Neutral Citation Number: [2026] EWCA Crim 353 Case No: 202303212 B5

IN THE COURT OF APPEAL (CRIMINAL DIVISION) ON APPEAL FROM THE CENTRAL CRIMINAL COURT HIS HONOUR JUDGE BARKER KC, THE COMMON SERGEANT OF LONDON

Royal Courts of Justice Strand, London, WC2A 2LL

Date: 25/03/2026

Before :

PRESIDENT OF THE KING'S BENCH DIVISION
MR JUSTICE WALL and
MR JUSTICE MANSFIELD

- -

Between :

Nicole Thomas (Previously Nicola Edgington) — **Appellant**

- and -

Rex — **Respondent**

- -

- -

Edward Henry KC and James Lloyd (instructed by Murray Hughman) for the Appellant Mark A. Heywood KC and William Davis (instructed by the CPS Criminal Appeals Unit) for the Respondent

Hearing dates: 18-19 February 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on Wednesday 25 March 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Dame Victoria Sharp P:

Introduction

1. On 7 February 2013 the appellant was convicted at the Central Criminal Court of the murder of Sally Hodkin and the attempted murder of Kerry Clark.

2. At trial, the appellant did not deny that she did the acts that constituted the crimes. Her defence to the charge of murder of Mrs Hodkin was that her state of mind was such that she should only have been guilty of the lesser offence of manslaughter on grounds of diminished responsibility. Her defence to the charge of attempted murder of Ms Clark was that she did not act with intent to kill. At the end of a 24 day trial the jury found her guilty of both murder and attempted murder.

3. In respect of the murder, she was sentenced to life imprisonment with a minimum term of 37 years. She received a concurrent life sentence for the attempted murder. The appellant sought to appeal both conviction and sentence. Leave to appeal was refused on 8 November 2013 (*R v Edgington* [2013] EWCA Crim 2185).

4. The matter comes before this Court again as a result of a reference from the Criminal Cases Review Commission (the CCRC). Following the reference, counsel were instructed for the appellant and grounds of appeal submitted. The appellant argues that the conviction for murder was unsafe and should be set aside and replaced with a verdict of manslaughter on grounds of diminished responsibility. Although there are three grounds of appeal, the essence of the appeal is an attack on the evidence of the prosecution's expert psychiatrist, Dr Philip Joseph. In support of the appeal, the appellant seeks to rely on fresh evidence, in the form of additional psychiatric reports prepared after the date of conviction.

5. At the end of the two day hearing of this appeal, we gave our decision: we refused to admit the fresh evidence and dismissed the appeal. We set out our reasons for doing so below.

Background Facts

6. On 4 November 2005 the appellant stabbed and killed her mother in her home. She disappeared for three weeks but was subsequently arrested and charged with murder. She pleaded guilty to manslaughter on grounds of diminished responsibility. The psychiatrists instructed by the prosecution and defence were then in agreement that the appellant had that defence available to her. The prosecution accepted that plea.

7. The appellant was made subject of a hospital order with a restriction order without limit of time under sections 37 and 41 of the Mental Health Act 1983. She was treated as an in-patient until September 2009 when she was conditionally discharged. From then until October 2011 she was managed in the community and reviewed regularly by a consultant

psychiatrist, social worker and community psychiatric nurse. Her last contact with these professionals was on 6 October 2011.

8. At about 3am on 10 October 2011 the appellant went to a minicab office in Greenwich and asked to be taken to Lewisham Hospital. She was subsequently taken to the Queen Elizabeth Hospital in Woolwich. There was a dispute with the driver as

the appellant could not pay, and she was taken back to the minicab office. The appellant was in a distressed state and said that she needed to be sectioned. Emergency services were called and the appellant was taken by ambulance to the Queen Elizabeth Hospital, arriving around 4.30am. The triage nurse referred her to the psychiatric team. While waiting for transfer, the appellant made a series of 999 calls, during which she said she might harm or kill someone.

9. At around 7.05am, while in the care of the psychiatric unit, the appellant left the unit and travelled by bus to Bexleyheath. On arriving in Bexleyheath, she went into Asda and bought a large knife. She went into the toilets and removed the knife's packaging. She then secreted the knife about her and disposed of the packaging before leaving the shop.

10. Almost immediately after leaving Asda the appellant approached a young woman, Kerry Clark, waiting at a bus stop to go to work, shouting obscenities and pointing the knife at her. Ms Clark fell and the appellant attempted to slash her with the knife. There was a struggle in which Ms Clark was able to take the knife from the appellant, though not without sustaining injury. The appellant demanded return of the knife, which Ms Clark refused.

