagnoses should be made using ICD-10, which was prepared by the World Health Organisation, rather than the American Psychiatric Association's DSM-V. BPS was not in ICD-10. Prof Thomson agreed with Mrs Harris's view on the appellant's condition being under the heading of trauma and that she had a dissociation amnesia, which was, along with the EUPD, relevant to diminished responsibility. Trauma was not a diagnosis but a causative factor in the development of a

mental disorder. The use of alcohol and drinks did not prevent an abnormality of mind being established.

[62] In cross, Prof Thomson said that she had not re-assessed her view of the appellant other than in the context of the passages from *HM Advocate* v *McLeod* (*supra*). The amount of alcohol and drugs which the appellant had taken had been less than she normally took. Prof Thomson had not found any cognitive impairment as a result of long term alcohol and drug abuse. At the material time, the appellant's reactions would have been a response to the threat which she was under, adrenalin and dissociation. She would have struck out at whatever was around. Her loss of control could be related to being overwhelmed by her emotions and the difficulties of the day and her previous experience of abuse. Prof Thomson had not had access to the appellant's testimony at trial. Her ability to give an account, including going to get a knife and dropping it, was consistent with her EUPD and dissociation.

[63] Ms Murphy testified to the psychotherapy, which she had provided to the appellant in 2016 and 2017; supporting the appellant's attempts to understand her life and to find a pathway out of it. The appellant had been referred to Ms Murphy because of concerns about her emotional instability and continuing self-abuse. Whereas psychology was about defining symptoms, psychotherapy was about the healing process. She had prepared a report of 15 February 2017. This had included the results of TEC (Trauma Experiences Checklist) and DES2 (Dissociative Experiences Scale) Tests, both of which had produced high scores. The appellant had a high level of dissociation. She had an attachment to cycles of toxic and violent relationships.

[64] Dr Quinn's involvement with the appellant had been entirely as a treating psychiatrist. He had first seen her in June 2012. The longitudinal observations had meant

that there was no doubt about the appellant's EUPD, as there had been at the time of her trial. He had wondered whether all of the facts had been put before the jury. This had prompted him to write to the appellant's law agents by letter dated 18 October 2013. He had been concerned that the original conclusions of the psychiatrists had not attached sufficient weight to her disordered personality. EUPD was an abnormality of mind which would have founded a plea of diminished responsibility. Dr Quinn was aware of the appellant's ingestion of alcohol and drugs, but she had not been noted as being intoxicated when detained or seen by the FME.

[65] Dr Quinn had produced a report dated 16 June 2014 in which he narrated the appellant's account of her childhood, adult relationships and the stabbing. The latter had not involving any planning, but had been an impulsive act in response to being attacked and prevented from escaping. Her recollection of the stabbing was "fuzzy". She had "snapped". Thereafter her memory was "blurry". Dr Quinn had not been aware of the appellant's account of getting and dropping the knife. He concluded that, in the context of emotional arousal, the appellant's EUPD would have led to a significant impairment of her ability to control her conduct. In cross, Dr Quinn modified "would" to "could". Her description of the act of killing was that of an impulsive act without clear and coherent thought. Her poor memory and recall were perhaps evidence of her high degree of emotional arousal. Despite the substances in her bloodstream, her actions were part linked to her personality disorder.

[66] Mrs Harris explained that she was a chartered psychologist with a speciality in trauma. She was an accredited risk assessor. She often looked at the effects of alcohol and drugs, although she had no training in pharmacology. Forensic clinical psychologists specialised in personality disorders. She was familiar with the neurobiology of trauma; how it acted on an individual's brain. Childhood trauma could cause functional changes. In 2008

not many psychiatrists had been trained in trauma. Things had not changed. Not many psychiatrists took into account the full effects of trauma; even if they had described that trauma in their reports.

[67] In her report of 4 March 2017, Mrs Harris had concluded that the appellant's severe history of complex trauma and dissociation would have impacted upon her ability to control her emotions and reactions on the night of the killing. She could have said "may" rather than "would" but, looking at the neurobiology, the appellant would have reacted to a trigger which reminded her of a traumatic event. The trigger was the inability to escape from the house. She had told Mrs Harris that she had had "flashes" of the event, but not a full memory. She said that she had lost control of her mind; she "wasn't there" that night. The appellant's brain had undergone functional changes. Her frontal cortex regulation did not work as it would in persons who had not experienced trauma. This could be vouched by neuro-imaging, although that had not been carried out in the appellant's case. Some people who were resilient would not experience this. In the appellant's case, the dissociative symptoms were quite clear.

[68] Mrs Harris had applied the SCID-D test for her supplementary report of 22 April 2017. She had reached the view that the appellant's ability to control her behaviour at the time would have been substantially impaired, as compared with a normal person. Mrs Harris was competent to express a view on the impact of intoxication. The appellant's use of substances would have had an impact, but her history of trauma would have had more of an impact. She had not consumed more than she would normally have done. The toxicology results of the samples taken at the time of her detention were negative for alcohol. Mrs Harris had understood that these samples had been taken at that time and that this was something which she had taken into account. On it being pointed out, during

cross-examination, that the samples had been taken some 12 hours after the appellant's detention, Mrs Harris said that this would not have affected her view. The police had said that she had not been intoxicated.

[69] Mrs Harris had not been aware, at the time of her reports, that the appellant had expressed a view that she had wanted to be rid of the deceased. Had she thought that the appellant was capable of planning things in detail, she would have been worried about that, but she did not think that she was. The trigger for the violence was not being able to get away from someone who was attacking her. It had been the effect of the EUPD rather than drunken violence. She had had a "lightbulb moment" involving flashes of all the men who had hurt her and her father. The appellant had had no memory of getting the knife. She had not told Mrs Harris that she had gone to get a knife from the kitchen.

