Neutral Citation Number: **[2006] EWCA Crim 955**

Case No: 2005 00654 D3

IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CRIMINAL DIVISION)

ON APPEAL FROM NEWCASTLE-UPON-TYNE CROWN COURT

HIS HONOUR JUDGE HODSON

Royal Courts of Justice

Strand, London, WC2A 2LL

Date: 15/05/2006

Before :

LORD JUSTICE RIX

MR JUSTICE MACKAY

and

HER HONOUR JUDGE GODDARD QC

- -

Between :

Regina Respondent

- and -

Damian James NEAVEN Appellant/ Defendant

- -

- -

Mr David Robson QC instructed by the Crown Prosecution Service for the Crown

Mr Gerard McDermott QC and Miss Laura Bell (instructed by **Darwen Law Chambers**) for the Appellant

Hearing date: 11 April 2006

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Judgment

This is the judgment of the court :

1. On 5 September 2001 in the Crown Court at Newcastle-Upon-Tyne before HHJ Hodson and a jury the appellant, Damian Neaven, was convicted, by a majority of 11 to 1, of murder and sentenced to life imprisonment. He now appeals against conviction, by leave of the single judge who also granted an extension of time, on the ground that at the time of his offence, unknown to himself or his legal advisors, he was suffering from schizophrenia and was entitled to a defence of diminished responsibility. It is submitted that new evidence of his mental illness should be admitted under section 23 of the Criminal Appeal Act 1968, that his conviction should, on the basis of that evidence, be considered unsafe and should therefore be quashed, and that a conviction of manslaughter on the ground of diminished responsibility should be substituted.

2. The Crown oppose this appeal, on the ground that the decision not to run a defence of diminished responsibility, but instead to rely on a defence of self-defence, was a tactical decision which binds the appellant and prevents him seeking now to advance an appeal based on new evidence of his schizophrenia at the time of his offence, albeit that diagnosis is now accepted. It is not said that he or his legal representatives knew of his condition, or even ought to have known of it, but that he was offered the opportunity of a medical assessment by a court appointed psychiatrist and declined it, instructing his solicitors and counsel that he did not wish to undergo assessment. It is said that this amounts to a form of shut-eye knowledge of what such assessment would or might have revealed.

3. The background of this appeal is as follows. On 4 March 2001, the deceased, David Huitson, was stabbed twice in the chest by the appellant. One blow entered the heart, and he died of that wound on 6 March in hospital. It was the prosecution case that the appellant had a grudge against Mr Huitson, had stalked and murdered him. The grudge arose out of the fact that Mr Huitson had given evidence against the appellant in previous proceedings when he had been charged with wounding a Mr Harmison and causing damage to Mr Huitson’s car. The appellant had served six months of

a one year sentence in detention. The earlier incident had occurred in 1997, and he had been released in June 1998.

4. The appellant gave evidence. He acknowledged the previous incident, but said that the aggression since then had been on Mr Huitson's part. He spoke of two meetings in 1998/1999 when he had met Mr Huitson at a pub or in the street and Mr Huitson had shouted at him. On 4 March 2001 he had gone for a walk after an argument with his girlfriend and had come across Mr Huitson by accident. Mr Huitson picked up a stick and said "Come here". He was unarmed. Mr Huitson pulled a knife on him, holding it in his left hand, but he managed to twist it out of his grasp. He was hit on the head with the stick, and lashed out twice with the knife in panic, and then dropped it. Both spoke to the driver of a passing BMW. Mr Huitson buried the knife in the snow and walked to his nearby home. He, the appellant, spoke to the police. It was self defence.

5. That account was rejected by the jury. Soon after his conviction the appellant told a probation officer, as well as a girlfriend in a letter, that his story of self-defence was wholly false. It remains unclear, however, on his own subsequent accounts, whether he came across Mr Huitson by accident or because he was following him.