11. The appellant walked away, crossed the road and entered a butchers' shop, where she took a 12-inch knife from the back of the shop. The appellant then ran to a small area of parkland where she encountered Sally Hodkin, who was walking to the train station on her way to work. Without warning the appellant attacked Mrs Hodkin repeatedly with the knife, inflicting severe wounds to the face, head and neck. Mrs Hodkin died at the scene. The appellant walked away and went into a shop, where she said that she thought she had killed someone. The police arrived shortly after and she was arrested.

12. The appellant was charged with the attempted murder of Ms Clark and the murder of Mrs Hodkin. The trial took place at the Central Criminal Court before the Common Sergeant of London, His Honour Judge Barker QC, and a jury.

13. The facts of the attacks were not in dispute. What was in issue was the appellant's state of mind at the time of the attacks.

14. The defence to the murder charge was one of diminished responsibility: that at all material times the appellant suffered a relapse into a psychotic state which impaired her ability to form a rational judgment or to exercise self-control.

15. The prosecution accepted that the appellant suffered from an abnormality of mental functioning arising from a recognised medical condition, though there was a dispute as to what her condition was. The defence case was that the appellant suffered from schizophrenia or schizoaffective disorder; the prosecution case was that she suffered from personality disorder, borderline type. Whatever the diagnosis, the prosecution disputed that the appellant's ability to form rational judgments or to exercise selfcontrol was impaired, or such impairment had caused the killing.

16. The prosecution called extensive evidence as to the appellant's movements from 6 October until the time of her arrest, as to the appellant's presentation before and after the killing, and as to the 2005 conviction and the medical position at that time and thereafter. That evidence included (among other things):

    i) Medical records and assessments from 2005;

    ii) Evidence from some of the professionals under whose care the appellant was after her release in 2009: Dr Janet Parrott (consultant forensic psychiatrist), Tanya Biebuyck (nurse) and Elizabeth Lloyd-Folkard (social worker);

    iii) Evidence from staff at the Queen Elizabeth Hospital who saw the appellant when she attended in early hours of 10 October;

    iv) Evidence from witnesses who saw the appellant on the day prior to the killing and on the day itself;

    v) Extensive CCTV footage of the appellant on the day of the killing and recordings of calls she made; and

    vi) Evidence from witnesses, including medical professionals, who dealt with the appellant in the period after her arrest.

17. In addition, extensive medical records were disclosed and available to the defence, including records relating to the period of the 2005 killing.

18. The defence called two expert psychiatrists, Dr Adrian Cree and Professor Nigel Eastman. The prosecution called Dr Joseph. They all prepared reports, gave oral evidence and were cross examined. Dr Joseph was cross examined by leading counsel for the appellant, John Cooper KC, for over a day.

19. Dr Cree's opinion was that the defence of diminished responsibility was made out. In summary, his opinion was as follows:

    i) The appellant suffered from paranoid schizophrenia – an abnormality of mental functioning arising from a recognised medical condition;

ii) In October 2011 she suffered a rapid and acute relapse involving symptoms of a psychotic and affective type;

iii) Her symptoms would have had a significant impairment on her ability to form a rational judgment and her ability to exercise self-control; and

iv) The abnormality of mental functioning was a significant contributory factor in causing the appellant to act as she did during the events of 11 October 2011.

20. Professor Eastman's opinion was that there was a clear and robust medical basis for the jury to conclude that the diminished responsibility was made out. His conclusions were similar to those of Dr Cree, save that he described the appellant's medical condition as schizoaffective disorder.

21. Dr Joseph's opinion, in summary, was that the appellant suffered from a personality disorder, borderline type. He did not believe that she had ever suffered from schizophrenia or schizoaffective psychosis. At the time of the killing, the appellant was suffering from an unstable personality disorder which is an abnormality of mental function arising from a recognised medical condition. However, he did not believe that she was suffering from psychotic symptoms which caused the killing. Taking into account the circumstances of the alleged offences, her abnormality of mental functioning did not substantially impair her mental responsibility at the time of the killing: she understood the nature of her conduct; she could make a rational judgment based on her feelings of anger and she did not appear to have lost her self-control.

22. During the course of his summing up, the judge summed up aspects of the medical and factual evidence in detail. He also summarised the essence of the case at the beginning of his summing up in terms which cannot be faulted and are not criticised in this appeal:

> We have examined, have we not, a considerable amount of distressing material over the past few weeks and there is virtually no dispute as to the factual core of this case. It is accepted that Ms Edgington did kill Sally Hodkin and attacked Kerry Clark with a knife in the circumstances we have heard about.
>
> It is submitted by the defence that she is not guilty of murder but guilty of the lesser charge of manslaughter on the basis of diminished responsibility as it is contended that she was suffering from an abnormality of mental functioning at the time and secondly, she is not guilty of attempted murder as she did not have the requisite intent and possibly out of fear.