Submissions

Appellant

Principal Issue

[70] The appellant submitted that the issue in the appeal was focused on her mental condition at the material time. The psychiatrists who had provided reports and given evidence at the time had misunderstood the law of diminished responsibility where intoxication interacted with a personality disorder. Thus Prof Thomson had revised her opinion in accordance with the law as it was now understood. The psychiatrists' misunderstanding had led them to adopt a flawed approach. It was accepted that the court did not know why the evidence of Prof Thomson had not been led at the trial.

[71] The absence of any reference to a misunderstanding on the part of the psychiatrists either in the SCCRC reference or the revised Note of Appeal should not hinder the court's

consideration of whether a miscarriage of justice had occurred. There had been a mishandling of the concept of diminished responsibility at the time of the trial. The defence had made a mistake, even if that did not amount to defective representation. There had been no inquiry at the time of the trial into whether the personality disorder had been a substantial cause of mental impairment at the time of the killing.

[72] The evidence of Mrs Harris was that the circumstances combined with the personality disorder operated as potential triggers at the material time. The appellant's reactions fell into a pattern, even if Mrs Harris did not say that the killing would not have happened in the absence of the ingestion of alcohol and drugs. The level of intoxication was not clear. The absence of the evidence of impairment skewed the picture for the jury. There was now evidence of that impairment. With the benefit of time, the nature of the interplay between the various factors was known. There was no reason to reject Mrs Harris's evidence. Trauma was a developing science, but there was no doubt that it had consequences.

[73] The charge in *HM Advocate* v *McLeod* (*supra*), which had been before the SCCRC and the SLC, could not be located. However, the law in Scotland should reflect that in England and Wales in *R* v *Dietschmann* [2003] 1 AC 1209 (at paras 30 and 41) and the SLC Report (*supra* at para 3.38). It was accepted that the appellant's representatives could have addressed the issue of mental impairment at the time of the trial. If it had been put before the jury, it would have been of material assistance to them. A verdict arrived at in the absence of the new evidence amounted to a miscarriage of justice.

Subsidiary Issues

[74] The appellant contended that, if psychiatrists gave evidence which was not medical,

but psychological, science, then a psychologist with special training, knowledge, qualifications and experience may be well placed to give evidence capable of displacing it. Psychiatrists required to study medicine and graduate with a general medical degree. That would be accompanied by clinical experience before specialisation. They were entitled to prescribe medication. They would have been trained in psychology, but it was only a component part of their knowledge and experience. An entry in the Royal College of Psychiatrists' website described psychiatry as using a diagnostic system to identify clusters of thoughts, feelings and behaviours (syndromes). These are investigated to find social, psychological and physical causes with a view to treatment. Psychology applies a more formal, experimental approach to exploring both normal and abnormal states of mind. Its emphasis is more on clarifying psychological mechanisms rather than physiological ones.

[75] Psychologists will have graduated with an arts or science degree in psychology. They may proceed to a masters before being accredited as chartered psychologists. They may specialise. They cannot prescribe. Both disciplines were able to assess and diagnose conditions which are constituted by behavioural abnormalities, feelings and thoughts. The court has accepted the competence of non-medical witnesses to provide evidence of an abnormality of mind which substantially impairs the ability of an accused (*Galbraith* v *HM Advocate* (*supra*) at para [54]). Conditions which are not diagnosed by any specific medical science, but by interview and assessment, are psychological conditions or disorders which are abnormalities of the mind not falling into the category of mental illness or disease *per se*. In this area, a jury would be entitled to prefer the evidence of a psychologist to that of a psychiatrist.

[76] In response to the court's request to be addressed on authorities from other jurisdictions, the appellant drew the court's attention to *R* v *Erskine* [2009] 2 Cr App R 29 in

which Lord Judge CJ, handing down the judgment of a court which included Thomas LJ and Treacy J, discouraged (at paras 63-75) the lengthy citation of authority in connection with the hearing of new evidence; a matter governed by statute. The authorities emphasised the fact specific nature of the test. Lord Judge continued (at para 76):

> "... [W]hen the advocate is considering what authority, if any, to cite for a proposition, only an authority which establishes the principle should be cited. Reference should not be made to authorities which do no more than either (a) illustrate the principle or (b) restate it."

[77] The case could be disposed of with a relatively brief consideration of authorities from other jurisdictions. It was competent to lead evidence of mental abnormality from psychologists (*Galbraith* v *HM Advocate* (*supra*) at para [53]; cf *R* v *Byrne* [1960] 2 QB 396 at 400 "specialists in psychological medicine"; *R* v *Dix* (1982) 74 Cr App R 306 at 311 "scientific evidence of a medical kind") although the jury did not have to accept it (*R* v *Byrne* (*supra*); *Walton* v *R* [1978] AC 788; *Sanders* v *R* (1991) 93 Cr App R 245). If the latter were true, it may be that medical evidence was not required at all (see *R* v *Dietschmann* (*supra*) at para 41). A psychologist may be competent to speak to the existence of an abnormality and whether it impaired the accused's functioning, even if the effects of alcohol and drugs may also be in play.

Crown

Principal Issue

[78] The advocate depute maintained that there was no reasonable explanation for any defence evidence relating to the appellant's mental state not having been heard at the trial (1995 Act s 106(3A); *Campbell* v *HM Advocate* 1998 SCCR 214 at 261, *Fraser* v *HM Advocate* 2008 SCCR 407 at para [131]). The Note of Appeal had contended that the reason, for the

testimony of Mrs Harris being regarded as new, was the development of this area of psychological understanding and diagnosis (see *D* v *HM Advocate* 2010 SLT 85 at para [34], *Reid* v *HM Advocate* 2013 SCCR 70 at para [15]). That was not the basis for the SCCRC reference. In so far as the appeal was based on an account given by the appellant which differed from that given by her at trial, there was no reasonable explanation for the appellant not giving that evidence in the first place. There was no reasonable explanation for the diagnosis reached by Mrs Harris not being made prior to trial.