6. At the time of the killing the appellant, who was born on 7 October 1978, was 22. His psychiatric history extends back to his mid teens, since when he had been in trouble for incidents of violence. In April 1994 his GP referred him to the Young Person's Unit after he had been expelled from school for an assault on a teacher, but the Unit did not see patients whose only reason for referral was violence. In January 1997 he complained to his GP of outbursts of aggression and was referred again to the Unit, but failed to attend. In May 1997 he was referred again by his GP and this time was seen by Professor Hoghugi, who described him as an emotionally immature, impulsive young man who experienced constant, high levels of tension. He was thought to be suffering from longstanding and severe personality disorders. He was recommended for a course of anger and anxiety management, and attended 16 sessions.

7. In January 1998 the appellant was before the courts on a charge of section 20 wounding and witness intimidation, which had occurred early on in his course. These were the earlier proceedings involving Mr Harneson and Mr Huitson. Professor Hoghugi wrote a report for the courts. He spoke of the appellant's anxiety and anger, but said that the anger management programme was successful since there had been no repetition of violence.

8. In October 1998, after his six months in detention, his GP referred him again, this time to the Kolvin Unit, but he did not attend his appointment. In July 1999 he was seen as an outpatient by a general adult psychiatrist, complaining of anxiety, paranoia, drug abuse and aggression. He was thought to be suffering from panic disorder and alcohol dependency, set against a background of a paranoid and antisocial personality. He was prescribed an anti-depressant (as he had been before). In September 1999 he took an overdose and was seen as an emergency in outpatients. He was prescribed another anti-depressant and failed to attend any follow-up appointments. In February 2000 he was again seen urgently in outpatients, complaining of mood swings and aggression. He became tearful for no apparent reason. An antisocial personality disorder and drug abuse were diagnosed. He again failed to attend follow-up appointments.

9. In September 2000 he attended outpatients again after another referral by his GP, complaining of thoughts of violence, which he said came with increasing frequency. He had started following strangers. He was afraid he might seriously harm someone. He became aggressive for no reason and any noise would trigger a panic attack. A personality disorder was again diagnosed. He was referred for further assessment.

10. In November 2000 the appellant took another overdose. This led to his first psychiatric admission, to Collingwood Court, where he spent about a month. He said that he took the overdose after suffering intrusive thoughts of killing his girlfriend: he had held a knife to her throat while she was asleep, but had felt horrified at what he was doing. He had written a suicide note. He spoke of violent fantasies, and of sexual arousal by violent thoughts. He was seen by a specialist registrar in forensic psychiatry, among others. He was diagnosed as having sociopathic and dependent traits,

anxiety disorder and substance abuse. He attended follow up appointments sporadically. In January 2001 he took another overdose, was admitted to hospital but discharged himself. In February 2001 he saw the forensic psychologist and spoke again about his violent fantasies. The killing of Mr Huitson occurred within the next month.

11. The appellant waived privilege for the purposes of his appeal. The court has before it letters from his senior and junior counsel at trial. Mr John Milford QC (now HHJ Milford QC), in his letter dated 23 March 2005, said that he had discussed the case with the other members of the legal team and had seen the solicitors' files. He referred to a written advice which he had given on 31 July 2001, inter alia as follows:

> "I first saw the defendant in consultation on 5th June 2001. It was then apparent, from medical records, that the defendant has a long standing psychiatric history. On what I read, I considered that it was likely that any psychiatric report on the defendant would be exceedingly unhelpful, in that it was likely that it would conclude that the defendant was dangerous.
>
> The defendant is not unintelligent and we discussed the option of a psychiatric report. His clear instructions were that he did not wish a report to be prepared and he has repeated those instructions on 26th July 2001. Furthermore, he has refused the prosecution access to his medical records and has declined to be examined by a psychiatrist who wished to report to the Court."

12. Judge Milford added that the appellant never exhibited any signs of schizophrenia recognisable to a layman; that, as he had never admitted to a murderous intent, there was no question of him entering a plea of guilty to manslaughter on the grounds of diminished responsibility; that the introduction of evidence of his psychiatric history would, on the basis of his medical records, have been fatal to self-defence, that he understood the issues and had made an informed decision.