> The approach of the defence team means there is no dispute but that the elements of murder have, in reality, been made out and the central issue for you to decide on count 2 is whether she has shown, to the appropriate standard (that is more likely than not) that at the time she was suffering from an abnormality of mental functioning so as to reduce the crime from murder to manslaughter.
>
> In the case of Kerry Clark, on count 1, there is no dispute as to what can be seen on the CCTV and what was described by the witnesses. The issue is whether the prosecution have proved she had intention to kill. You will note the standards of proof are different and I will return to those matters in more detail in a moment.
>
> The essence of the prosecution case is that the proper conclusion to be drawn from the entirety of the evidence is that on the morning of 10 October 2011, although suffering from an abnormality, she was sufficiently in control and that it was anger and frustration arising out of her personality that led her to do what she did.
>
> The defence, on the other hand, say this was a sudden relapse into a psychotic state.

23. The judge's direction as to the relevance of expert evidence was as follows:

> Expert evidence is permitted in a criminal trial to provide you with scientific and professional information and opinion which is within their expertise but which is likely to be outside our experience and our knowledge. They are clearly experienced people and you may think their evidence carries considerable weight. It is by no means unusual in criminal trials for evidence of this nature to be called but it is important that you should see it in its proper perspective which is that it is before you as part of the evidence as a whole to assist you with regard to particular aspects of the evidence including the cause of death and, most importantly here, the psychiatric conditions that are thought to be relevant.
>
> A witness called as an expert is entitled to express an opinion in respect of their findings and they have all done so here and you are entitled and would no doubt wish to have regard to this evidence and to the opinions expressed by the experts when coming to your own conclusion about the central aspects of this case. There is, of course, a clear and stark dispute between them and you have to reach your

> final judgment on one side or the other having evaluated not only what they say but evaluated the whole of the evidence.

24. After directing the jury as to the legal test of diminished responsibility, the judge went on to summarise the issues in this case as follows:

> So (i) when the stabbing took place, she was suffering from an abnormality of mental functioning which arose from a recognised medical condition.
>
> Now all three psychiatrists say, one way or another, she was suffering from an abnormality of mental functioning at the time, maybe different types of mental functioning, but (i) is satisfied.
>
> The law says you must go on to consider (ii) and this is where there is a dispute; her abnormality of mental functioning substantially impaired her ability to form a rational judgement or to exercise self-control and substantial means something which is more than trivial or insignificant.
>
> Also (iii), her abnormality of mental functioning provides an explanation for her conduct when she stabbed Mrs Hodkin in that the abnormality caused or significantly contributed to the defendant doing what she did and significant means something which is more than trivial or insignificant in causing the conduct and significant has its proper English meaning.
>
> You know, from listening to this case, that there is a stark difference of opinion between the expert witnesses in this case. Dr Cree is of the opinion that Ms Edgington, on one view of the evidence presented, was at the time likely to have been suffering from an abnormality of mental functioning which arose from a recognised medical condition, namely, paranoid schizophrenia, which was coupled with prominent mood disorder. Further, that this disorder impaired her ability to form rational judgment and that it impaired her ability to exercise self-control and thus, the defence is open to her.
>
> In broad terms, Professor Eastman agrees although he uses a different diagnostic description, namely, a schizo-affective disorder

but also agrees that the path of the case could be open to her subject to your judgment.

On the other hand, Dr Joseph's assessment of her condition at the time is that she suffered from a borderline personality disorder and she was not suffering from any schizophrenic or schizo-affective psychosis. Although borderline personality disorder is a recognised medical condition, it did not, in his view, substantially impair her ability to form rational judgment and did not provide an explanation for her conduct. On the contrary, it is his view that she knew what she intended to do at the relevant time and she proceeded to do it.

Dr Cree and Professor Eastman both conclude that she was correctly assessed with a predominant psychotic illness in 2005 and the killing of Mrs Hodkin was the result of a sudden relapse into that state. Dr Joseph, however, concludes that with the benefit of hindsight, now we have looked at the whole history, that the predominant condition throughout was this personality/mood disorder and that she was in control while she was in Bexleyheath shopping centre.

You must approach all these questions in a broad, commonsense way. If the defence fail to prove any of those elements on the balance of probability. Providing the prosecution have proved the ingredients of murder to which I have referred, then your verdict is guilty of murder. If, on the other hand, the defence have satisfied you that it is more likely than not the [elements] of the defence of diminished responsibility were present, when Nicola Edgington killed Sally Hodkin, then your verdict must be not guilty of murder but guilty of manslaughter on the grounds of diminished responsibility.

As to those elements mentioned above, although the medical evidence which you have heard is important, you must consider not only the evidence of the doctors but also the evidence relating to the killing and the circumstances in which it occurred and you consider the behaviour of the defendant before and after the event and taking into account the medical history or indeed the lack of it.

You are not bound to accept any particular medical evidence if there is other material before you which in your good judgment, conflicts with the particular medical view and outweighs it; you choose. You

> consider not only the various pieces of medical evidence but the evidence of the whole facts and the circumstances of the case.