[79] On the materiality of the evidence, the court had to be satisfied that the new evidence was: (a) capable of being regarded as credible and reliable; and (b) likely to have a material bearing on the determination of a critical issue at the trial (*Megrahi* v *HM Advocate* (*supra*) at para [219]). The SCCRC reference related only to the materiality of the evidence of Mrs Harris and Ms Murphy.

[80] There was no basis for the submission that the psychiatrists called by the Crown at the trial had misunderstood the law. If they had been wrong, the trial judge ought to have corrected them. He had not done so and there was no criticism of that. Their evidence had been that the alcohol and drugs had drowned out the effects of any personality disorder. They had given proper weight to the factors beyond intoxication. Standing the principle in relation to the voluntary ingestion of alcohol in *Brennan* v *HM Advocate* 1977 JC 38 (at 46), *R* v *Dietschmann* (*supra*) was of little assistance. Mental abnormality was not the same as brain damage.

[81] There were fundamental difficulties with accepting Mrs Harris's evidence. These had been commented on by the trial judge in his report on the appeal. First, she had not been provided with a transcription of either the appellant's police interview or her evidence at trial. The account given to Mrs Harris was that the appellant had a "lightbulb moment"

and became "somewhat different"; thus leading Mrs Harris to her conclusion that the appellant had been overwhelmed by her traumatic past. That was not what the appellant had said in evidence. When asked about the fatal incident, and specifically about her emotional or mental state, she had not mentioned past abuse. Mrs Harris's description of the appellant not being able to recall the event was also at odds with the appellant's testimony. The appellant could have given evidence in the appeal to the effect that what she had said at trial had been wrong, but she had not done so. Had Mrs Harris given evidence at the trial, much of what she had said would have been inadmissible, as not having a basis in fact.

[82] One curious feature of Mrs Harris's evidence was her inability to accept that information that she had been unaware of, such as the text message or the timing of the toxicology samples, could affect her view. Mrs Harris's evidence was based upon the appellant's account being truthful, but it had been rejected by the jury in their rejection of the plea of provocation. Contrary to Mrs Harris's report, the appellant had been able to make rational decisions at the time of the killing.

Subsidiary Issues

[83] In *Galbraith* v *HM Advocate* (*supra*) the court accepted (at para [53]) the possibility of evidence being given of a recognised abnormality caused by sexual or other abuse by "those, such as psychologists, having the appropriate professional expertise, even though they were not medically qualified". When it was proposed that diminished responsibility should become a statutory concept (Criminal Procedure (Scotland) Act 1995, s 51B) the Scottish Law Commission has referred to the need for "psychiatric evidence" as a necessary part of the proof (SLC Report (*supra*)).

[84] In England, after diminished responsibility had been introduced by the Homicide Act 1957 (s 2), an accused required to show that he had an abnormality of mind; that being a question for the jury (*R* v *Byrne* (*supra*) at 402-3) based upon "scientific evidence of a medical kind" (*R* v *Dix* (*supra*)at 311). As amended, the statutory definition referred to an abnormality of mental functioning which "arose from a recognised medical condition"; a matter of psychiatry (*R* v *Brennan* [2015] 1 WLR 2060 at paras 49 and 51; *R* v *Brown* [2012] 2 Cr App R (S) 27 at para [23]). The Law Commission (Report No. 304: *Murder Manslaughter and Infanticide* (2006)) had noted (at paras 5.110-114) that "abnormality of mind" was not a psychiatric term and that "recognised medical condition" was to be preferred (as it was by the Royal College of Psychiatrists) (cf *R* v *Dowds* [2012] 1 Cr App R 34 "acute intoxication").

[85] In Ireland, diminished responsibility had been introduced by the Criminal Law (Insanity) Act 2006 (s 6) which referred to a "mental disorder". The defence of insanity required evidence from a consultant psychiatrist (s 5(1) and this applied to diminished responsibility too (*DPP* v *Hefferman* [2015] IECA 310 at paras 94 and 95).

[86] Although unchallenged evidence from a psychologist may be admissible and sufficient to establish an abnormality of mind, it was hard to envisage how it could "displace" any psychiatric evidence. The latter would have a broader base of reasoning and thus carry greater weight, since the aim of a psychiatrist was to "integrate biological, psychological and social levels of explanation". Unless a psychologist could demonstrate sufficient knowledge of pharmacology, his evidence on the likely effect of alcohol and drugs as an underlying condition would be inadmissible (*Kennedy* v *Cordia (Services)* 2016 SC (UKSC) 59 at para [43]).

Decision

Principal Issue

[87] It is undoubtedly correct, as the appellant was anxious to emphasize, that, in any criminal appeal, the court is looking to see whether there has been a miscarriage of justice. The identification of that feature is the prime function of the appellate criminal courts. However, the court is not an inquisitorial one. It cannot, and does not, embark upon its task without the benefit of a structure in which the appellant and the respondent play their traditional adversarial roles within a set of principles and rules which control these roles and govern the scope of the court's powers

[88] The principles are set out in the primary statute; the Criminal Procedure (Scotland) Act 1995. Section 106(3)(a) enables the court to look outside the trial process by taking into account the existence and significance of evidence which was not heard at the trial; so called "fresh evidence". However, the court's ability to do this is circumscribed by a sub-principle (s 106(3A)), whereby there must be a reasonable explanation of why the new evidence was not heard during the trial. Were it to be otherwise, an accused could often frustrate the criminal process by the use of simple expedients. The first task of the court is to identify the new evidence which, it is contended, could have had a significance, had it been heard at first instance. The second is to determine whether there is a reasonable explanation for it not being adduced at the original trial.