13. Mr Barry Robson, the appellant's junior counsel, wrote in similar vein in his letter dated 7 April 2005. He also said that the appellant never exhibited any symptom of schizophrenia recognisable to a layman. He also referred to the solicitors' notes, from which, he said, that it was clear that "diminished responsibility with respect to his medical background was discussed with him" and that after this discussion he indicated that he did not want a psychiatrist's report. He added that after his conviction the appellant had admitted that he had been watching Mr Huitson for some time, planning "to do" him.

14. In the meantime, however, and unknown to either the defence or the prosecution, Dr Jill Poole, a locum consultant forensic psychiatrist at Durham Prison where the appellant was on remand awaiting trial, was moving towards a differential diagnosis of schizophrenia. She wrote three letters to the medical officer at the prison. The first was dated 28 March 2001, not long after the offence. She wrote that the appellant's description to her of his psychiatric history was essentially to the effect that he had been previously diagnosed as having anxiety disorder. He spoke of his homicidal thoughts and of commands such as "kill them". She concluded that "He himself believes that both his past and his current symptomatology are due to his previous substance abuse" but that her overall impression was that he "may well have a diagnosis of schizophrenia given that he describes both command and third person auditory hallucinations, passivity phenomena and visual hallucinations." She decided to review him in two weeks time.

15. On 27 April 2001 Dr Poole wrote her second letter. She concluded: "His symptomatology is somewhat confusing both to himself and to myself. It is certainly not classically schizophrenic. At interview although he has a somewhat staring eye contact, his social interaction is relatively normal with spontaneity." However, she decided to increase his anti-psychotic medication.

16. Dr Poole's third letter is dated 20 December 2001, after the appellant's conviction. This letter is addressed to Ashworth High Secure Hospital, and requested an assessment for suitability of the appellant for transfer to Ashworth for further assessment and treatment for his mental disorder. She

described his complaints of both third person voices outside his head and of command hallucinations inside his head telling him to harm others. She concluded:

> "Indeed fitting the whole picture together, I think it is quite likely that his index offence was psychotically driven, and if not was certainly committed at a time when it sounds like he was psychotic. Indeed it was very interesting at the time of his trial that his solicitor advised him not to co-operate with psychiatrists. And indeed he would not discuss the index offence with myself at that time, nor would he co-operate in the obtaining of a psychiatric assessment by the CPS for the trial."

17. On 31 January 2002 the appellant was assessed at Durham Prison for admission to Ashworth by Dr J D Collins, a consultant forensic psychiatrist approved under section 12(2) of the Mental Health Act 1983. The appellant described outside and inside voices. He had been hearing them for years. The inside voice had started when he was about 15. It told him to kill himself or others. As a result of this assessment he was accepted for admission, but it was not until January 2003 that a bed became available for his reception. In the meantime he had been put on antipsychotic drugs. At Ashworth the appellant started to make good progress and co-operated with all recommended therapies.

18. Dr Collins became the appellant's responsible medical officer at Ashworth. The diagnosis he had formed at the January 2002 assessment was of schizophrenia, confirming the differential diagnosis of Dr Poole and further confirmed by the improvement which the appellant had made at Ashworth.

19. In May 2004 a report to Northumberland Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of the appellant concluded that the psychiatrists treating him prior to the killing of Mr Huitson had acted appropriately in forming a diagnosis of generalised anxiety disorder, substance misuse and antisocial personality traits, and in failing to diagnose schizophrenia or any other

psychotic disorder. It referred to a “hindsight diagnosis of schizophrenia” (at para 3.13.15).

20. In September 2005 Dr Collins prepared two reports on the appellant: a lengthy draft Mental Health Review Tribunal report, and a shorter psychiatric report for this court, to be read in conjunction with the longer draft. His psychiatric report attached the three letters from Dr Poole referred to above. The longer report included an account of the killing of Mr Huitson which the appellant had given Dr Collins in June 2004. The appellant accepted he had a grudge against Mr Huitson (“I felt he owed me 6 months”) and that he was obsessed with revenge. He had started to watch him in January 2001. On the day of the killing he had walked four miles “lost in my own little world”, after an argument with his girlfriend, and had come across Mr Huitson in the area of the latter’s home village.

