A CASE OF MURDER BY A SEVERELY MENTALLY DISORDERED YOUNG PERSON, SYSTEMIC FAILURES, THE PROBLEMS CAUSED WHERE A DEFENDANT WHO SUFFERS DIMINISHED RESPONSIBILITY DOES NOT ACCEPT THAT HE KILLED THE VICTIM AND WHAT HAPPENS WHEN A JUROR WHO IS SO DISTRAUGHT AT THE EVIDENCE SEEKS SUPPORT.

I**NTRODUCTION**

1. RICHARD BARRACLOUGH KC leading MAX REEVES recently represented a young man who murdered his mother by stabbing her in the neck. He killed her at home in front of his brother. Four psychiatrists agreed that his responsibility was diminished. A plea to diminished was acceptable. The problem was that D did not accept that he had killed her despite a jury having found that he did the act when he had been unfit to plea. Now that he was (just about) fit to plead he was brought back to court to be tried for the murder of his mother.

2. The four psychiatrists all eminent in their field were instructed both by the Prosecution and the Defence. They all agreed that if D did kill his mother intending either to kill her or at least do her serious harm then he was not guilty of murder but rather of manslaughter because of the mental disorder which prevented him from being rational and controlling himself and thus substantially impairing his responsibility for what he did. The jury were so directed and returned a verdict of not guilty of murder but guilty of manslaughter.

THE MENTAL CONDITION

3. F25.0 Schizoaffective disorder, manic type is described by the ICD-10 as follows:

    a) A disorder in which schizophrenic and manic symptoms are both prominent in the same episode of illness.
    b) The abnormality of mood usually takes the form of elation, accompanied by increased self-esteem and grandiose ideas, but sometimes excitement or irritability are more obvious and accompanied by aggressive behaviour and persecutory ideas.
    c) In both cases there is increased energy, overactivity, impaired concentration, and a loss of normal social inhibition.
    d) Delusions of reference, grandeur, or persecution may be present, but other more typically schizophrenic symptoms are required to establish the diagnosis. People may insist, for example, that their thoughts are being broadcast or interfered with, or that alien forces are trying to control them, or they may report hearing voices of varied kinds or express bizarre delusional ideas that are not merely grandiose or persecutory. Careful questioning is often required to establish that an individual really is experiencing these morbid phenomena, and not merely joking or talking in metaphors.

4. Schizoaffective disorders, manic type, are usually florid psychoses with an acute onset; although behaviour is often grossly disturbed, full recovery generally occurs within a few weeks.

5. To better understand '*schizophrenic symptoms'* (ICD-10) one of the consultants described:

    a) "The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect. The disturbance involves the most basic functions that give the normal person a feeling of individuality, uniqueness, and self-direction.

    b) Perplexity is also common early on and frequently leads to a belief that everyday situations possess a special, usually sinister, meaning intended uniquely for the individual.

c) *In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the fore and utilized in place of those that are relevant and appropriate to the situation. Thus, thinking becomes vague, elliptical, and obscure, and its expression in speech sometimes incomprehensible.*

d) *Mood is characteristically shallow, capricious, or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism, or stupor.*

e) *Characteristic symptoms may include:*

A. *Thought echo, thought insertion or withdrawal, and thought broadcasting;*

B. *Delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;*

C. *Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;*

D. *Persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);*

E. *Persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;*

F. *Breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;*

G. *Catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;*

H. *"Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;*

I. *A significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal."*

6. Another eminent psychiatrist has elsewhere described the condition in the following way:

"*The prevalence rate for Schizophrenia is approximately 1.1% of the population over the age of 18. This disorder is characterised by fundamental and characteristic distortions of thinking and perception, with inappropriate or blunted affect. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time. Further characteristic symptoms include a disturbance of the most basic functions that give the normal person a feeling of individuality, uniqueness, and self-direction. The most intimate thoughts, feelings, and acts are often felt to be known to or shared by others, and explanatory delusions may develop that are often bizarre. Hallucinations, especially auditory, are common and may comment on the individual's behaviour or thoughts. A wide variation occurs in the course of Schizophrenia. Some people have psychotic episodes of illness lasting weeks or months with full remission of their symptoms between each episode; others have a fluctuating course in which symptoms are continuous but rise and fall in intensity; others have relatively little variation in the symptoms of their illness over time. In terms of cognitive functioning/memory, in general, memory remains intact for individuals with this disorder,*