[89] In relation to its first task, there is a further restriction stemming from the statutory and procedural rules which, notwithstanding the overall search for a miscarriage, bind the scope of the court's endeavours. The first stems from the nature of the Note of Appeal. The Note must contain "a full statement of all the grounds of appeal" (1995 Act, s 110(3)(b)). Except by leave of the court, on cause shown, it is not "competent for an appellant to found

upon any aspect of his appeal on a ground not contained in the note of appeal" (*ibid* s 110(4)). In an ordinary appeal, leave would be required in order to advance any ground contained in the Note. This is not applicable where there was been a reference from the SCCRC. In that event, however, the grounds must relate to one or more of the reasons for making the reference contained in the Commission's statement of reasons" (*ibid* s 194D(4A)). The court may grant leave for an appellant to found the appeal upon "additional grounds", but only if it is in the interests of justice to do so (*ibid* s 194D(4B)).

[90] There has been no application to found upon any matter falling outside the grounds of appeal stated in the Note. There has been no application to amend the Note by adding any additional grounds. This appeal is therefore confined to the grounds stated in the reference in so far as these are reflected in the Note of Appeal. The court understands that the new evidence is primarily that of Dawn Harris, although there is no significant distinction between the views of Mrs Harris and those of Prof Thomson.

[91] In relation to the second task, at the Procedural Hearing, the court specifically cautioned that, unless some reasonable explanation, based on evidence from the defence representatives at the trial, was advanced for the new evidence not having been adduced, the appellant may have difficulties in this part of the appeal (see *WB* v *HM Advocate* 2014 SCCR 376, LJC (Carloway), delivering the opinion of the court, at para [19]). By the time of the final hearing, the name of the trial solicitor advocate had been added, albeit without the authority of the court, to the appellant's list of witnesses. He was not called. The court does not have any explanation, far less a reasonable one, for medical or other evidence relating to diminished responsibility not being led at the trial. It has read and heard of some speculative theories about why, for example, Prof Thomson was not called. After all, Prof Thomson had reported that at least battered person syndrome (BPS) could be

considered to be a psychological condition which was "relevant to" diminished responsibility in terms of *Galbraith* v *HM Advocate* 2002 JC 1.

[92] *Galbraith* v *HM Advocate* (*supra*) was, and is, a very well known, if not somewhat controversial, authority, which would be at the forefront of any legal practitioner's thinking in a case of this nature where a woman, in an allegedly abusive relationship, had killed her partner. Although what some may regard as significant factors are not made clear in the law report, Mrs Galbraith had waited until her husband was asleep in bed at their home in Inveraray. In the early hours of one morning, she had taken the deceased's high powered deer rifle, activated it by inserting the bolt, loaded it and shot him through the head at close range. What was decided in the appeal was that the judge had misdirected the jury (see *infra*). The conviction for murder was quashed and a retrial ordered at which Mrs Galbraith's plea of guilty to culpable homicide on the grounds of diminished responsibility was accepted by the Crown. She was sentenced, after an appeal, to 8 years imprisonment. The court in *Galbraith* opened up the plea of diminished responsibility to a wide range of conditions (see *infra*). If evidence were led that an accused suffered from a "recognized [mental] abnormality caused by sexual or other abuse", the plea would be available.

[93] It has to be assumed that the appellant's defence representatives were aware of the relatively open parameters of the defence as set out in *Galbraith*. It would be astonishing if at least the solicitor advocate acting for the appellant, who was, and is, a very experienced criminal practitioner, was not aware of the impact of *Galbraith*. His speech to the jury, with its references to: past domestic abuse; the appellant finally "cracking" in the context of her emotionally unstable personality disorder (EUPD); and EUPD being a "recognized mental disorder", makes it clear that he was aware of the *dicta* in *Galbraith* and that it could have

founded a plea of diminished responsibility. He advanced that defence to the jury. The problem was that the judge decided that the evidence upon which he relied, notably Dr Lenihan's diagnosis of EUPD, was insufficient as a foundation.

[94] It seems probable that, had the appellant led Prof Thomson, there would have been sufficient evidence for the plea to go to the jury (*Galbraith* v *HM Advocate* (*supra*), para [41]). It would also have been open to the appellant to have instructed such other inquiries and experts, as she deemed fit, to support the plea. It may be that the precise nature of the evidence, and its use of general trauma, as distinct from more specific disorders, as a causative effect, would not have been exactly the same as it might be now, but it would not have been significantly different. Prof Thomson's view has not changed, other than in relation to her understanding of the legal test. Mrs Harris's opinion, had it been solicited at the time of the trial, would have been similar to, if not the same as, that which she advanced both at the time of her reports in 2017 and during the appeal hearing. There is no explanation given as to why that opinion, or one from other practitioners in the trauma field (eg the psychologists in *Galbraith* at para [7], who appear to share the same general views), was not obtained.

[95] In these circumstances, this appeal fails at the first hurdle; an absence of any explanation for the new evidence not having been adduced at trial.

[96] If the court had been satisfied that a reasonable explanation had been proffered, it would have required to go on to determine whether the new evidence was of such significance that the fact that it was not heard at the original trial must be regarded as a miscarriage of justice. As was said in *WB* v *HM Advocate* (*supra,* at para [20], following *Al Megrahi* v *HM Advocate* (*supra*) LJG (Cullen), at para [219]):

> "This means that the court must be satisfied that the evidence is capable of being regarded by a reasonable jury as credible and reliable. …If it is, then it must be of such a kind and quality that it was likely to have had a material bearing on the jury's consideration of a critical issue at the trial."