21. In his shorter report Dr Collins concluded that at the time of the offence the appellant had been suffering from schizophrenia (probably beginning in his mid teens) “which was affecting his perceptions, thinking, mood and behaviour in almost all aspects of his life”. His substance abuse was inextricably linked to his illness, and both had contributed to and exaggerated his sense of grievance against Mr Huitson. Albeit with the advantages of hindsight, it was his opinion that at the time of the offence the appellant was “suffering from such an abnormality of mind (arising from inherent causes) as to substantially impair his mental responsibility” (cf section 2(1) of the Homicide Act 1957).

22. In preparation for this appeal the Crown requested another forensic consultant psychiatrist, Professor Don Grubin, to assess the appellant, which he did at Ashworth on 20 March 2006. His findings are contained in his report for the court dated 4 April 2006. He is also approved under section 12(2) of the Mental Health Act 1983. He agreed with Dr Collins that at the time of the killing the appellant suffered from schizophrenia. He said that this was most notable in his paranoid thinking, his irrational pre-occupation with the Huitson family, and his intrusive violent thoughts. To some extent his illness had been masked by his heavy alcohol and drugs abuse. On the question of diminished responsibility, he again agreed with Dr Collins that

his grudge will have been coloured by his mental illness, so much so that he considered it to be irrelevant whether the appellant set out looking for Mr Huitson on the day of his death and the killing was premeditated or whether their encounter was accidental. It was his opinion that "a jury may very well have reached a verdict of manslaughter on the grounds of diminished responsibility if his mental state was understood at the time."

23. Both Dr Collins and Professor Grubin gave evidence orally to the court. In the course of his evidence Professor Grubin went further than he had done in his report in stating that he would feel comfortable now to give as his own opinion that at the time of the killing the appellant's responsibility was substantially impaired by his mental illness.

24. It was therefore common ground that at the relevant time the appellant was suffering from schizophrenia, a mental illness and abnormality of mind, and also that – although this is at root a jury rather than a medical question – his mental illness had substantially impaired his responsibility.

25. Section 2 of the Homicide Act 1957 provides:

> "(1) Where a person kills or is party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts or omissions in doing or being a party to the killing.
>
> (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."

26. On one question only did Dr Collins and Professor Grubin disagree, and that was on the question whether it could be said that the appellant's schizophrenia had affected his decision to refuse psychiatric assessment for the purposes of his trial. The question arose because in the most recent leading case relating to an appeal based on new evidence, post conviction

for murder, of a defendant's mental illness at the time of the killing, this court regarded it as highly relevant, to the question whether it would be "expedient in the interests of justice" for the purposes of section 23 of the Criminal Appeal Act 1968 and the question whether to receive new evidence, that a defendant's decision to rely on self defence and to eschew a known condition of schizophrenia was significantly affected by the illness: see R v. Weekes [1999] 2 Cr App R 520 at 529.

27. On this question Dr Collins gave evidence that in his opinion the appellant's condition had affected his decisions for his trial. If the appellant had known of his schizophrenia, he might well have pleaded differently. Dr Collins wrote in his report:

> "It is my view that, when he was considering how he should plead and instruct his legal team, Mr Neaven had no understanding of the nature of his illness, its seriousness, its far reaching consequences, or its implications for his own health in the long term and his legal situation at the time. In other words, he was making a decision based on incorrect information."

28. In his oral evidence, he elaborated on this opinion. He emphasised the appellant's lack of understanding and insight of his condition. His experience of psychiatric care had left him without benefit: he had received diagnoses of disorders which did not amount to mental illness and could not be treated (other than the early help he had received in techniques of anger management). In fact his schizophrenia could be treated. Moreover, his condition exacerbated his sense of injustice of Mr Huitson's role in his teenage detention: and that sense of injustice could not be assuaged by a plea of guilty. This evidence was barely challenged.

29. Professor Grubin, however, gave to some extent conflicting evidence. He did not dispute the appellant's lack of knowledge or insight, but in his report he said:

> "In my opinion, Mr Neaven's schizophrenia had no affect on his instructions he gave to his legal team, his refusal to allow

> psychiatric reports to be prepared, or his decision to plead self defence. In his account to me he was clear that his decision on plea was based on what he thought gave him the most chance of acquittal, and that given this decision psychiatric reports would have been harmful to his defence…Dr Collins suggests that Mr Neaven's plea and instructions were influenced by the fact that he did not understand the nature of his illness…[E]ven if Dr Collins is right it remains the case that it was not his mental illness that prevented him from giving appropriate instructions to his legal team, but a lack of awareness of his mental illness."