25. Before going on to address the evidence in detail, the judge gave what he described as a "birds eye view" of the case:

> What the prosecution say is really as a result of various stresses and her emotionally unstable personality, this lady became increasingly troubled over that weekend and by the early hours of the Monday morning, she wanted help and security. She felt she was not being taken seriously and then finally made a conscious decision to carry out the offences. They say the death of Sally Hodkin was the product of the violent and controlled [actions of] an angry woman. They say to all outward appearances, she was acting rationally just before, during and just after the attack. There also appear to be admissions that she was aware immediately afterwards of what she had done. They point out that there were no general signs of psychotic behaviour before or after and evidence of hallucinations or delusions did not surface until the interview with Dr Cree despite her having, during those intervening months, continual contact with the staff at the Three Bridges Unit.
>
> They say although her condition can be classified as an abnormality of mental functioning, that is, [you can be] satisfied of (i), it did not substantially impair her mental responsibility at the time of the killing. As for intent, she understood the nature of her conduct and could make a rational judgment on the basis of anger and rejection and she does not appear to have lost her self-control.
>
> The defence, on the other hand, say she had been diagnosed with paranoid schizophrenia with a mood component after killing her mother in 2004 and that her treatment and medication from the Bracton Centre continued on that basis. They submit that when in the community, she continued to take her medication and that the evidence of the Monday morning was the result of a sudden relapse back into the mental illness she had and that she was, at the time, experiencing delusions and hallucinations. They submit, to use Dr Cree's expression, that she had a "consolatory (?) declivity" which significantly impaired her ability to form a rational judgement and her ability to exercise self-control and her abnormality of mental

functioning substantially contributed to her behaviour thus satisfying (ii) and (iii). They point to the fact that there was no change in the diagnosis when was at the Three Bridges Unit and that the prescription of anti-psychotic medication continued.

So overall, they say, her description of hallucinations and or delusions can be relied on and she was properly mentally ill at the time.

The 2013 appeal

26. The appellant applied for leave to appeal against her conviction and sentence. The one ground of appeal against conviction was that the judge had erred in refusing to permit evidence to be led, in re-examination of the appellant's expert, as to whether as a matter of practice the appellant would ever be released if convicted of manslaughter and sentenced under the Mental Health Act. The appeal was conducted by trial counsel. No criticisms of Dr Joseph's evidence were made in that appeal. The Court of Appeal refused leave.

The CCRC Reference

27. The appellant applied for a review of her conviction and sentence in June 2016. On 13 November 2017 the CCRC made a provisional decision not to refer the conviction or sentence to the Court of Appeal. In relation to further psychiatric evidence, the CCRC stated that it was reluctant to conduct speculative enquiries in the absence of new medical evidence provided by the appellant. Following further correspondence from the appellant's solicitors and a report from the appellant's responsible clinician, the CCRC instructed Professor Rix to assess the appellant and prepare an up to date report.

28. Professor Rix submitted a report dated 11 July 2023. That report is one of the pieces of fresh evidence on which the appellant now seeks permission to rely. Professor Rix's opinion (to which we will return later in this judgment) was that the defence of diminished responsibility was made out. He disagreed with Dr Joseph on a number of issues, set out in detail in his report.

29. Following receipt of Professor Rix's report, the CCRC referred the appellant's case to the Court of Appeal on the ground that there was a real possibility that the conviction for murder would not be upheld. The core of the CCRC's reasoning was as follows:

    i) The fresh expert opinion of Professor Rix is in agreement with the evidence presented by the defence experts at trial;

ii) Although Professor Rix's report is largely based upon evidence that was available at the time of trial, Professor Rix also considered the evidence of the appellant's treating physicians in the ten years post-trial, which confirms the diagnosis of schizoaffective disorder;

iii) Dr Joseph's evidence was selective and ignored important aspects of the evidence available to him. He gave the jury a misleading impression of the evidence that existed in relation to Ms Thomas' mental health;

iv) The judge's summing up mirrored those errors, thus further misleading the jury.

The Grounds of Appeal

30. Following the reference, fresh leading and junior counsel were instructed for the appellant and Grounds of Appeal lodged. There are three grounds:

i) Ground 1: the prosecution psychiatric evidence wrongly and prejudicially disputed that schizophrenia was the cause of the 2005 killing of the appellant's mother;

ii) Ground 2: the prosecution psychiatric evidence (a) ignored or discounted material facts; (b) was selective and gave an incomplete picture of the evidence to support a diagnosis of schizoaffective disorder; (c) misstated known psychiatric conditions and diagnoses;

iii) Ground 3: in relation to both killings, the prosecution evidence misled the jury.

The Law

Diminished responsibility

31. Section 2 of the Homicide Act 1957 sets out the conditions for the partial defence of diminished responsibility. So far as material it provides:

> (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.