The critical issue is of course diminished responsibility. There is a question of whether Mrs Harris's evidence would have been admissible at all at trial, given the conflict (*infra*) between the content of the appellant's police interview and her testimony at trial, on the one hand, and the account which she gave many years later to Mrs Harris, on the other. Assuming that her evidence would have been admissible, the question is whether it could have been regarded by a reasonable jury as reliable. The answer to that is in the negative for several substantial reasons.

[97] First, Mrs Harris's opinion was formed in the absence of what were, on any view, certain critical pieces of information. The first was the text message, which the appellant sent to Mrs Burns prior to the killing. This amounted to a threat to kill the deceased if he did not leave. It was strongly indicative of a pre-meditated intention to kill the deceased in precisely the manner in which the killing was carried out. It conflicts directly with the notion that the appellant acted, as Mrs Harris concluded, "on impulse". Before any post trial opinion could be formed in relation to the appellant's mental state at the material time, this text would have to have been considered. Mrs Harris's view, that, had she known about the text, it would have made no difference because of Mrs Harris's views on the appellant's capability to plan in advance, is unconvincing. The fact, that she had been unaware of this text prior to her first two reports, significantly undermines the reliability of her testimony.

[98] Secondly, and related to the first since it would also have revealed its existence, at the time Mrs Harris formed her view on the appellant's mental state at the time, she had the benefit neither of the appellant's police interview nor her testimony at trial. Unless it were

to be contended, which it was not, that the appellant's testimony was in some way false, any post trial opinion on her mental state would have to have had regard to that account, and not one given several years later, as a material consideration. The appellant's versions are materially different.

[99] At the time of her interview, the appellant gave an account of: attempting unsuccessfully to leave the flat; being hit by the deceased; going into the kitchen and getting a knife; the deceased trying to wrestle the knife from her; the knife falling to the floor; picking the knife up; and stabbing the deceased four times, but aiming for his arms and legs rather than his heart. She did say that she had "flipped" and did not seem to be in control of her mind, but she had nevertheless remembered a considerable amount of detail. She gave evidence to a similar effect at the trial, but spoke of having "snapped" and being afraid for her own life. For what it might have been worth, she said that she had known what she was doing.

[100] This is in contrast to the account given to Mrs Harris, several years later, in 2017 when there was very little detail of events, other than experiencing a "lightbulb moment" involving flashes of all the men who had hurt her, and her father. These latter matters were factors which appear to have been of some importance in the eventual diagnosis and Mrs Harris's view that, at the material time, the appellant had lost control "in a moment of feeling overwhelmed". They are in contrast to what the appellant said both in her interview and at the trial.

[101] Thirdly, it is tolerably clear that the jury rejected the appellant's testimony to the extent that it tended to suggest that the deceased had provoked the attack. Indeed, they must have had no reasonable doubt about this. Had the jury believed the appellant, that she had been prevented from leaving the flat, had been attacked by the deceased by being rugby

tackled and held in a head lock, causing her to be in fear of her life, they would almost inevitably, especially against the background of past abusive relationships, have acquitted the appellant of murder and convicted her of culpable homicide by reason of provocation. The fact that they did not do so is instructive of the simple fact that the jury did not believe the essentials of the appellant's version of events.

[102] Fourthly, for Mrs Harris's testimony in relation to the effects of trauma to be regarded as reliable, it would have to have had an adequate foundation in fact. The foundation which it did have was, primarily, the account of events given to Mrs Harris by the appellant about her background. Mrs Harris focused in part on the effects of trauma experienced in the appellant's childhood. There is little doubt that the appellant had a difficult childhood; with a mentally disturbed mother and an alcoholic father. However, there was no evidence at trial of any substantial sexual or physical abuse at the hands of her parents or others during her childhood. It is remarkable that the appellant's brother, who gave evidence, was not asked about the appellant's childhood or the existence of any such abuse. The appellant's childhood was, tragically, not dissimilar to that of many persons who, with a normal degree of resilience, mature into responsible adults with no significant mental abnormality. There does not appear to be any dispute that the appellant became involved in abusive relationships, but the evidence about the nature of that with the deceased is, at best for the appellant, mixed. There is no substantial evidence that, at the material time, the appellant was in a relationship characterised by regular physical or sexual abuse on the part of the deceased. Rather, as the trial judge put it, the violence was "on both sides".

[103] Fifthly, Mrs Harris took into account the absence of alcohol in the appellant's bloodstream at what she thought was the point of the appellant's detention; ie upon her

arrival at the police station shortly after midnight. As has already been noted, her blood samples were not taken until more than 12 hours later. When this matter was put to her, Mrs Harris said that it would not have made any difference to her conclusions. This is unconvincing. The level of alcohol in the appellant's system at the material time had to be an important factor in any conclusion that the psychiatrists, who had given evidence at the trial, were wrong in their view that the alcohol had outweighed the effects of any personality disorder. A finding that, within two or three hours of the event, the appellant was entirely alcohol free would have been a very significant factor pointing to the inaccuracy of the psychiatrists' conclusions. The fact that she was free of alcohol 14 or 15 hours later would have been broadly neutral.