Professor Grubin also said, contrary to Dr Collins' evidence, that he did not consider that the appellant's obsessive grudge was a factor in his decision to plead not guilty on the ground of self defence.

30. Professor Grubin was asked, in cross-examination, on what his opinion in this respect was based, and he made it clear that it was based on what the appellant had told him: it was his understanding of the facts and not, in this instance, an expert medical opinion. He also said that he considered that the appellant had spoken to him openly and without guile. The difficulty about this part of Professor Grubin's evidence, however, is that in the earlier, narrative, part of his report Professor Grubin had stated this:

> "19. In his account to me, Mr Neaven said that in the period leading up to his trial he was comfortable with the advice given to him by his legal team, and he was not suspicious or mistrustful of them in any way; indeed Mr Neaven indicated that he had been using the same firm of solicitors since he was 14 years of age. He told me his barristers discussed with him his psychiatric history, which included reports of his violent thoughts and behaviour, and he understood why a psychiatric report was not being recommended by them. According to him, his decision not to cooperate with psychiatric assessment was based on advice given to him by his lawyers in the context of his defence – he told me that he was informed that medical reports would be required only

> if he was putting forward a defence of diminished responsibility, but otherwise they could only serve to harm his case…
>
> 20. In relation to his claim of self defence, Mr Neaven told me that he knew at the time that the account he gave was untrue, but it was an attempt "to get off with it"…He told me that in retrospect he should have pleaded diminished responsibility as he now recognises that he was mentally ill at the time of the killing."

31. This account is consistent with Judge Milford's original written advice, set out in his recent letter (see para 11 above) to the effect that, on what he had read of the appellant's medical record, it was likely that any psychiatric report would be exceedingly unhelpful in that it was likely to conclude that the appellant was dangerous. It is not clear to us how Professor Grubin's narrative findings are consistent with his later conclusion that the appellant's lack of awareness of his mental illness had not affected the instructions he had given to his legal team.

32. In these circumstances, it seems to us that the factual basis of this appeal is that (1) it is common ground that the appellant was suffering from schizophrenia at the time of killing Mr Huitson and that his schizophrenia at least exacerbated, and may have been the dominant cause (per Professor Grubin) of, the killing; (2) it is common ground therefore, on the medical evidence before us, that at the time of the killing the appellant was suffering from such abnormality of mind as substantially impaired his mental responsibility, in other words had a defence of diminished responsibility; (3) it is common ground that, at the time of trial, his schizophrenia was unknown to the appellant or his legal team, and that he received advice that, on what was known about his psychiatric history, he would receive a psychiatric assessment which would be unhelpful to any defence and portray him as dangerous; (4) there is a dispute between Dr Collins and Professor Grubin as to whether (a) his mental illness, or (b) his ignorance of his mental illness, affected his defence at trial.

33. In these circumstances, what does relevant jurisprudence tell us?

34. In R v. Dodd (10 June 1971, unreported) the defence was one of provocation. The senior medical officer in the prison where the defendant was on remand reported in emphatic terms that there was no sign of mental illness. It was said that fresh evidence of diminished responsibility was later available. Fenton Atkinson LJ said:

> "In the view of this court, cases must be rare indeed when the defence have chosen to run at the trial as their only defence the defence of accident or provocation, or the combination of the two, and when that defence has failed can consult and call a psychiatrist, or a psychiatrist seeing the defendant for the first time many months after the event, with a view of getting a retrial to run a defence of diminished responsibility. It may well be that if subsequent evidence of diminished responsibility was really overwhelming, the court might well feel moved to substitute a verdict of manslaughter, or to order a new trial."

That statement has been cited in several cases since. It appears that the fresh evidence of mental illness was not common ground.

