APPEAL COURT, HIGH COURT OF JUSTICIARY

Lord Justice Clerk
Lord Bracadale
Lord Marnoch

[2013] HCJAC92
XC237/07

OPINION OF THE COURT

delivered by LORD CARLOWAY,
the LORD JUSTICE CLERK

in

APPEAL AGAINST SENTENCE

by

JOHN STEWART JOHNSTONE

Appellant;

against

HER MAJESTY'S ADVOCATE

Respondent:

_____

Appellant: A Ogg, Solicitor Advocate; McKennas Law Practice, Glenrothes
Respondent: Wade, AD; the Crown Agent

1 August 2013

Statutory background

[1] Section 58(1) of the Criminal Procedure (Scotland) Act 1995, as originally enacted and applicable to the present case, provided that, where a person was convicted of an offence, the court could order that person's detention in a hospital if certain conditions were met. The first of those was that the court was satisfied:

> "(a) ... on the written or oral evidence of two medical practitioners ... that the grounds set out in -
>
> (i) section 17(1) ... of the Mental Health (Scotland) Act 1984 apply ...".

Section 17(1) applied where a person was:

> "(a) ... suffering from mental disorder of a nature of degree which makes it appropriate for him to receive medical treatment in a hospital, and
>
> (i) in the case where the mental disorder ... is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct, such treatment is likely to alleviate or prevent a deterioration of his condition; or
>
> (ii) in the case where the mental disorder ... is a mental handicap, the handicap comprises mental impairment (where such treatment is likely to alleviate or prevent a deterioration of his condition) ... and
>
> (b) it is necessary for the health and safety of that person or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained ...".

Section 1(2) of the 1984 Act defined "mental disorder" as "mental illness or mental handicap however caused or manifested". It also defined "mental impairment" as:

> "a state of arrested or incomplete development of mind ... which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned ...".

The term "mental handicap" was replaced with "learning disability" in the Mental Health (Care and Treatment) (Scotland) Act 2003 (s 328(1)).

[2] The second condition that required to be met under section 58(1) was that the court be satisfied, having regard to all the circumstances, that the most suitable method of disposing of the case was by means of a Hospital Order. The State Hospital could be specified only when, on account of the offender's dangerous, violent or criminal propensities, he required treatment under conditions of special security. It was a requirement of any Hospital Order that it specify the form of mental disorder ("being mental illness or mental handicap or both") concerned and no order could be made unless the offender was described by each of the medical practitioners as suffering, at least in part, from the same form of mental disorder (s 58(7)).

[3] The focus in the appellant's case, at the original sentencing diet and in the appellate proceedings, was on whether he suffered from a mental disorder in the form of a mental handicap comprising mental impairment of a nature or degree which made it appropriate for him to receive medical treatment which was likely to alleviate or prevent deterioration of his condition. There was no dispute that the appellant's character, antecedents and the other

circumstances of the case, including the nature of the offence, made a Hospital Order with a Restriction Order the most suitable method of disposal were he to be suffering from that type of mental disorder.

[4] The appellant continues to be detained in the State Hospital because, notwithstanding that the psychiatric staff may now consider that there is no effective treatment for his condition which could not also be provided in prison (see *infra*), he continues to suffer from a mental disorder (which, as now described, includes a personality disorder) the effect of which is that, if released, he would pose a risk of serious harm to the public. Because the grounds for release are now more stringent than those applicable to the making of an Order (the so called "lobster pot" effect; following Mental Health (Public Safety and Appeals) (Scotland) Act 1999, section 1, amending the 1984 Act in the aftermath of *R* v *Secretary of State for Scotland* 1999 SC (HL) 17), he is not presently eligible for release under the mental health regime.