[104] The view of Mrs Harris, that the effects of the combination of alcohol and drugs on the appellant would have been limited because she said she was taking no more, and possibly less, than she normally did, is neither supported by the evidence nor does it coincide with the not inconsiderable experience of the court in dealing with the violent effects of the combination of alcohol with, as in this case, a cocktail of prescribed and non-prescribed drugs including, most notably, amphetamine. Although some of her neighbours, who saw the appellant before and after the incident, did not consider that the appellant had been adversely affected by alcohol or drugs, this was not the universal view. The opinion of the appellant's brother is significant in this context, even if he was speaking on the basis of a telephone conversation with the appellant. If it is assumed that the appellant was telling the truth about her alcohol and drug consumption, she had had a significant amount of alcohol in combination with amphetamine and diazepam. Once more, even if the police did not consider her to be substantially impaired when she was detained at or around midnight, the effects of this combination must have been significant. The two forensic psychiatrists, one of

whom had seen the appellant on 5 June, considered that to be the case. Their expertise in this area is not in doubt. Having regard to the court's conclusions on the reliability of Mrs Harris's evidence on this aspect, it is not persuaded that her testimony would have affected the jury's consideration of the views of Drs Lenihan and Morris that any contributory element of the appellant's personality would have been outweighed by the effects of drink and drugs.

[105] The court does not consider, in this context, that there is any basis for assuming that the two psychiatrists, who saw the appellant in the aftermath of the killing, misunderstood the law in relation to diminished responsibility. This is not, of course, a ground of appeal, nor is the judge's decision to withdraw the plea, which was based upon their testimony. Even if it had been, it could not have succeeded. The law remains that stated in *Galbraith* v *HM Advocate* (*supra*). The abnormality of mind has to have substantially impaired "the ability of the accused, as compared to a normal person, to determine or control his acts". However, "no mental abnormality, short of insanity, which is brought on by the accused… taking drink or drugs… will found a plea of diminished responsibility" (*ibid* para [54]). This test means, first, that the abnormality has to be a substantial cause of the impairment. No doubt, in terms of the elusive charge said to have been given in *HM Advocate* v *McLeod*, 24 October 2002, High Court of Justiciary, Forfar, unreported (SLC Report (no 195; *Insanity and Diminished Responsibility* (2004)) para 3.38, fn 44), looked at in abstract or in theory, it need not be the only cause of the impairment. The test also means, secondly, that the impairment must not be brought on by the voluntary ingestion of drink or drugs. In that regard, the court endorses the terms of the model charge set out for juries in England and Wales by the House of Lords in *R* v *Dietschmann* [2003] 1 AC 1209 (Lord Hutton at para 41):

> "Drink cannot be taken into account as something which contributed to … any impairment of mental responsibility arising from [his mental] abnormality. …[Y]ou may take the view that both the defendant's abnormality and drink played a part in impairing his mental responsibility for the killing and that he might not have killed if he had not taken drink. If you take that view, then the question for you to decide is this: has the defendant satisfied you that, despite the drink, his mental abnormality substantially impaired his mental responsibility for his fatal acts…".

[106] This is consistent with the policy considerations explored in *Brennan* v *HM Advocate* 1977 JC 38 in which the Lord Justice General (Emslie), delivering the opinion of the full bench, said (at 46):

> "… [A] person who voluntarily and deliberately consumes known intoxicants, including drink or drugs, of whatever quantity, for their intoxicating effects, whether there effects are fully foreseen or not, cannot rely on the resulting intoxication as the foundation of a special defence of insanity at the time nor, indeed, can he plead diminished responsibility."

If the jury considers that an accused's personality disorder is nevertheless an operative (ie substantial) cause of his or her actions, the plea of diminished responsibility remains available.

[107] This was the approach taken by Drs Lenihan and Morris, in concluding that the effects of the substantial quantities of drink, in-mixed with the cocktail of drugs, outweighed the effects of the appellant's personality disorder. In short, if drink is taken out of the equation, the appellant's personality disorder would not have had the effect of substantially impairing her ability, as compared to a normal person, to determine or control her acts.

[108] Sixthly, the court has difficulty with the idea that the evidence of a psychologist, based upon interviews with the appellant almost ten years after the event, has a significant potential to undermine the views of the psychiatrists who saw the appellant in the days after the event. In determining the effects of trauma on the appellant's mental state now, a major factor might have been thought to be that most traumatic event in the appellant's life; her

killing of her partner by multiple stab wounds on the day of her father's funeral. This event does not appear to have been at the forefront of Mrs Harris's reasoning.

[109] In these circumstances, and without criticising Mrs Harris's good faith or expertise, the court is not persuaded that her evidence in relation to the appellant's mental state at the material time was capable of being regarded as reliable or that, even if it were, it was likely to have had a material bearing on the issue of diminished responsibility. The evidence of Ms Murphy does not add anything to the general equation. The court does not consider that a miscarriage of justice has occurred because the jury did not have the benefit of the testimony of either Mrs Harris or Ms Murphy.

Subsidiary Issues

[110] In *Galbraith* v *HM Advocate* (*supra*) a Full Bench reconsidered and redefined diminished responsibility as requiring evidence that "the accused was suffering from an *abnormality of mind* which substantially impaired the ability of the accused, as compared with a normal person, to determine or control his acts" [emphasis added] (LJG (Rodger) delivering the Opinion of the Court, at para [54]). It is very important to note the context of *Galbraith* and to understand what it decided and what is *obiter dicta*. In relation to context, the Crown did not lead any psychiatric or psychological evidence at the original trial. The Crown's position was that the abuse, which the appellant said that she had suffered at the hands of the deceased, was a fiction. There was therefore no basis in fact for a plea of diminished responsibility.

[111] The testimony, regarding the appellant's abnormality of mind, had been given partly by two defence psychologists. Neither was medically qualified. The first had said that the appellant had suffered from a form of PTSD, which had overwhelmed and fragmented her

ability to think clearly or rationally at the material time. The second had said that the appellant had been in a state of "learned helplessness". Medical evidence was led by the defence from Dr Thomas White. Although it may not be clear from the Opinion, he is a well-respected forensic psychiatrist. He said that:

> "the extent of [the appellant's] mood disturbance would not normally justify a report favouring diminished responsibility but, looking at the totality of the case, and looking at the absence of other factors and the absence of previous instability ... this would weigh the evidence in favour of diminished responsibility."