35. In R v. Kooken (1981) 74 Cr App R 30, although it was known that the defendant was suffering from schizophrenia, she refused to put forward a defence of diminished responsibility, and ran a defence of provocation. The Official Solicitor promoted an appeal, against her own wishes. This court rejected an application to admit fresh evidence of her mental condition. Lord Lane CJ said (with reference to the test in section 23(1) of the Criminal Appeal Act 1968):

> "In the end one comes down to asking oneself whether it is "necessary or expedient in the interests of justice" to allow this evidence to be given. We are asked, properly, to act in the interests of this applicant. But can it be in her interests to call evidence she does not wish to be called? To achieve a result which she does not want? And a result which, apart from one respect, will have no practical effect upon the way she is treated, or her future or her disposal?"

36. In 1987 came R v. Straw [1995] 1 All ER 187 where the defendant was known by both prosecution and defence at trial to be suffering from schizophrenia at the time of her offence. She was fully advised as to her defence of diminished responsibility, but she declined to allow it to be put before the court. After conviction, she changed her mind and sought an appeal. This court held, in the judgment of O'Connor LJ, that it was not permissible for her to do so and therefore refused her application for the introduction of fresh evidence and for leave to appeal.

37. In R v. Ahluwalia (1993) 96 Cr App R 133 Lord Taylor of Gosforth CJ made these general remarks (at 142):

> "Ordinarily, of course, any available defences should be advanced at trial. Accordingly if medical evidence is available to support a plea of diminished responsibility it should be adduced at trial. It cannot be too strongly emphasised that this Court would require much persuasion to allow such a defence to be raised for the first time here if the option had been exercised at trial not to pursue it…Likewise, if there is no evidence to support diminished responsibility at the time of trial, this Court would view any wholly retrospective medical evidence obtained long after the trial with considerable scepticism."

38. In 1997/1999 three cases came along which illustrate this Court's approach to such principles. In R v. Borthwick (27 October 1997, transcript 96/7084/X5, [1998] Crim LR 274, this Court admitted the fresh evidence and subsequently substituted a verdict of manslaughter for that of murder: on the basis that there was clear evidence of diminished responsibility at the time of the killing and also that the defendant had not been able to give rational instructions as to the way in which his defence was to be run. The Crown had itself, subject to this Court's approval, accepted that a substituted verdict was the appropriate course. Waller LJ said:

> "He, in their [the reporting psychiatrists'] view, would have been very suspicious of the psychiatrists who were seeing him and of his legal advisers and that may very well have been the reason why he

> ran the defence that he did, which was that he had no responsibility at all."

39. Subsequently, in R v. Shah (30 April 1998, transcript 94/00393/Y5, unreported) the defendant again asked for fresh evidence of his mental condition to be admitted on appeal. However, this court found that his evidence was not capable of belief, and that the medical evidence he sought to rely came into existence long after the offence, relied on his own flawed account, and was challenged by the evidence of other psychiatrists. His appeal therefore failed. It was in those circumstances that Kennedy LJ said this:

> "Mr Fitzgerald submits that even if a defendant puts forward a lying defence the interests of justice may require this Court to permit him or her to put forward a different defence if persuasive evidence is available by the time the case reaches the Court of Appeal. We recognise that in some situations that may be the case, but we see little room for the operation of such a principle in a case of murder where a defendant has freely chosen to deny responsibility for the acts or omissions which caused the death. If his choice was forced upon him by his illness then of course the position is quite different, but in general no one is entitled to more than one trial…[O]nly in exceptional circumstances will this Court receive fresh evidence to enable a defence to be advanced which was not put forward at trial."

40. Finally, in R v. Weekes [1999] 2 Cr App R 520 there were three reports in existence before trial which all concluded that the defendant had a proven defence of diminished responsibility. He was advised that a plea to that effect would be accepted, but he refused to follow that advice and instead put forward a defence of self defence and provocation. He was convicted. He then sought to put forward on appeal the very evidence which was available at trial, but also further psychiatric evidence that his judgment at the time of trial would have been seriously affected by his mental illness and that this might have prevented him from coming to a reasoned decision about his plea. His appeal succeeded, and a verdict of manslaughter on the ground of

diminished responsibility was substituted. Schieman LJ reviewed the cases mentioned in this judgment and concluded (at 529):