Pre trial reports

[5] Although there was no express reference to any psychiatric reports in the oral testimony adduced at the trial, there was an inventory of productions, which had been lodged by the appellant, containing four such reports: one from Dr Isobel Campbell, who was then a consultant forensic psychiatrist at Hartwoodhill Hospital, Shotts, dated 9 July 1997; and three from Dr John Baird, dated 23 November 1990, 25 January 1991 and 4 November 1997. Dr Baird was the physician superintendent at the State Hospital, Carstairs, and later consultant forensic psychiatrist at Leverndale Hospital, Glasgow. The appellant would also have had sight of reports from Drs Campbell and Baird, instructed on his behalf, dated respectively 3 and 6 April 1998. There were two psychiatrists on the list of witnesses appended to the indictment. One of these was Dr Raymond Antebi, consultant at Parkhead Hospital, Glasgow. He produced a report, dated 24 July 1997, which was presumably available to both the Crown and the defence, although it is not clear that it was formally lodged as a production. Finally, it is highly likely (see *infra*) that the appellant would also have had sight of a pre-trial report, dated 2 February 1998, from Dr Colin Gray, consultant forensic psychiatrist at the State Hospital, which had been instructed by the Crown.

Drs Campbell, Baird and Gray all gave evidence at the appeal hearing and it is therefore of some significance to ascertain their views as expressed prior to sentencing.

[6] Dr Campbell's report (Appendix 1/5) was supplementary to one, which is not before the court, dated 12 December 1996. The report (App 1/5) was instructed by the appellant's former agents in respect of earlier crimes involving possession of cannabis and a breach of the peace. It is dated only a few days before the homicide which is the subject of the current proceedings (*infra*). It refers to the appellant's past psychiatric history and comments that:

> "In general he has been regarded as suffering from borderline mental handicap and as having problems with alcohol abuse".

The report continues:

> "Cognitive function: he functions in the borderline handicap range of intelligence. He interprets things in a rather naive way and is reluctant to ask for an explanation when he does not understand what has been said which obviously can lead to problems".

In her report of 3 April 1998 (App 1/7), Dr Campbell, who was by then at Dykebar Hospital, Paisley, wrote:

> "The principal diagnosis throughout his contact with psychiatric services had been that he suffers from borderline mental handicap. Some people have regarded him as having sufficient criteria to meet the definition of mental impairment within the Mental Health (Scotland) Act 1984. Few consultants have considered him to meet the criteria for detention".

An IQ on the WAIS-R (Weschler Adult Intelligence Scale) scale of 74 was recorded, along with details of his cognitive function, which accorded with that in previous reports. Dr Campbell stated that: "The notional 'cut-off' for mental handicap is a score of 70 ...". Nevertheless, she considered that he met the criteria for mental impairment. However, she took the view that treatment in hospital was not likely to alleviate his condition or prevent deterioration and on that basis did not regard him as detainable under the mental health regime.

[7] Dr Baird's first report, in 1990 (App 1/18), related to a murder charge (*infra*) which the appellant then faced and which, after being reduced to one of culpable homicide, was found not proven. The appellant had initially been committed to HM Prison, Barlinnie where he was seen by Dr Baird. The records relating to the appellant's past psychiatric care had not at that time been made available. However, Dr Baird was able to ascertain that the appellant

had considerable difficulty adding simple figures (eg 2 + 3 = 4), could barely read and had difficulty with counting money. He was unable to name any towns in Scotland, apart from Glasgow. It was Dr Baird's view that the appellant was suffering from a "mental disorder" in terms of the 1984 Act, although the nature of the disorder was not specified. He recommended that the appellant be remanded at the State Hospital. In due course this was what occurred, following a petition, at the appellant's instance, to the *nobile officium*.

[8] Dr Baird's 1991 report (App 1/20) was made after he had been able to examine the appellant's psychiatric history. He noted the following:

> "Testing his intellectual functioning he is virtually illiterate being able only to read a few simple words and to print his address. In general conversation it is apparent that his knowledge of the world around him is very limited and his attitudes generally are rather superficial and childlike".

Dr Baird concluded that the appellant:

> "suffers from a mental illness and also from mental handicap and that the mental handicap comprises mental impairment".