including memories of psychotic experiences which often remain ingrained in the patient's experience even when they are relatively well, making reference to such experiences actually happening as it appeared real to them at the time. Patients with Schizophrenia tend to have what is known as a relapse signature in that the symptoms they initially present with, in terms of the content of their psychotic beliefs, tend to persist. So, if an individual recovers from their illness and becomes essentially symptom-free, when they relapse again similar, if not identical, delusional beliefs re-emerge in terms of themes, which will often become more developed over time. This relapse pattern is a key element in terms of risk management for the individual."

7. D was a proven risk to his mother. He was first old "*sectioned*" as having paranoid schizophrenia when he was 16 years. There followed some 12 further "*sections*" under Mental Health Act Section 3. He was reported to be aggressive to his mother. He spoke of films as if he was involved in some computer game. He experienced being spoken to through television and other appliances.

8. On 2 December 2016 it was reported that D was detained by the police under Section 136 of the Mental Health Act after he had assaulted his mother by grabbing her around the throat accusing her of not being his "*real mother."* When the police arrived, he was apparently saying the police were Germans and that he was a soldier. On arrival to the 136 suite D reported that his mother had been "*replaced"* and there were dead bodies in the wall.

9. The mother was reported to be afraid for her life. It was concluded that he posed high risks towards her. There came a time when he was not permitted to live with her. Despite that he was treated in the community but was reluctant to take his medication and in particular the depot.

PSYCHIATRIC OPINION RE DIMINISHED

10. D was very ill. More seriously ill than the consultant psychiatrist who cared for him on the acute ward for a number of years had experienced.

11. One psychiatrist opined that D "*continued to hold delusional beliefs around the nature of the index offence and the identity of his mother. He remained fixated on the idea that he did not kill his mother and repeatedly wished to speak to his mother".*

12. Another said that he, "*had formed an extended delusional belief system about his biological mother, and, due to his ongoing psychosis, believed that he was acting on the instructions of his mother to relieve her of the pain that she was experiencing at the time*."

13. D told another psychiatrist that he believed that his mother was being tortured and was not disclosing this to anyone. He said that he wanted to put her out of her misery, saying, *"no one has to live like slaves, she had no teeth, she was incontinent…I know the crime scene as I watch TV but the wound I gave her was not fatal…".*

14. When on the acute ward where he remained for a number of years his views of what happened had fluctuated '*for example he has stated that he has not killed his mother and wishes to speak to her. At other times he has stated that he killed his mother to get her out of her misery on other occasions he has stated that she was a 'rubber' and therefore could not die*'.

15. To another psychiatrist he said that his mother was an *"imposter, she was petrified she was in pain…put her out of her misery… stabbed her…..she would have thanked me for it (releasing the imposter)…she doesn't seem happy to me (pretending to be his mother)…I didn't think it was fatal…I think my mum is at home…waiting for me to get better…I have memories of seeing her replaced when I was 15 or 16…I don't know if she is dead or not"*

16. And so he was suffering from a severe and enduring mental illness at the time of the killing. In this deeply distressing and delusional state, he was likely convinced beyond any doubt that the victim, was indeed not his mother but an impostor.

17. There was evidence of more psychotic symptoms and beliefs when he told police officers that he had ripped a cable from the wall of his mother's house which was evidence, in his mind of why he did the killing - evidence which was only comprehensible in his psychotic mind.

18. It was not until the inquest and seeing post mortem images that he got any closer to accepting that his mother was dead. Nevertheless, he maintained that he had not killed her. He stated that when he had left the house his mother was still alive.

19. He had developed an extended delusional belief system involving his own identity (he believed he was a boy who had been kidnapped in Greece many years ago), his family being persecuted and tortured by an organisation he called OCG and around his mother being an imposter. When acutely unwell, he had expressed on several occasions that his mother was not his real mother, and he was not her biological son.