> "In the last analysis as appears from all these decisions each case turns on its own facts. Nothing we say is capable of encouraging future defendants or their advocates to make tactical decisions in the hope that in the event of a conviction this Court might admit evidence which permits a substitute defence to be run. We emphasise that we are quite satisfied that this did not happen here. If it were to occur, that alone is likely to be a reason why it would not be in the interests of justice to admit fresh evidence in this Court.
>
> We respectfully endorse all that was said in Jones (Steven), Shah, and Ahluwalia as to the crucial obligation of a defendant to advance his whole case before the jury. We draw attention that in the present case the evidence of diminished responsibility was both unanimous and accepted by the Crown. If it were disputed by the Crown it would no doubt be very unlikely that it would subsequently be in the interests of justice to admit it in this Court, with the consequence that a retrial became necessary. Further, in the present case there is evidence both plain and undisputed that the defendant's decision not to allow the issue of diminished responsibility to be canvassed was significantly affected by his mental illness. That does not appear to have been the situation as the Court understands matters in Straw, though it was the case also in Borthwick. Lastly, although as Borthwick shows, an exceptional case may arise, we think it much less likely that it will be in the interests of justice to admit evidence of diminished responsibility which comes into existence only after the trial, rather than was unanimous and undisputed at the time of trial. The former is, we think, likely to founder on the principle explained in Jones (Steven) and Ahluwalia."

41. We draw from these authorities the following guidance. (1) That the obligation on a defendant to advance his whole case at trial, and the scepticism directed towards tactical decisions, remain fundamental. (2) That it therefore takes an exceptional case to allow it to be in the interests of justice to admit and give effect to fresh evidence, not relied on at trial, designed to promote a new defence of diminished responsibility. However, subject to this, (3) each case turns on its own facts. Therefore, (4) where the evidence of mental illness and substantial impairment is common ground or otherwise clear and undisputed, it may be in the interests of justice (in the absence of opposition from the appellant himself – see Kooken) to admit it. (5) This is especially so if the potential vice of tactical decisions is met by undisputed evidence that such decisions were affected by the defendant's illness itself. (6) The emergence only after conviction of evidence of mental illness and of the potential of a defence of diminished responsibility is of little weight, unless perhaps there is unanimity as to the conditions necessary for such a defence at the time of offence. In this connection it may be observed that only in the special case of Kooken was clear and undisputed fresh evidence on appeal of a good defence of diminished responsibility to the killing not acted upon in this court.

42. If we seek to apply this guidance to the present case, it is immediately noticeable that there are here two special factors not met in the earlier cases. The first is that, although the evidence of diminished responsibility is common ground, it was unknown at the time of trial. The second is that, although there is evidence both that his mental illness and his ignorance of his illness affected the appellant's decision making at trial, that evidence is not undisputed.

43. We think that the first of these factors is quite exceptional: it is certainly not to be found in any of the previous cases. In principle, knowledge of a defendant's mental illness and its affect on him for the purposes of his offence should make it very difficult to introduce such evidence for the first time on appeal: see, in particular, section 23(d) of the Criminal Appeal Act 1968, which mandates this Court, in considering whether to receive any evidence on appeal, to have regard in particular to "whether there is a reasonable explanation for the failure to adduce the evidence in those

proceedings". Even so, where the illness also affects the defendant's ability to give rational instructions, the interests of justice may still require a different result: see Borthwick and Weekes. In this case, there is only disputed evidence as to the affect of his mental illness on the appellant's instructions to his legal team, but the novel feature is that everyone concerned in the appellant's defence was ignorant of his illness, and this is common ground. Not only that, but his psychiatric history persuaded his leading counsel to advise him that a psychiatric assessment would be likely to be "exceedingly unhelpful" and reveal that he was dangerous. Subsequent reports (and Dr Poole's more or less contemporaneous letters) have shown that, although this advice was mistaken, in as much as the appellant's mental illness was already well established and there to be found, it was nevertheless entirely appropriate advice on the information and repeated diagnoses then patent for consideration: see, in particular, the May 2004 report of the Independent Inquiry Panel. In these circumstances, we do not think that it can be said that the appellant (or his legal advisers) made a tactical decision with knowledge or insight which should be considered to bind him. Although Dr Collins' evidence as to the effect of the illness is disputed, we do not think that we can accord any substantial weight to Professor Grubin's view that knowledge of his condition (and the advice which would have been tendered in the light of such knowledge) would have made no difference to the appellant's instructions. That view was admittedly put forward as one based on the appellant's own account and not on any expert understanding, but the appellant's account recorded in Professor Grubin's report did not support his conclusion.