Dr Baird described the mental impairment as a lifelong and enduring condition, although the mental illness varied in severity. He was firmly of the opinion that the appellant was mentally disordered at the time of the offence and that his responsibility for his actions was diminished. He took the view that, in the event of the appellant being convicted, he ought to be made the subject of a Hospital Order.

[9] In his 1997 report (App 1/9) in connection with the offence concerned in the current appeal, Dr Baird reported that psychiatric opinion on the appellant in the past had been to the effect that he suffered from a "mild to borderline degree of learning disability". This remained Dr Baird's opinion. He did not consider that the disability was of sufficient severity to render him of diminished responsibility, but that a further opinion should be sought from the State Hospital.

[10] Dr Baird's 1998 report (App 1/11) is marked as having been typed on 6 April and would have been available prior to sentencing. It contains the following, amongst other, conclusions:

> "I do not consider that he is suffering from any ongoing psychotic mental illness but his intellectual level is significantly below average and he is in the category of borderline learning disability. In addition, his history clearly demonstrates that when he is outwith a structured mental health environment his mental state and his

behaviour deteriorate very markedly and I therefore consider that he suffers from mental impairment. I consider that this condition is a lifelong condition. It would have been affecting him at the time of the alleged offences and thus could render him to be of diminished responsibility.

I consider that if he is convicted of a reduced charge, then in order to protect the public the Detention Order made in respect of him should be of indefinite length with his eventual release, if that stage is reached, only being possible when those responsible for him are thoroughly satisfied that he no longer presents a risk, and, of equal importance, only possible when those responsible for him are satisfied that the arrangements for supervision and aftercare are adequate.

The need to protect the public could equally be met, either by a sentence of life imprisonment or the imposition of a Hospital Order, together with a Restriction Order without limit of time to the State Hospital, but in addition and viewed from the perspective of [the appellant's] need for long-term treatment in a clinical setting and long-term clinical supervision, committal to hospital via a Hospital Order would provide this in a more consistent and structured manner and would have significant advantage.

I have put forward my opinions in these terms because I do consider this to be a marginal case and it could well be that medical opinion presented to the court will be divided".

[11] Dr Gray's 1998 report (App 1/6) is marked as being production No. 70. As the indictment had 69 productions, it is highly probable that this document was added to the list by way of a section 67 notice (Criminal Procedure (Scotland) Act 1995 s 67(5)). The report stated the appellant's IQ to be 74 (see *supra*). The opinion of Dr Gray was that the appellant:

"suffers from limited intellectual capacity or mental impairment. ... It is likely ... this his responsibility for his actions may be diminished by this impairment.

Should [the appellant] be convicted of offences for which the penalty is not fixed, it would not be possible to recommend a hospital disposal as appropriate. I do not believe that the degree of his disorder would allow his detention in hospital under the auspices of the Mental Health (Scotland) Act 1984".

[12] Dr Antebi's report (App 1/8) noted that the appellant's intelligence was below average "perhaps in the borderline area". Dr Antebi noted, for example, that the appellant had told him that there were nine months in the year, but he could only name three of these. The appellant's numeracy skills were better than they had appeared to Dr Baird, but he could not subtract 2 from 24 accurately. He was unable to read and could only write his name. The report quoted a passage from a report of Dr Jenni Connaughton, consultant psychiatrist, during a period of admission to the State Hospital in July 1994, as follows:

> "Although there have been occasions in the past when [the appellant] has been diagnosed as suffering from mental handicap this has not been confirmed during his present admission. Not only have the psychological assessments found him to be functioning within the borderline to low normal level of intelligence, he also demonstrates sufficient adaptive skill as to exclude a diagnosis of mental impairment".

Dr Antebi considered that he might have been exaggerating the extent of his low intelligence. He did not consider that diminished responsibility had been present. He expressed the clear opinion that the appellant was suffering from a personality disorder, but not a mental illness.

The trial

[13] On 8 April 1998, on the fourth day of his trial at Glasgow High Court on a second charge of murder, the appellant pled guilty to culpable homicide whereby, on the night of 16/17 July 1997, at a flat in Rosemount Street, Royston, he had assaulted the deceased, aged 27, raped her and thrown her from a window to her death.