CCRC Reference

32. The CCRC may refer a conviction to the Court of Appeal pursuant to section 9 of the Criminal Appeal Act 1995. The conditions for such a reference are set out in section 13 of that Act, which provides:

(1) A reference of a conviction, verdict, finding or sentence shall not be made under any of sections 9 to 12B unless—

(a) the Commission consider that there is a real possibility that the conviction, verdict, finding or sentence would not be upheld were the reference to be made,

(b) the Commission so consider—

(i) in the case of a conviction, verdict or finding, because of an argument, or evidence, not raised in the proceedings which led to it or on any appeal or application for leave to appeal against it, or

(ii) in the case of a sentence, because of an argument on a point of law, or information, not so raised, and

> (c) an appeal against the conviction, verdict, finding or sentence has been determined or leave to appeal against it has been refused.
>
> (2) Nothing in subsection (1)(b)(i) or (c) shall prevent the making of a reference if it appears to the Commission that there are exceptional circumstances which justify making it.

Fresh evidence

33. The Court's jurisdiction to receive fresh evidence is governed by section 23 of the Criminal Appeal Act 1968. By section 23(1) the Court may, if they think it necessary

or expedient in the interests of justice, receive any evidence which was not adduced in the proceedings from which the appeal lies. By section 23(2), the Court of Appeal shall, in considering whether to receive any evidence have regard in particular to-

i) whether the evidence appears to the Court that the evidence is likely to be credible;

ii) whether the evidence would have been admissible in the proceedings from which the appeal lies on an issue which is the subject of the appeal;

iii) whether there is a reasonable explanation for the failure to adduce the evidence in those proceedings; and

iv) whether the Court is satisfied that the evidence, if admitted would not afford any ground for allowing the appeal.

34. The test to be applied in considering a fresh evidence appeal remains as stated by Lord Bingham in *R v Pendleton* [2001] UKHL 66, [2002] 1 WLR 72.

> "The Court of Appeal can make its assessment of the fresh evidence it has heard but save in a clear case it is at a disadvantage in seeking to relate that evidence to the rest of the evidence which the jury heard. For these reasons it will usually be wise for the Court of Appeal, in a case of any difficulty, to test their own provisional view by asking whether the evidence, if given at trial, might reasonably have affected the decision of the trial jury to convict. If it might, the conviction must be thought unsafe."

35. In relation to fresh expert evidence, in *R v Kai-Whitewind* [2005] EWCA Crim 1092 Judge LJ said:

> "Where expert evidence has been given and apparently rejected by the jury, it could only be in the rarest of circumstances that the court would permit a repetition, or near repetition of evidence of the same effect by some other expert to provide the basis for a successful appeal. If it were otherwise the trial process would represent no more, or not very much more than what we shall colloquially describe as a 'dry run' for one or more of the experts on the basis that, if the evidence failed to attract the jury at trial, an application could be made for the issue to be revisited in this court. That is not the purpose of the court's jurisdiction to receive evidence on appeal."

36. The Court reiterated these principles in *R v Hunnisett* [2021] EWCA Crim 265, at paras 35 to 38.

The Fresh Evidence

37. The appellant now seeks to rely on the following as fresh evidence:

    i) The report of Professor Rix, dated 11 July 2023;

    ii) A report of Dr Frank Farnham, consultant forensic psychiatrist, dated 6 January 2025;

    iii) The underlying medical records and reports referred to by these reports, including the reports of Drs Langley, White and Inga. These are all clinicians who have treated the appellant post-conviction.

38. Dr Farnham was instructed because Professor Rix retired after preparing his report. The Crown raised no objection, procedural or otherwise, to the Court considering the evidence of both Professor Rix and of Dr Farnham in these circumstances. Dr Farnham has not examined the appellant, but has reviewed the medical evidence, including the reports of the appellant's Responsible Clinicians post-conviction (see para 46 below). He addresses those reports in his own report.

39. In response to this evidence, the Crown seeks to rely on a report of Professor Nigel Blackwood, consultant forensic psychiatrist, dated 8 April 2025.

40. At the hearing of the appeal Dr Farnham and Professor Blackwood gave oral evidence and were cross examined. The Court considered the written and oral evidence relied on as fresh evidence and in response, *de bene esse*.

Professor Rix

41. Professor Rix, on the instruction of the CCRC examined the appellant's medical records, including those after the date of the appellant's conviction for murder; and he examined the appellant. In summary, his opinion was as follows:

i) At the time of the killing the appellant suffered from an abnormality of mental functioning arising from a recognised medical condition, namely schizoaffective disorder;

ii) Abnormal personality traits, whether or not sufficient to make a diagnosis of personality disorder, are likely to have contributed to the abnormality of mental functioning;

iii) As a result of her abnormality of mental functioning there was a substantial impairment in the appellant's ability to form a rational judgment, to understand her own conduct and to exercise self-control;

iv) Her abnormality of mental function provides an explanation for her acts in doing the killing;

v) Professor Rix was not persuaded that the appellant also had an emotionally unstable personality disorder, but if she did, that strengthened his conclusions on diminished responsibility.