20. The psychiatrists on the unit commented: *"The team had also held a view that the denial likely serves an important protective psychological function for D protecting him from a painful reality that is too difficult for him to confront".*

THE EVIDENCE OF D's CONDITION FROM THE FAMILY'S POINT OF VIEW

21. The brother gave evidence that when D was sectioned, his mother and family visited him. His mother always tried to help him and been understanding of his mental health problems. For his part the brother loved him as a brother. He tried to introduce him to his gym. His aunt gave evidence that he was admitted to hospital "*loads of times*" (it was at least 11 times). It was a *"regular pattern of behaviour over the years*". At Christmas 2018 he had his hands round his mother's neck/throat. He was again "*sectioned".* There were then meetings with nurses and psychiatrists. He was not allowed to live at home. His behaviour was too volatile. He still contacted his mother and she would visit him to try to help him. She would try to do her best for him. His mother was described as *"a good person….a good neighbour…very pleasant and very kind".*

22. The aunt gave evidence about D's behaviour before the killing. A couple of months before, he had told her that his medication was coming to an end. She was concerned because he was "*really unwell"* and needed help. They should not stop the depot. "*He went mental. Shouting at them. Out of the blue and no warning. Nothing seemed to prompt the outburst".* He shouted *"know your place woman what have you done - you've ruined my life. Who is this doctor. He's not even a real doctor. He doesn't even know me. I'm going to be doing life. This is my life from now on. Throw away the key."* Three days later he was telling them that someone had come into his flat. "*Out of nowhere he started shouting "I know how to stab someone…I know how to cause maximum damage…..stick it in and twist…I'm gonna be doing life.."*

THE DAY OF THE KILLING

23. On the day of his mother's death his behaviour was again evidenced by the family. He was telling his family that he had a rat in his flat and wanted to move back home but he was not permitted because he was a danger to his mother.

24. Again, on the day of the killing *"he was squeezing hand gel and rubbing his face and hair. He was acting in a strange way…"* The family took him shopping. When they got outside a shop he was standing at a wall and touching holes. He was flicking a coin on the ground. At home he was examining his mother's photos and ornaments. He filled a kettle and came back with a packet of crisps which he crushed. His cousin didn't like what he was doing; she was on edge. She asked the mother not to leave her. That behaviour flowed through not only to what happened to his mother and what he said to his brother when he said "*she's not real….there's nothing you can do"* but also what he did afterwards. His movements were captured by CCTV as he left the home and walked away. He smeared blood on a lamppost. He wrote his mother's name in blood on a garage window. He smeared his name on a

yellow line. He was bending down to the pavement pointing and talking to himself. He was wearing one trainer when arrested. He lost a sock. He rang the emergency services. The whole thing unfolded as a film in which he was an actor. He talked about sexual orientation and gender. He said *"I'm bleeding everyone's bleeding…I'm just chilling".*

25. To the police he listed members of his family, his mother, his dead father. He said he had a girlfriend who shot him in the head with an assault gun. He would wait for a "*real police car".* He wanted a "*concrete ETA*", referring to the police car and asked "y*ou reckon they'll hurt me these policemen?*" He was, he said "*trying to protect my family….I just want a trial to be honest get some justice and peace…..please don't let them take me to the nut…..hospital…take me west towards Wales or they could take me north towards Scotland or south towards Africa*".

26. The police officers acted with enormous understanding despite the horror of what had happened. He had blood on his jogging bottoms, his jacket and bare chest, face, mouth and hair where he kept running his fingers. An officer said, *"He would be talking incomprehensible nonsense a lot of the time and lacked understanding of explanations by appearing blank in expression or replying in nonsensical terms. When talking to him he would become distracted and ramble about something unrelated or become distant".*

27. In the ambulance he was saying "*can I go to my mum quick*". He was asked to keep calm as he started to become irate. The officer decided not to handcuff him; he believed that he could keep him calm enough. It was as if a film: "*soldier innit yeah soldier*". When told about what he had done he exclaimed *"I grew up in London…I love my mum and I love my dad. And I love my brother. I love them man. I had to do what I had to do…I attempted to murder her…you're soldiers…army".* When told that he was bleeding (he had taken hold of the knife by its blade as he struggled with his brother) "I *don't know your training. I'm just being careful lads….I might give up smoking today…I beg you don't let them take me to the mental health place".* When in the ambulance *"Can I just check on my mum"* but when asked about the knife *"I used it to cut my mums throat".* The paramedics noted *"He had a lot to say but nothing about what happened…He also made a comment regarding his mum and step mum and that he had done it to his step mum but wouldn't do it to his real mum….He looked as if he was looking straight through us and appeared vacant". A*s to what he did, "*I slashed my mums throat…I meant to do it*".