[14] The evidence which had been led revealed that the appellant and a male friend had spent the day drinking, latterly at the flat of the deceased in a tower block. The deceased was known to the appellant. During the course of the evening, sexual intercourse took place between the appellant and the deceased, which the appellant's companion had described as being against the will of the deceased (ie rape). The CCTV images from the security camera in the tower block recorded the body of the deceased falling from a sixth floor window to the pavement below, where the deceased was subsequently discovered by the night watchman in a fatally injured state. The CCTV had also recorded the appellant and his companion passing the body on the pavement as they left the building. They paid no apparent attention to it.

[15] As noted above, the appellant had already been acquitted of homicide in 1990. This was known to his counsel, who had defended him on that occasion also. In a commendably full and frank note, which counsel prepared following upon allegations by the appellant of defective representation at the second trial, counsel describes, with some concern, that the earlier trial had involved the appellant meeting a man in George Square and going back to that man's flat. The appellant was then said to have killed that man. Because it was clear at that time that the appellant was psychiatrically ill (see Dr Baird's reports *supra*), counsel

reports that the Crown proceeded against him on an indictment charging only culpable homicide. Counsel's note, in connection with the second trial, continues as follows:

> "The problem was that as far as the expert evidence was concerned the picture was less clear than before. There was ... a suggestion that [the appellant] was not mentally ill but had a severe psychopathic personality disorder. I am not now quite sure how this change of attitude had come about. It may simply be that there was a development in psychiatric attitude regarding the distinction between illness and personality disorder. Certainly that distinction has been a cause of great difficulty over a long period and was at the time of [the appellant's] offending. In any event the Advocate Depute was at first reluctant to accept a plea on the grounds of diminished responsibility.
>
> All of this was discussed with [the appellant]. It was explained to him that if there was no plea to the reduced crime of culpable homicide and if he was convicted of murder, as seemed likely, he would be in prison for life and, standing the background I have outlined, with no foreseeable prospect of release. On the other hand if the Crown could be persuaded to again deal with him as committing culpable homicide then he would be detained in the State Hospital and dealt with in that system.
>
> [The appellant] was very clearly of the view that he did not want to go to prison and asked us to try and persuade the Crown to accept culpable homicide on the grounds of his mental state ...".

[16] Counsel did persuade the advocate depute to accept a plea to culpable homicide. He did not challenge the psychiatric evidence as to do so would have conflicted with his instructions. Counsel accepts that there may have been a body of psychiatric evidence in this case which contradicted the agreed plea and would have militated against the making of Hospital and Restriction Orders. However, what is clear from counsel's note is that the plea to culpable homicide was agreed with the Crown on a very specific basis. That basis was that (subject to the view of the court) a Hospital Order, and not a prison sentence, would follow. Had that consequence been resisted by the appellant, the Crown would not have accepted the plea to culpable homicide and the trial for murder would have continued. Accordingly, counsel was able to express the view that, so far as the appellant was concerned at the time, the resultant Hospital Order was not a miscarriage of justice.

[17] What happened after the plea had been recorded was that the trial judge heard testimony, in very short compass and without any apparent reference to any of their reports, from Drs Baird and Gray to the effect that the appellant did suffer from a treatable mental handicap, being mental impairment, sufficient to meet the conditions of section 58. This

testimony was not challenged by the appellant. Given that the psychiatrists were also agreed that the appellant posed a serious danger to the public, a Hospital Order with a Restriction Order in terms of section 59, was recommended. The sentencing judge accepted that recommendation.

Post trial developments

[18] On 2 April 2007 the court granted the appellant an extension of time within which to lodge a Note of Appeal against sentence. This decision permitted a Note to be lodged nine years after sentence had been pronounced. On 21 April 2007, leave to appeal was granted. The judge determining leave at first "sift" stated that he was "unable to characterise the present grounds of appeal as unarguable, especially on the subject of defective representation". This is not, of course, the correct test, which is rather that leave should be refused unless it can be said positively that the grounds are arguable (1995 Act, s 107(1)). Furthermore, in early course, it was made clear on behalf of the appellant that the defective representation ground was not a discrete one, but simply a part of a narrative which, it was hoped, would persuade the court to hold that the Hospital Order had not been "appropriate".