44. On behalf of the Crown, Mr David Robson QC, in his "preliminary" but in the event final skeleton argument for the appeal, said that in the interests of justice the Crown would not resist an application on behalf of the appellant to receive Dr Collins' oral evidence, "but, on the contrary, would welcome it so as to enable the Crown properly to explore the evidence so far adduced". That was before Professor Grubin was instructed. It was not clear from that skeleton whether the appeal would be opposed by the Crown, albeit it was there submitted that, if the Court were minded to quash the murder conviction, it was not accepted that a verdict of manslaughter should be automatically substituted, since a jury should be entitled to consider

whether the appellant's mental illness was outweighed for the purposes of a defence of diminished responsibility by the other factors of substance abuse and the grudge against Mr Huitson, which were identified by Dr Collins as contributing to the offence.

45. As matters developed at the hearing, however, Mr Robson's submissions were clarified or modified in at least two respects. First, at the outset of the hearing, Mr Robson said that the appeal was opposed, on the ground that the appellant's instructions for trial, although not an informed decision in a narrow sense, was to be regarded as amounting to turning a blind eye to any possibilities of a psychiatric defence. However, for the reasons set out above, we do not consider that this submission was made good. Secondly, by the end of the hearing, and after hearing Professor Grubin in the witness box saying that he was comfortable to give the opinion that the appellant had not only been suffering from schizophrenia but that his mental responsibility for the offence was substantially impaired by that illness, Mr Robson was submitting that, if the Court was minded to allow the appeal, it was not clear that the Crown would wish to continue to say that it would be in the interests of justice for there to be a retrial on the defence of diminished responsibility.

46. Nevertheless, Mr Robson continued to oppose the appeal. He submitted that the sole test was whether the appellant's mental illness had itself prevented him from reaching a rational decision as to his defence. He stressed in this context the importance of section 23(2)(d) of the Criminal Appeal Act 1968. Otherwise, the floodgates of multiple trials would be opened. The overall interests of justice would be seen to be maintained in equilibrium when consideration was given to the fact that the appellant's safe and secure custody within a hospital setting would not be affected by the dismissal of the appeal. Certainty and security would be preserved.

47. We have considered these submissions carefully. As stated above, we have no doubt that the principles in favour of one trial and against changing tactics remain of paramount and fundamental importance. However, we do not think that any floodgates are opened on the exceptional facts of this case. And we reject, as did Professor Grubin himself, the submission that the

appellant’s position in custody was unaffected whether he was held in hospital, after transfer from prison, on a conviction of murder, or was detained in hospital following a successful plea of diminished responsibility.

48. In our judgment therefore, we would receive the evidence of Dr Collins and of Professor Grubin on the ground that it is necessary or expedient to do so in the interests of justice, having considered the factors mandated in section 23(2) of the 1968 Act. On that basis, we consider that the appellant’s conviction for murder has been shown to be unsafe. It will therefore be necessary to quash that conviction.

49. We have considered with the assistance of counsel the question whether there ought to be a retrial or a substituted verdict of manslaughter pursuant to section 3 of the Criminal Appeal Act 1968. Mr Robson on behalf of the Crown, having heard the evidence of Dr Collins and of Professor Grubin in court, and having consulted on the question, does not seek a retrial. We are satisfied that the interests of justice do not require a retrial. We therefore substitute a verdict of manslaughter and, on the basis of the evidence we have read and heard from Dr Collins and Professor Grubin, are satisfied that the conditions for making an order for the continued detention of the appellant at Ashworth Hospital under section 37 of the Mental Health Act 1983, and for a restriction order under section 41 of that Act, have been satisfied, and we so order.