28. At the hospital *"I'll know the truth whether she is my mum or not… I know my mum…she aint my mum…she is under the thumb…I murdered my mum today….she wasn't actually my mum. I have a mum and a mother She was just there…I want to see the body of my mum - where's the blood and actual evidence…something in me wanted to batter her to death…she couldn't do it herself so I did it for her, I gave her her wish…she lived it…I felt she was going to kill me…Am I going to see the autopsy…am I going to see my mum…am I going to see what I have done…I'd love her if she was my mum…I love my mum…I got two mums a mum and a mother…it's not her fault…she's a soldier…she wanted to go…I was hurting…she was hurting*".

29. When in the police station *"I want to see the body of my mum…that was the plan. something in me wanted to batter her to death".* An officer spoke of *"other unintelligible words that I could not understand or hear properly as he said it almost under his breath…he continued to speak to himself almost as if he was speaking to another person who wasn't there".* But then *"She couldn't do it herself so I did it for her. I gave her her wish…this hand had nothing to do with it….this does…Soldiers, soldiers. this has nothing to do with it, this hand. but this hand…..this bit here…"*. When charged with murdering his mother he replied "*that's not her name by the way*"

THE INQUEST

30. Following an inquest hearing on 17.4. 2023 the Coroner found as *Medical cause of death as 1a Stab Wound to The Neck"* The conclusion of the Coroner as to the death was:

"Unlawful killing. (The mother) *was killed by a person who was known to her. That person had an established history of mental health problems and had been identified as posing a risk to* (her) *previously. Following the person's discharge from his hospital, he was subject to a community treatment order. There was a failure to properly manage that community treatment order, those caring for the person in the community did not have adequate experience in managing the risks that the person posed, nor were they always aware of the existence of the community treatment order or the terms of it. At times, the titration of the person's medication was aimed at satisfying his wishes and feelings rather than his actual treatment needs and this led to the medication being reduced which increased the risk of harm to others. Despite showing significant signs of relapse throughout 2019, there was a failure to properly consider how the risk to the public should be managed and no significant consideration as to the impact this had on the person's risk. Policies that were in place to manage non-concordance with his treating team were not followed and the need to safeguard (the mother) from these risks was not appreciated. The failure to properly manage and deliver the person's treatment in the community was ultimately causative of (her) death"*

CAN D RAISE DIMINISHED IF THEY PLEAD NOT GUILTY

31. The first issue was whether a defendant is able to raise diminished if they do not accept that otherwise they had murdered the victim. It has been suggested that, unless they do admit murder, "*diminished"* is not available. That is plainly wrong. There are many cases where for whatever reason a defendant cannot bring themselves to accept that they have killed because it is part of their delusional beliefs. Nevertheless, if they did kill it may be plain that they were "*diminished".* It may be that the delusional beliefs make them unfit to plead. In this case D was assessed to be fit to plead.

32. Section 2(1) Homicide Act was amended by section 52(1) of the Coroners and Justice Act 2009.

33. Section 52(1) now reads:

> (1) A person ('D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—
>
> (a) arose from a recognised medical condition,
>
> (b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and
>
> (c) provides an explanation for D's acts and omissions in doing or being a party to the killing.
>
> (1A) Those things are—
>
> (a) to understand the nature of D's conduct;
>
> (b) to form a rational judgment;
>
> (c) to exercise self-control.
>
> (1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.
>
> (2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section not liable to be convicted of murder.
>
> (3) A person who but for this section would be liable, whether as principal or as accessory, to be convicted of murder shall be liable instead to be convicted of manslaughter.
>
> (4) The fact that one party to a killing is by virtue of this section not liable to be convicted of murder shall not affect the question whether the killing amounted to murder in the case

of any other party to it

34. Thus, it is obvious that where the jury finds that the defendant did kill they will not be guilty of murder but of manslaughter where "*diminished*" is otherwise engaged.