[19] The Note of Appeal has at its core the proposition that the sentencing court should not have made either a Hospital Order or a Restriction Order because the appellant was not at the time suffering from a mental disorder in terms of section 58. This is, as will be obvious, notwithstanding that, at the trial, the appellant expressly accepted the exact opposite. The Note states that the psychiatrists erred in their assessment and that their evidence had been contradicted by the content of reports from Dr Campbell, dated 9 July 1997 and 3 April 1998, Dr Gray, dated 2 February 1998, and Dr Antebi, dated 24 July 1997. It is said that, had these reports been placed before the court and appropriate evidence led, no Hospital Order would have been made. As noted above, reports from Drs Campbell, Gray and possibly Antebi were before the court at least in the sense of having been lodged in the trial process. In addition, it is contended that significant new evidence is available in the form of reports from Dr John Crichton, dated 12 January 2004, and Dr Rajan Darjee, dated 25 August 2004, to the effect that the appellant did not suffer, and has never suffered, from any mental impairment. In due course, a further report from Dr Tom White, dated 8 January 2008, was said to be to the same effect. All of this indicated, according to the appellant, that the

disposal of the case by the imposition of a Hospital Order and a Restriction Order amounted to a miscarriage of justice.

[20] Notwithstanding the fact that the case passed the sift as early as April 2007, it proceeded slowly, principally because it was decided that it should await the outcome of a similar appeal from Alexander Reid in respect of a Hospital Order dating back to 1967. Mr Reid's appeal was advised, after protracted procedure, in November 2012 (*Reid* v *HM Advocate* 2013 SLT 65), when the relative Hospital and Restriction Orders in his case were quashed and a discretionary life sentence of imprisonment imposed with an expired punishment part of ten years.

The evidence in the appeal

[21] On 7 December 2012, the court appointed the appeal to "a full hearing with all arguments in relation to the appeal to be heard. If it transpired at that hearing that evidence in relation to the psychiatric position would be required" then a further hearing would be appointed. The purpose of that interlocutor was for the court to hear all the legal arguments in relation to the appeal and to require oral testimony only if a relevant and material dispute of fact arose. This approach appears to have been departed from by the court at the subsequent hearing because the court appointed a further two day diet to hear testimony from six psychiatrists *before* hearing legal argument. It is regrettable that the court should have effectively reversed the decision of the earlier court of identical quorum.

[22] The appellant led all the six psychiatrists. Most of the testimony involved the doctors being referred to the content of their reports, of which the court had already had sight in advance of the hearing. The content of the reports was often repeated in other or later reports by different or the same doctors. This exercise took the full two days and a third day required to be set aside for the hearing of submissions.

Dr Crichton

[23] The first of the psychiatrists was Dr John Crichton, consultant forensic psychiatrist at the Orchard Clinic, Edinburgh, and formerly medical director of the State Hospital. He had first met the appellant in November 2003 (ie after the Hospital Order had been made). He produced his first report on 12 January 2004 (App 1/12). He noted that, when the appellant had been aged only 13, he had been assessed as having an IQ of only 59 (verbal 69,

performance 57) "which would have comfortably placed him in the learning disability range". In 1981, he had been admitted to Lennox Castle Hospital, upon the order of the court, and had his IQ measured at 60. In 1990, when he was transferred to the State Hospital while awaiting trial for homicide, this had apparently risen to "between 60 and 70" ("mild learning disability"). There was "clear evidence of childhood conduct disorder and adult anti-social personality disorder". Dr Crichton noted that a new (1998) psychology assessment recorded the appellant's IQ at 74, which "comfortably placed him within the borderline range of intellectual ability, which would not normally be satisfactory to justify detention in terms of mental impairment". He stated that, after the making of the Hospital Order, the appellant had not been accepted by the Learning Disability Service (LDS) at the State Hospital, where he was held in a "mental illness" and not a "learning disability" ward.