Dr White had spoken to the appellant's depression which was, as the trial judge directed the jury, a mental disease or illness, upon which the plea might be sustained.

[112] In directing the jury, the trial judge had followed the guidance in *Connelly* v *HM Advocate* 1990 JC 349 that, for the plea to be made out, there had to be evidence of a "mental disease". The court in *Galbraith* v *HM Advocate* (*supra*) held that this was a misdirection; *Connelly* having proceeded upon a misunderstanding of the Lord Justice Clerk's (Alness) charge to the jury in *HM Advocate* v *Savage* 1923 JC 49. It was on this basis, which had been conceded by the Solicitor General, that the conviction was quashed. That is the ratio of *Galbraith*. What follows is *obiter dicta*, albeit from a highly persuasive source, arrived at in the absence of argument, and, in particular, a contradictor.

[113] In delivering the Opinion of the Court in *Galbraith* v *HM Advocate* (*supra*), the Lord Justice General (Rodger) recognised that diminished responsibility was a legal concept, and not a medical one:

> "[41] ... [I]t is not the function of the witnesses lay, psychological medical or psychiatric, to say whether an accused's responsibility can properly be regarded as diminished. Rather they give evidence as to the accused's mental state. It is then for the judge to decide whether, at its highest, this evidence discloses a basis upon which the law could regard the accused's responsibility as being diminished."

He referred (at para [51]) to the possibility of the abnormality taking "a number of forms", whereby there was something "far wrong" with the accused, but heightened emotions or failings would not suffice. The abnormality could (para [52]) spring from a variety of causes, including the external. He continued:

> "... we can see no reason in principle why a recognised abnormality caused by sexual or other abuse inflicted on the accused might not also be relevant for the same purpose.
>
> ... [T]he abuse must result in some recognised mental abnormality. Subject to that important qualification we again see no reason in principle why evidence of such a condition could not be given by those, such as psychologists, having the appropriate professional expertise, even though they were not medically qualified."

[114] This leaves a number of unanswered questions. First, although the evidence of a psychologist (or indeed a lay person, according to *Galbraith* v *HM Advocate* (*supra*)) may be admissible in order to demonstrate to the jury that an accused suffers from a recognised disorder, can there be a sufficiency of evidence of a "mental abnormality" in the absence of any medical evidence? If there is medical evidence, in the form of a psychiatric opinion, that an accused did not suffer from a mental abnormality, or at least not from one that was not self-induced, can that evidence be contradicted and discounted on the basis of psychological or other testimony? In a case where the effects of long and short term alcohol and drug abuse are in play, is a psychologist qualified to give opinion evidence on these effects and their interaction with other mind altering factors?

[115] The answers to these questions may require to await a suitable case for determination. In light of the court's decision in this case, the general import of psychological evidence, in contrast to the psychiatric, does not require to be definitively determined. The *dicta* in *Galbraith* v *HM Advocate* (*supra*) creates a wide window for the introduction of testimony from many professional disciplines, and even from lay witnesses,

on the mental state of an accused at the time of the incident under consideration; leaving it to the jury to answer the ultimate question of whether the accused's mental responsibility had been diminished. However, at least in relation to opinion evidence from whatever discipline, it remains important that the court ensures that the witnesses, who are called to speak to the state of the accused's mind and its effect on his actions, have the appropriate qualifications, by training and experience, to give expert evidence (*Kennedy* v *Cordia (Services)* 2016 SC (UKSC) 59, Lords Reed and Hodge at para [42] following *R* v *Bonython* (1984) 38 SASR 45, King CJ at 46-47).

[116] At the time of the appellant's trial, the common law test for diminished responsibility, as modified in *Galbraith* v *HM Advocate* (*supra* at para [54]), bears repeating. It was whether the accused "was suffering from an abnormality of mind which substantially impaired the ability of the accused, as compared with a normal person, to determine and control his acts… The abnormality must be one that is recognised by the appropriate science". The test is now contained in section 51B of the Criminal Procedure (Scotland) Act 1995, which followed upon the SLC Report (*supra*). It is that the accused's "ability to determine or control conduct… was… substantially impaired by reason of abnormality of mind". Although such an abnormality includes a mental disorder, it is not expressly confined to such a disorder. A mental disorder includes a personality disorder (Mental Health (Care and Treatment) (Scotland) Act 2003 s 328(1)(b)). It is assumed that the abnormality must be a recognised one in terms of *Galbraith*, notwithstanding the absence of any statutory provision to that effect (see SLC Report (*supra*) para 3.15). There would thus, at least, have to be opinion evidence from a skilled witness that the accused suffered from such an abnormality. This leaves a question as to the nature of the expert's skills; whether medical, such as psychiatric, or other, including clinical psychological analysis.

[117] The SLC (Report (*supra*) at para 3.26) were of the view that "Psychiatric evidence is a necessary part of the proof in any criminal trial where some form of mental abnormality is in issue". That has been the court's understanding of the practice, at least in the vast majority of cases, even if the *dicta* in *Galbraith* v *HM Advocate* (*supra*) contains suggestions that it may not be an absolute requirement. The court was appreciative of the appellant's reference to Lord Judge CJ's strictures on the lengthy citation of authority in criminal appeals (*R* v *Erskine* [2009] 2 Cr App R 29 (at paras 63-76). It is happy to endorse the view that only authorities which establish a principle, as distinct from illustrating or restating it, should normally be cited. This should not, however, restrict parties from citing authorities from other jurisdictions, which state the principle applicable elsewhere, where the court has specifically requested that citation.