IF DIMINISHED IS AVAILABLE HOW IS IT TO BE DEALT WITH AT TRIAL

35. It was submitted by the Prosecution that because the burden is on the defence to establish diminished the Crown would not open the case by raising "*diminished*". That would mean that the Defence would have to make an opening speech and then call all four psychiatrists including those instructed by the Crown. That in itself would put them in a difficult position as regards their client who may not accept that they suffer a mental condition when plainly they do.

36. The Court is entitled to require that the true issues be placed squarely before the jury so that the overriding objective is met and in particular R1.1(2)

> *(d) recognising the rights of a defendant, particularly those under Article 6 of the European Convention on Human Rights;…*
> *(f) dealing with the case efficiently and expeditiously;…*
> *(h) dealing with the case in ways that take into account—*
> *(i) the gravity of the offence alleged,*
>
> *(ii) the complexity of what is in issue,*

37. See also (at Blackstones D4.9) and R3.2(2) the need to identify the issues and, *"as to the evidence, to ensure that, whether disputed or not, it is presented in the shortest and clearest way"* and (D4.13) R 3.3 which imposes on the parties a duty actively to assist the Court in fulfilling the Court's obligation actively to manage the case which therefore includes assisting the Court in the early identification of the real issues.

38. The Crown accepted that they would have at least to raise the matter of "*diminished"* in the opening not least because failing to do so might give the appearance of them concealing an obvious matter from the jury. But that created difficulty because there was no dispute that this was a case of "*diminished".* Eventually and on the principles discussed infra it had to be conceded that the jury should be told that it was agreed that if D did murder his mother, then he could not be guilty of murder. That in itself created a problem because the count of murder could not by concession be withdrawn from the jury save unless the defence adduced the primary evidence. And so it was accepted that the judge should direct the jury at the conclusion of the case that they could not return a verdict of guilty to the count of murder but only one of manslaughter.

39. There were in fact two counts on the indictment, murder and manslaughter but on the basis of lack of intent. The jury were directed that they were able to return a verdict of manslaughter either on the basis of unlawful act or "*diminished".*

LEGAL PRINCIPLE

40. The underlying legal principles are as follows.

41. If the defendant pleaded guilty to manslaughter on the basis of "*diminished*" then that plea would be accepted. This reflects the following at Blackstones (B1-33):

> *"It has already been noted that one cannot initially charge manslaughter on the basis of diminished responsibility, and so D has to be indicted for murder no matter how clearly D appears to come within the terms of the Homicide Act 1957, s. 2(1). In a large number of cases the prosecution have been able to accept a plea of manslaughter to an indictment for murder. In Cox [1968] 1 All ER 386, Winn LJ said*

(at p. 310):

... that there are cases where, on an indictment for murder, ***it is perfectly proper, where the medical evidence is plainly to this effect, to treat the case as one of substantially diminished responsibility and accept, if it be tendered, a plea to manslaughter on that ground, and avoid a trial for murder****.*

Notwithstanding the discussion in Brennan [2014] EWCA Crim 2387 and Golds [2016] UKSC 61 (see B1.30) about the rare occasions justifying withdrawing a murder charge from the jury during the trial (where the prosecution are opposed to that course), ***if the prosecution are willing to accept a plea of manslaughter at the outset, that quite common practice is still clearly justified under the defence as now formulated, provided it is clear that all the elements of the defence of diminished responsibility are unequivocally supported by uncontradicted reputable expert evidence".***

42. True it is that where the defence raise "*diminished*" the burden lies on them to prove it on the balance of probabilities. It was agreed that the burden would be discharged in this case.

43. If it had been a case where the defence were submitting insanity the Prosecution would be permitted to argue "d*iminished*".