[24] Dr Crichton's report recorded that he was "very surprised" that the appellant had ever been admitted to the State Hospital on the grounds of learning disability, especially given that there was a letter from Dr Tom White, consultant psychiatrist, dated 10 May 2000, to Dr Steve Young at the LDS, stating that he had concluded that the appellant was "not mentally impaired". Dr Crichton did not consider that the appellant, whom he viewed as meeting the criteria for a psychopathic disorder diagnosis, was amenable to treatment for his personality disorder. He concluded as follows:

> "6. The most surprising aspect of this case is that prior to the current hospital disposal it was accepted by the State Hospital consultant psychiatrist, confirmed by a State Hospital clinical psychologist, that [the appellant] did not suffer from mental impairment. This opinion is reinforced by the fact that the [LDS] was not involved with his care or treatment and have declined to be involved in his care and treatment...
>
> I understand that [the appellant] was re-admitted to the State Hospital on the basis of mental impairment but it should have been clear at the time that mental impairment was not present...".

[25] A supplementary report from Dr Crichton, dated 30 March 2007 (App 1/13), recorded that a neuropsychiatric report of 2004 had documented a full scale IQ of 75. Verbal IQ had dropped from 74 to 72, but performance had increased from 77 to 80. The WAIS-3 gave a full scale IQ of 63. On these figures, Dr Crichton considered that the appellant fell above the learning disability range and should therefore not have been detained on the grounds of mental impairment. He noted that the appellant had shown a degree of application in

relation to what he had learned at the Hospital and "in that sense there is evidence of treatability". Any treatment of this type could, however, be carried out in prison during courses on alcohol, drugs, sex offending and anger management. Dr Crichton accepted in cross examination that the appellant's RMO (Responsible Medical Officer), Dr Connaughton, had taken a different view on "treatability". She had believed that there was treatment at the State Hospital which could at least prevent a deterioration in the appellant's condition

[26] Dr Crichton explained that he did not understand how the Hospital Order had come to be made. Although Dr Baird had been consistent, Dr Gray had appeared to change his mind and this was not explained in his testimony at court. It would have been better if an interim order had been pronounced, thus allowing a period for reflection. Dr Crichton accepted that the assessment of mental impairment was not an exact science. IQ was only one factor. The figure of 70 was not rigid. The assessment of a person's day to day functioning, notably his ability to carry out daily tasks, was another factor. Different psychiatrists could reach different answers. There was room for professional disagreement and, since *R* v *Secretary of State* (*supra*), it was the practice to have a much more detailed examination within the context of an interim Compulsion Order.

[27] Dr Crichton's third report, dated 14 September 2007 (App 1/13), recorded that the appellant had applied himself well to a programme of therapeutic services, which had been laid out by his RMO in the context of a possible transfer to England, where there are specialist units dealing with persons with personality disorders. His fourth report, dated 15 April 2008 (App 1/29), repeated his former conclusion that the appellant had been "wrongly disposed of at the time of sentence". A fifth report, dated 12 August 2009 (App 2) was to a similar effect; stating that, if the appellant were to be referred to him today, he would not recommend any psychiatric disposal.

[28] A sixth, lengthy, report, dated 1 March 2013 (App 2A), to a large extent summarised Dr Crichton's previous reports. It identified Dr Gray's report of 2 February 1998, in which he had said that he did not consider that the appellant's degree of disorder merited a mental health disposal. He thought it unusual for Dr Gray to recommend such a disposal without consulting the LDS specialist, namely Dr Young. If he had consulted Dr Young then, Dr Crichton accepted in cross examination, that might make his change of mind easier to understand. Equally, it would be a surprise if it turned out that the appellant had spent a

year with LDS. When it was pointed out that this was in fact the case, Dr Crichton was "happy to correct" himself in that regard. The report concludes:

> "(4) [The appellant] is inappropriately placed within the State Hospital and should never have been given a restricted hospital order disposal in the first instance. A discretionary life sentence would be a suitable mechanism for managing his future risk to others."