42. Professor Rix was largely in agreement with Dr Cree and Professor Eastman, save that (i) Professor Rix disagreed with Dr Cree that the primary diagnosis was schizophrenia, preferring a schizoaffective disorder; and (ii) unlike either Dr Cree or Professor Eastman, Professor Rix was of the opinion that there was evidence of a substantial impairment of the appellant's ability to understand her own conduct.

43. Professor Rix disagreed with Dr Joseph's opinion in many respects, both as to his overall conclusions and as to points of detail. Professor Rix's criticisms of Dr Joseph's evidence form the heart of appellant's challenge in this appeal.

44. Importantly, given that this is an application to rely on fresh evidence, Professor Rix said the following at paragraph 7.24 of his report:

> My opinion is not based on information which was not available to the experts at the time of the trial, but it is strengthened by the

> following information insofar as, after she was sentenced, the Applicant suffered a relapse of what was regarded as having been a correctly diagnosed schizo-affective disorder and a relapse considered so serious that she was transferred urgently from prison to hospital.

45. We further note that although Professor Rix's report runs to 247 pages, (excluding Appendices) he deals with the appellant's history since conviction in only 11 pages, giving an account of the appellant first at HMP Bronzefield and then at Rampton Hospital, and referring to the decisions of the Mental Health Tribunal between 2013 and 2022. He records that the diagnosis of schizoaffective disorder was maintained, and that in 2022 Dr Inga made the first definite diagnosis of emotionally unstable personality disorder of the borderline type.

Dr Farnham

46. As already indicated, Dr Farnham reviewed the expert evidence given at trial and the post-conviction reports of the appellant's Responsible Clinicians: Dr Langley (23 November 2018), Dr White (1 April 2022) and Dr Inga (11 July 2022). He did not examine the appellant, nor was he provided with any other primary or original source medical records.

47. The bulk of Dr Farnham's evidence is a summary of the reports of Dr Langley, Dr White and Dr Inga. Dr Farnham's opinion is that the primary diagnosis is one of schizoaffective disorder. It is possible that the appellant also suffers from a personality disorder, though he says it is probably not necessary to make a separate diagnosis of personality disorder. Dr Farnham's report does not address the evidence given at trial, nor does it state a view on the component elements of diminished responsibility. When cross examined, he explained that he had confined himself to material relating to events after trial. He did not think it was appropriate to address Dr Joseph's evidence, as providing an opinion on that evidence would involve transporting himself back to a trial which had occurred over 10 years ago. He said that, in any case, Professor Rix had already outlined his concerns so it would not be a helpful exercise.

Professor Blackwood

48. Professor Blackwood examined the appellant in March 2025. He reviewed, among other evidence, the reports of Professor Rix and Dr Farnham (together with the material relied on by Professor Rix) and the psychiatric evidence given at trial.

49. In summary, Professor Blackwood's opinion was as follows:

i) The appellant's history is consistent with a Cluster B personality disorder, features of which are manifest across the lifespan before the killing and operational at the time of the killing.

ii) While the diagnosis of schizoaffective disorder may be a reasonable one, any potential psychotic symptoms at the time of the killing which arose from that disorder operated in the context of an established Cluster B personality disorder and voluntary skunk cannabis misuse. He disagreed with Professor Rix's minimisation of what were important co-morbid diagnostic constructs.

iii) At paragraph 147 Professor Blackwood said this:

> I am sympathetic to the approach taken (and doubts expressed) by Dr Joseph at the original trial. There was an abnormality of mental functioning, arising from her personality disorder, voluntary skunk cannabis misuse and her schizoaffective disorder (if her account of the psychotic symptoms is accepted; the mood instability features which Professor Rix accords particular significance to at the time are more readily accounted for by her personality disorder). However, whatever the precise combination of disorders and substance misuse, the cluster of mental state abnormalities which Ms Thomas has described with varying degrees of consistency as operating at the material time did not in my view *substantially* impair her ability to understand the nature of her conduct, form a rational judgement or to exercise self-control at the time of the killing, and I do not accept that the partial defence of diminished responsibility should have obtained at the time of the 2013 trial.

iv) At paragraph 150 he said:

> Professor Rix disagreed with Dr Joseph on numerous issues. I concur with Dr Joseph with respect to the personality disorder and the lack of substantial impairment. I am equally sceptical of the appellant's recourse to amnesia for the offences given her descriptions to the police in the immediate wake of the offences. Dr Joseph appropriately described the Russet Ward team's approach and provided a reasonable if less exhaustive summary of her treatment therein in his report and in oral evidence. I do not consider that he significantly misrepresented the complex clinical picture: his arguments are capable of belief.

Discussion

Should the fresh evidence be admitted?