"*The prosecution are themselves allowed to allege diminished responsibility where D puts forward a defence of insanity (Criminal Procedure (Insanity) Act 1964, s. 6), and in such a case (which it is difficult to imagine arising very often, but see Nott (1958) 43 Cr App R 8) the prosecution must satisfy the normal burden of proof beyond a reasonable doubt".* (see Blackstones B1.28)

44. Blackstones deal with the question of fitness and who is to raise the issue at D12.6

" If the issue was raised by the defence, the burden of proof is on them to establish on a balance of probabilities that the accused is unfit (Robertson [1968] 3 All ER 557); if raised by the prosecution, they bear the burden of proof beyond reasonable doubt (Podola [1960] 1 QB 325). ***While it will normally be raised by the defence, the prosecution might wish to assert that the accused is unfit to plead either because of the general principle that prosecuting counsel should act as a 'minister of justice' assisting the court, or because in certain circumstances (e.g., where the offence charged requires proof of a specific or ulterior intent on the part of the accused) it may in practice be difficult to establish guilt if, at the time of trial, the accused is manifestly suffering from mental illness".***

45. If the Prosecution did not accept "*diminished"* then they would call their evidence in the normal way.

46. It seems an odd proposition that where all the evidence of *"diminished"* is agreed the Prosecution should not be permitted to make the jury aware of that fact.

47. If for whatever reason a defendant found himself without representation it would be an odd state of affairs if the Prosecution knowing that the case was plainly one of "*diminished*" were not permitted to raise the matter.

48. The Court would expect and the Crown as minister of justice would wish to deal with the proceedings so that the jury is aware of what the true issues are. In fact the only "*issue*" was whether D killed his mother.

49. There is of course the case of CAMPBELL1987 84 CR APP R 255 where the Court was met with an appeal on the basis that psychiatric evidence going to provocation should also have been considered for "*diminished"* despite the fact that defence Counsel had not argued "*diminished"* and the psychiatric opinion did not consider impairment. The Court of Appeal said:

"Accordingly when Dr. MacKeith left the witness box there was not before the jury even prima facie evidence of the defence of diminished responsibility. The defence had not undertaken to prove diminished responsibility, nor had they succeeded in doing so, even per incuriam. So the judge was right when he said that there was no evidence whatsoever to substantiate that defence".

The Court continued:

"If there had in fact been prima facie evidence, a difficult situation could have arisen. It is unnecessary for us in this case to attempt finally to resolve that difficulty. As Mr. Burton for the appellant pointed out, where on the evidence a defence such as self-defence or provocation can be seen to exist, a judge must leave that defence to the jury, even if it is not relied upon by those appearing for the defendant at the trial (see, for example, Porritt (1961) 45 Cr.App.R. 348; [1961] 3 All E.R. 463). He submits that the same onus should be cast upon the trial judge if there is evidence of diminished responsibility.

However, section 2(2) of the Homicide Act 1957 provides that "it shall be for the defence to prove" diminished responsibility. It seems to us that those words not only dictate which party shoulders the burden of proof once the issue is raised, but also leave it to the defence to decide whether the issue should be raised at all. As this Court indicated in Kooken (1982) 74 Cr.App.R. 30, 33 , this is really an optional defence, and, at least in cases where the defendant is represented by counsel, it seems to us that the most that a trial judge should do if he detects, or thinks that he detects, evidence of diminished responsibility is to point out to defence counsel, in the absence of the jury, what he has detected, so that the defence can decide whether they regard the issue as one for the jury to consider. The judge's knowledge of the evidence available in relation to the issue of diminished responsibility will inevitably be limited, and if he does more than I have indicated he may cause serious damage to a defence which has been put forward, without adding anything to the case".

50. This was a far cry from the circumstances of this case and it might be thought does not deal with the procedure to be adopted where "*diminished*" is agreed.

51. In GOLDS 2016 UKSC 61 (referred to in Blackstones B1-30):

"*Lord Hughes also commented on Brennan [2014] EWCA Crim 2387, in which the Court of Appeal had said that the charge of murder should not have been put to the jury where the partial defence of diminished responsibility was unequivocally supported by reputable expert evidence which is not contradicted by any prosecution expert evidence. While not disapproving of the result in Brennan, his lordship advised caution in withdrawing the defence from the jury at the close of evidence. Amongst the reasons for this was the burden of proof, since (at [50]–[51]):*

The Galbraith process is generally a conclusion that no jury, properly directed, could be satisfied that the Crown has proved the relevant offence so that it is sure. In the context of diminished responsibility, murder can only be withdrawn from the jury if the judge is satisfied that no jury could fail to find that the defendant has proved it … a finding of diminished responsibility is not a single-issue matter; it requires the defendant to prove that the answer to each of the four questions … is 'yes' …