[118] In England and Wales, where the introduction of diminished responsibility in the Homicide Act 1957, was heavily influenced by the Scots experience, the definition (s 2) also involved a abnormality of mind. Medical evidence of some description, but not necessarily psychiatric opinion, seems to have been the norm, at least initially. Thus in *R* v *Byrne* [1960] 2 QB 396, the evidence was given by "Three medical witnesses… the senior medical officer… and two specialists in psychological medicine" (Lord Parker CJ at 400). They described the appellant as a sexual psychopath "as indeed was abundantly clear from the other evidence in the case" (*ibid*). The witnesses were all doctors. Their evidence was described as "medical", but none of them was described as a psychiatrist. Lord Parker referred (at 403) to the importance of the medical evidence, even if the jury were entitled to take into account all the evidence and could reject that of the doctors. Nevertheless, "The aetiology of the abnormality of mind… does… seem to be a matter to be determined on expert evidence". In *R* v *Dix* ((1982) 74 Cr App R 306), Shaw LJ, delivering the judgment of

the court (at 311), referred to the need for "scientific evidence of a medical kind", which he derived from Lord Parker in *Byrne* (*supra*). "Medical evidence", although not required by the statute, was a "practical necessity". In so saying, he endorsed the trial judge's view (at 310) that whether an accused was suffering from an abnormality of mind was a matter for "medical evidence".

[119] The 1957 Act was amended in 2009 so that the definition of diminished responsibility included the existence of "an abnormality of mental functioning which – (a) arose from a recognised medical condition, (b) substantially impaired [the accused's] ability to" understand his conduct, form a rational judgment or exercise self control. In *R* v *Brennan* [2015] 1 WLR 2060 the one purpose of the new wording was said (at para 49) to be "to ensure 'a greater equilibrium between the law and medical science'. The new wording gives significantly more scope to the importance of expert psychiatric evidence". Davis LJ, delivering the judgement of the court, continued (at para 51):

> "… most, if not all, of the aspects of the new provisions relate entirely to psychiatric matters. …[I]t is both legitimate and helpful… for an expert psychiatrist to include in his or her evidence a view …including a view as to whether there was substantial impairment. As Professor Ormerod explains in his paper: 'Since the question of whether there is impairment of ability is a purely psychiatric question, it would also seem appropriate for the expert to offer an opinion of whether there is substantial impairment'".

[120] In Ireland, the Criminal Law (Insanity) Act 2006, which introduced diminished responsibility again using the Scots principle, refers (s 6) to a "mental disorder". The Act provides (s 5) that, in relation to such a disorder, evidence requires to come from a "consultant psychiatrist". This provision was held to apply to diminished responsibility as it did to the defence of insanity (*DPP* v *Heffferman* [2015] IECA 310, Edwards J, delivering the judgment at paras 94-95, upheld [2017] IESC 5).

[121] In South Africa, diminished responsibility applies to all criminal offences and, if established, is taken into account in sentencing (Criminal Procedure Act 51 of 1977, s 78(7)). The court itself can make the relevant inquiries and may do so, in serious cases, by requesting a report from a panel of at least two psychiatrists, with, following an amendment to the legislation in 1998, the possibility of the panel being joined by a clinical psychologist (s 79). The inclusion of a clinical psychologist is at the court's discretion. In other cases, the report requires to come from a psychiatrist.

[122] In Australia, in some of the states and territories where diminished responsibility operates in relation to murder, there is an interesting specific statutory prohibition on an expert expressing an opinion on whether an abnormality of mind so impaired the accused as to warrant a reduction of a charge to manslaughter. Medical evidence of the existence of the abnormality is still required. The problem of disagreements arising between psychiatrists and psychologists was raised in a review carried out by the New South Wales Law Commission in 1997, but this did not lead to any specific statutory provision. In Queensland, the question of whether a murder accused, who has carried out the killing, was suffering from diminished responsibility can be referred to the Mental Health Court (Mental Health Act 2016 s 21). The Court consists of a judge and two clinicians, who may be either psychiatrists or persons with expertise in the care of persons who have an intellectual disability. At present the panel consists only of psychiatrists.

[123] In some jurisdictions, then, there is a clear requirement for the relevant evidence of mental abnormality to be given by a psychiatrist. In others, it may be given by a clinical psychologist. At present in Scotland, provided that the test in *Kennedy* v *Cordia (Services)* (*supra*) is met, there is no prohibition on persons, who are not psychiatrists (ie not having a formal medical degree), expressing an opinion on whether a person suffers from an

abnormality of mind and whether this was present at the time of a relevant incident. There may be great value in hearing testimony from a clinical psychologist on, for example, whether an accused suffers from a recognised personality disorder, especially if clinical tests, accepted as valid by the profession, support that conclusion.

[124] In terms of *Galbraith* v *HM Advocate* (*supra*), evidence from psychologists was regarded as admissible, even if the matter was not the subject of debate, for the purpose of establishing more than just a diagnosis of personality disorder but the impact of the abnormality on the accused at the time of the incident. It is for the court to determine, following *Kennedy* v *Cordia (Services)* (*supra*), whether a particular clinical psychologist has the appropriate qualifications, by training and experience, to give evidence on such matters, which are otherwise generally within the expert province of the consultant forensic psychiatrist. In that regard, although a clinical psychologist may well be able to diagnose a personality disorder, it might be a different matter if the psychologist is being asked to give evidence about the interaction of alcohol, and more especially certain drugs, with the disorder. The same may apply where the psychologist purports to speak, as Mrs Harris did, to organic changes, which have not been vouched by scanning, in a person's brain. It may be that the SLC, in its current review of the law of homicide (see Tenth Programme of Law Reform (February 2018)), can give consideration to this matter and make appropriate recommendations on the qualifications which should be demanded by the court before a witness is asked to give evidence on what can be a very important matter in the context of a murder trial.