50. The first question for us is as to whether we should admit the fresh evidence. Fresh evidence is only admissible if it complies with section 23(1) Criminal Appeal Act 1968. We consider the four tests set out in that section.

    i) The evidence is capable of belief. It comes from respected psychiatrists, Professor Rix and Dr Farnham. There is no suggestion that they have acted other than in good faith using their professional expertise.

    ii) Similarly, their evidence, had it been available at the time of the original trial, would have been admissible. The evidence goes to the central issue in the case on count 2, namely the psychiatric condition of the appellant and how that had an impact, if at all, on her actions on the day of the killing.

    iii) Some of the evidence could not have been adduced at trial, as it concerns the appellant's history of treatment and the assessment of her after the date of the trial. However, much of the material traverses the same ground as was covered, or could have been covered, at the trial.

    iv) The true issue is whether the new evidence affords any ground for allowing the appeal.

51. The appellant's case depends upon the criticisms of Dr Joseph's evidence identified in the report of Professor Rix. Dr Joseph is criticised for giving evidence that is said to have been materially incomplete and demonstrably inaccurate. In support of that case, we were taken to a series of examples, set out in the appellant's Skeleton Argument at paras 51 to 54 and developed orally at the hearing. It is not necessary for us to address those points in detail.

52. An appeal is not an opportunity for the case to be relitigated on the same issues as were canvassed at trial. That is clear from the decisions of this Court in *KaiWhitewind* and *Hunnisett.* If the new evidence contains material which had not been properly considered at trial, it would potentially be admissible. However, in this case, it does not for the following reasons.

53. Professor Rix himself, when making criticisms of the approach of Dr Joseph, accepts that he is basing those criticisms on material that was available at the time of the original trial.

54. Moreover, those criticisms were levelled at Dr Joseph in the course of the trial in a cross examination which lasted for approximately one day. He was criticised then, as he is now, for being partisan, for placing improper reliance on his view that the prosecution was wrong at the time of the trial for the murder of her mother to accept that her killing was the result

of diminished responsibility, and for being dismissive of schizoaffective disorder as a proper diagnosis. It may be right that the defence did not put all of the criticisms that are now made of his evidence to Dr Joseph during the trial, but that is the nature of the trial process. The material upon which all of the criticisms could have been made was available to defence counsel – both in the form of the raw material (i.e. the medical records) and in the form of the expert reports on which the defence then relied. It was then counsel's duty to ask Dr Joseph about those points which he considered might be most persuasive and which might best support the appellant's case. Those criticisms having been articulated by trial counsel, Dr Joseph answered them and the jury were left to consider them. The fact that these criticisms are now made by a fresh expert does not render the evidence itself fresh such as to make it admissible.

55. It is of note that trial counsel has not been criticised for any decision taken by him at trial. It has not been said that he was not sufficiently robust in his cross examination of Dr Joseph nor that he missed points which he ought to have made. We have read a transcript of that cross examination: it was lengthy, robust and thorough. The only point taken on appeal by trial counsel was unrelated to any of the issues now canvassed in this appeal. It can be inferred therefore that it was not trial counsel's professional judgment that there was a point on appeal to be taken either on the alleged shortcomings of the evidence of Dr Joseph, or on the alleged shortcomings in the summing up which they are said to have led to.

56. Professor Rix states that the criticisms of Dr Joseph which he based on the evidence available at the time of trial are now further supported by what has happened since. Some of the material might be said to support at least Professor Rix's opinion as to the nature of the appellant's condition. For instance, those who have treated the appellant since the time of the last trial have adopted a working diagnosis of her suffering from schizophrenia or an allied condition. However, that is not true of all of the vast amount of material accumulated since the time of trial. Dr Inga, one of the appellant's treating psychiatrists, has voiced support for the view that the appellant suffers from a personality disorder. It would be wrong to say that all of the post trial evidence points in a single direction.

57. Were we to admit the evidence of Professor Rix and Dr Farnham, we would also admit the evidence of Professor Blackwood. He was of the opinion that the diagnosis of personality disorder made by Dr Joseph was a reasonable one to have made at the time and remains a reasonable diagnosis based on the evidence available today.

58. It follows that if the evidence of Professor Rix, Dr Farnham and Professor Blackwood were to be admitted, the position would be similar to - indeed to all intents and purposes the same as - that which was faced by the jury at trial. Two psychiatrists relied on by the defence who concluded that the primary diagnosis was one of schizophrenia (or schizoaffective disorder) and that the defence of diminished responsibility was made out on the balance of probabilities; and one psychiatrist relied on by the prosecution who concluded that the

primary diagnosis of personality disorder was reasonable on the evidence and the defence was not made out.