Where, however, in a diminished responsibility trial the medical evidence supports the plea and is uncontradicted, the judge needs to ensure that the Crown explains the basis on which it is inviting the jury to reject that evidence. He needs to ensure that the basis advanced is one which the jury can properly adopt … [The trial judge] needs to make it clear to the jury that, if there is a proper basis for rejecting the expert evidence, the decision is theirs—that trial is by jury and not by expert—it will also ordinarily be wise to advise the jury against attempting to make themselves amateur psychiatrists, and that if there is undisputed expert evidence the jury will probably wish to accept it, unless there is some identified reason for not doing so. To this extent, the approach of the court in BRENNAN is to be endorsed."

POSSIBLE APPROACHES

52. There were a number of possible approaches to the proceedings:

1) The Crown to open the case and call evidence without reference to "d*iminished*", leaving the matter to be raised by the Defence. That had the merit of reflecting the fact that the burden lies on the Defence to establish diminished.

2) The problem with that approach may be as follows:

    i. The jury would be left in a confusing position of receiving evidence knowing that on any view there was a substantial body of material which showed that something was terribly wrong with D when he killed his mother as they would undoubtedly find he did. At the very least the jury would be left with a skewed impression of the case.

    ii. Whilst the statute puts the burden of establishing "*diminished"* on the Defence, (whilst it is difficult to conceive of this position) if the defendant instructed his lawyers not to call evidence, then, despite the Court and the Prosecution and indeed the Defence lawyers knowing that he was not guilty of murder but of manslaughter by reason of "*diminished",* requiring hospital treatment he would be at risk of being convicted of murder unless the Crown were able to do something about it. It may be that at that stage the Court would have to go down the fitness path although as in this case despite our own misgivings the psychiatrists opined that D was fit to plead.

    iii. Whilst the burden of proof is on the Defence would the Prosecution as minister of justice be prevented from adducing evidence and inviting the Court to find that the evidential burden is discharged whoever calls the evidence and whatever delusional views the defendant might hold and whatever protests they might make?

3) The count of murder to remain and the jury told that should they find that D did kill his mother with intent then all psychiatrists agree that he was guilty not of murder but of manslaughter on the basis of "*diminished"* and the jury directed to find him not guilty of murder bit guilty of manslaughter on that basis. That would mean presenting to the jury a set of agreed matters.

4) The advantage of that approach was:

    i. It reflected the reality of the situation.

    ii. There is nothing in the Homicide Act which would prevent this approach.

    iii. Whilst it would be unusual it would be no more unusual than providing to the jury agreed facts.

    iv. In principle there can be nothing wrong with the Prosecution and Defence agreeing the matters at Section 1, 1A and 1B of the Act.

5) The Prosecution open the case. The Defence then address the jury at the end of the Prosecution opening in order to set out the matter of *"diminished*". The Crown then calls the primary evidence and the Defence call the psychiatrists. This evidence would be adduced without cross examination. The Crown would then accept that murder should be withdrawn from the jury and the jury be directed to find manslaughter.

6) The advantages/disadvantages of this are:

    i. There is something artificial about this approach but it has the merit of reflecting where the burden lies.

ii. It becomes a "*box ticking*" exercise.

iii. The Defence call all the psychiatrists including those instructed by the Prosecution. That is an unusual state of affairs.

iv. There is potentially a huge waste of time and resources but that is by no means determinative of the matter.

v. The advantage of this approach is that the public hear the extent of D's condition and the reason for the Court accepting "*diminished."* We would then be using the jury trial as a mechanism for public awareness which may not be the best reason for adopting this approach.

THE JUDGES VIEWS

53. The court favoured option 3). The Prosecution called the evidence of murder. The defence would read a set of agreed facts setting out the psychiatric opinion and call one treating psychiatrist who would not be cross examined.

CALLING THE DEFENDANT TO GIVE EVIDENCE

54. Before we reached that point, at the close of the Prosecution case we had to decide whether to call D to give evidence. We assumed that he would take advice and not give evidence. We were not counting on his delusional belief that he did not kill his mother. He insisted on his desire to tell the jury what had happened namely that when he left her, his mother was alive and it must have been either the OCG or a neighbour who killed her. The link with the neighbour was evidenced by a wire that he had removed from the wall and wrapped round his penis.

FITNESS TO PLEAD

55. D had a delusional belief that he did not actually stab her despite all the evidence to the contrary including what he had told others. He remained convinced that someone else must have come into the house and killed her. Someone probably associated with the organised gangs was in the loft and must have come downstairs.

56. We were concerned that he did not have the required mental capacity to come to a balanced decision with regard to his mental ill health and his actions and lacked capacity to weigh up each of the relevant pieces of information that would help him come to a balanced decision due to a lack of insight in relation to his diagnosis and associated symptomatology. To that extent his ability to instruct his Counsel and Solicitor so as to prepare and make a proper defence was significantly impaired. He failed the capacity test under MCA 2005 S3(1)(c).

57. Nevertheless, the psychiatrists were of the view that however delusional he was technically fit to plead.

58. The pre trial psychiatric opinion was *"D **presented with the previously held persecutory delusional beliefs** that he had harboured around the time of the index offence. He presented with **persecutory delusions** (being persecuted by OCG)**, ideas of reference** (being watched by the neighbour), **delusional misinterpretation** (interpreting all normal perceptions in a delusional manner in keeping with his delusional beliefs such as sister being assaulted by OCG when she had suffered injuries due to fall) as well as **delusional misidentification** (believing his mother to be an imposter)….. **his core delusional ideas about being persecuted by the OCG prior to the alleged offence still persist….**During the interview D stated that his mother was " a shell of her former self" He had believed that his mother suffered from incontinence and impaired mobility due to repeated torture and abuse from the OCG. He*

also stated that it was only humane to relieve her of the misery, however, maintaining that he had not killed her. ***Although both of his beliefs are delusional in nature,*** *the latter belief which incorporates the fact that the victim was indeed his mother who required emancipation from immense torture and suffering allows him to justify and accept to a degree that even if she had died as a result of his actions, it was only merciful.* ***It is likely that Ds denial serves an important protective psychological function for him, protecting him from a painful reality that is too difficult for him to confront****."*

59. Despite that assessment the opinion was that he was fit to plead.

60. And so, the judge allowed time to reflect and with the help of the treating psychiatrist D became rational enough to take advice not to give evidence. His previous insistence on giving evidence had been but part of a psychotic episode.

SECTION 35 INFERENCE

61. That then engaged the S35 inference direction. We were asked whether we had given D advice that if he did not give evidence the jury may draw such inference as they think fit from his failure to give evidence. Our response in front of the jury was plain. We had given positive and firm advice and indeed we had told D that he must not give evidence. Needless to say, the judge directed the jury that they must not hold it against him that he had not done so. To call him to give evidence of his delusional beliefs as to what happened would have made a mockery of the entire process.

ACCIDENT

62. D being unable to accept that he had killed his mother we had to explore any defence which might be open to him including accident. There was some minimal evidence that when the brother came downstairs having heard a scream and saw the mother and D standing side by side there was no blood. There was then a struggle and they all ended up on the ground. It was when they stood up that blood was noticed. Accident was inconsistent with what D had said on the day of the killing. The pathologist did not think it likely by reason of the wound track. Nevertheless, accident was an issue left to the jury.

THE JURY PROBLEM

63. The final problem came with the jury. First it appears that at some stage, for whatever reason they were having difficulty reaching a verdict. We knew that because the Court was informed that a juror had discussed the matter with their partner. Such was contrary to the judge's directions and a contempt of court. The juror was questioned in court and accepted that they had indeed discussed not the merits of the case but rather the fact that the evidence had been so distressing to them that their partner asked what the matter was and thus it emerged. That juror was discharged. The problem then was that the paranoid schizophrenic defendant was convinced that they must have discussed the matter with the other members of the jury or at least have caused whatever the partner might have said, to influence their own contributions to the deliberations. In fact, on analysis of the timings this would not have been possible. Nevertheless, we had at least to make a submission for the discharge of the entire jury which was rightly rejected.

64. D was convicted of manslaughter – whether on the ground of diminished or unlawful act without intent to kill or do serious injury, we will never know but our guess is that it was on the basis of "*diminished"* and that is how the judge will deal with it on disposal.

RB KC