59. In other words, any new jury, were they to be asked to retry the case today, would be in a similar evidential position to the jury at trial. The change would not be in the quality of the evidence but in the identity of those presenting it. This is the sort of thing which this Court in *Kai-Whitewind* and *Hunnisett* has warned against. In short, the trial process is not to be treated as a dress rehearsal.

60. The appellant seeks to distinguish the instant case from *Kai-Whitewind* and *Hunnisett* by basing this appeal on the suggestion that Dr Joseph has been discredited by the fresh evidence. That is not a sustainable argument. Had the appellant been given material to attack the evidence of Dr Joseph only after the conclusion of the trial, or had the appellant been denied access to an expert to address Dr Joseph's alleged failings at trial, then such an argument potentially at any rate, might have been open to the defence (whether it would have prevailed of course is a different matter). But the defence not only had the material on which to base a thorough cross examination challenging Dr Joseph, they actually employed it. Further, the appellant's argument ignores Professor Blackwood's opinion that Dr Joseph's diagnosis of personality disorder was a reasonable one to have made at the time and remains a reasonable diagnosis today.

61. There is an additional important point, not addressed on behalf of the appellant in this appeal. In order to decide how relevant any new evidence might have been, the criticisms of Dr Joseph's evidence have to be seen in the context of the evidence as a whole and the two central issues the jury had to determine at trial.

62. As to the issues, the judge was clear in his direction that all the psychiatric evidence was to the effect that the appellant suffered from an abnormality of mental functioning. The nature of that impairment was not agreed (even as between the two psychiatrists relied on by the defence) but there was unanimity that there was an abnormality of some kind.

63. It followed that the issues for the jury were (i) whether the appellant's condition, whatever it was, substantially impaired her ability to do one or more of understanding the nature of her conduct, forming a rational judgment or exercising self-control and (ii) whether it provides an explanation for the killing. However far apart the experts were as to the psychiatric condition from which the appellant suffered, their evidence on the two issues which mattered was before the court and open to consideration.

64. As to the evidence, the jury were instructed by the judge that these issues should be considered not on the psychiatric evidence alone but on the totality of the evidence. In that context, the jury had a significant amount of extra material to rely on. They had a large amount of CCTV footage on the day of the attacks which appeared to show the appellant

acting rationally and deliberately. In particular, they could watch the appellant travelling calmly on a bus for an extended period, and looking at her mobile phone, when she claimed to be in the grip of a psychotic episode in which, according to the appellant, she believed that she was travelling through a "post-apocalyptic landscape". They could watch the appellant buying and secreting the knife, stealing a second knife and appearing to target two lone women to attack. They had evidence that she admitted what she had done shortly after the event and only raised the suggestion of having had a psychotic episode at a much later stage. The prosecution with conspicuous fairness also called or made available all those who had treated the appellant in the period between the time of the killing of her mother and the attacks in 2011.

65. This was not a case therefore where the jury had to make these crucial decisions on the basis of the psychiatric expert evidence alone. There was a large volume of cogent evidence upon which the jury could have reached the conclusions they must have reached and rejected the views of the defence experts. That evidence has not changed since the time of trial.

66. It follows that, having heard the new evidence *de bene esse*, we do not admit it. We disagree with the view of the CCRC that there is some argument or piece of evidence which was not considered as part of the original trial justifying a retrial.

67. Having decided not to admit the new material as fresh evidence, this appeal must fail. We address briefly the specific grounds.

Ground 1

68. There is no evidence that the prosecution psychiatric evidence at trial *"wrongly and prejudicially disputed that schizophrenia was the cause of the 2005 killing of the Appellant's mother".* This was the genuine view of Dr Joseph. He could not have given his evidence coherently without expressing it. The defence case was predicated on the basis that the appellant's responsibility was diminished in 2005, nothing had changed, and her responsibility was similarly diminished at the time of this killing. It would have been a nonsense had Dr Joseph been prohibited from giving his view which was that a mistake had been made in 2005 which ought not to be repeated. It was his view that, at the time of the killing of Sally Hodkin, there was more evidence of the appellant's psychiatric condition available which highlighted that earlier mistake. Had he been prevented from giving the evidence he did, his evidence would have appeared to the jury as an opinion that her responsibility was greater in this case than it had been at the time of her mother's killing. That was not Dr Joseph's view.

Ground 2

69. The allegations that "*the prosecution psychiatric evidence (a) ignored or discounted material facts, (b) was selective and gave an incomplete picture of the evidence to support a diagnosis of schizoaffective disorder, and (c) misstated known psychiatric conditions and diagnoses*" were explored at trial. A huge body of medical evidence, both documentary and witness evidence, was before the jury and available to the defence team. The new evidence does not significantly affect the strength of these contentions.

Ground 3

70. Ground 3 is essentially a reformulation of Ground 2. There is no material supportive of the contention that the prosecution psychiatric evidence was misleading, nor that the jury was misled.

Conclusion

71. We refuse to admit the fresh evidence. We dismiss the appeal on all grounds.