Dr Darjee

[29] The second psychiatrist was Dr Raj Darjee, consultant forensic psychiatrist at the Orchard Clinic, Edinburgh and a specialist in personality disorders and violent and sex offenders. He had produced a report dated 25 August 2004 (App 1/14), after the making of the Hospital Order, which detailed the appellant's previous psychiatric history. This included reference to a diagnosis in February 1992, by a consultant at Hartwoodhill Hospital, that the appellant was suffering from a severe personality disorder with low average intelligence. In 1994, during the appellant's second admission to the State Hospital on charges of attempted murder, he was recorded, after assessment, as not having any mental illness but a personality disorder with mild mental handicap. During the appellant's assessment at the State Hospital, and prior to the making of the Hospital Order, Dr Darjee focused on the appellant's RMO (Dr Gray) stating, in his report dated 2 February 1998, that it was not possible to recommend a hospital disposal as appropriate.

[30] Dr Darjee noted that most of the appellant's first year at the State Hospital had been spent on Cromarty Ward, which was one for patients with intellectual impairment. This was because his admission had been on the basis of his borderline intellectual state. The reason for his transfer out of that ward had been because of his behaviour and, in particular, a serious assault on another patient on 23 October 1998. His continued detention came to be based not upon mental impairment but because of his personality disorder.

[31] Dr Darjee reported that the State Hospital did not consider that the appellant was suffering from any learning disability. Rather, his measured IQ had underestimated his actual IQ due to certain factors, including lack of education and a degree of deafness. Although the appellant was below average intelligence, his deficit was not of such a degree as to qualify for a diagnosis of learning disability. Therefore "neither at the time of his disposal nor at any point during his admission to the State Hospital could he be said to fulfil the legal criteria for mental impairment". In essence, it was Dr Darjee's opinion that the

combination of the appellant's IQ and his level of functioning did not justify a finding of mental impairment. Equally, he did not think that the appellant's mental state was such that justified the acceptance of a plea to culpable homicide on the basis of diminished responsibility.

[32] Dr Darjee prepared a second report, dated 7 July 2006 (App 1/15), which repeated his previous assessments. Yet another report, dated 24 September 2009 (App 3/2) again reiterated his earlier views. It was "highly unlikely that any psychiatrist, either then or now, would recommend a hospital disposal in such a case". Had a hospital disposal been considered, then an interim Hospital Order would have been the appropriate way forward.

[33] Dr Darjee explained that the criterion of treatability did not come into the equation when dealing with persons with severe personality disorders. Any treatment suitable for those types of conditions was available in prisons. All the programmes which the appellant had been undertaking at the State Hospital were also available in prisons. Some personality disorders could respond to treatment in terms of broad nursing care and individual, or group, psychological work, or in terms of drugs. However, there was no standard treatment for persons with personality disorders. Sometimes the appellant's behaviour was better than at other times. However, the appellant would not respond to treatment to such a degree that he no longer posed a risk to the public.

[34] In cross-examination Dr Darjee accepted that, in 1998, the psychiatrists had indeed diagnosed the appellant as having learning difficulties. He himself would not have done so, but he accepted that the views of an expert in learning disability, such as Dr Young, would prevail. The social functioning of persons was affected by their having antisocial personality disorders. Although it was highly unlikely that a psychiatrist would make a recommendation for a psychiatric disposal in a case such as that of the appellant now, Dr Darjee accepted that that is in fact what had happened. If there had been sufficient information to justify such a disposal, he would have accepted that. A different psychiatrist could have reached a different view from his own, in respect of a borderline IQ of 70 with difficulty in social functioning. It could have been a factor in the decision-making process that at the time treatment was thought to be available. The criteria were different now and the threshold was higher.

Dr Campbell

[35] Dr Campbell was retired by the date of the appeal hearing from her position as principal medical officer in forensic psychiatry for the Scottish Government. She had also been an honorary consultant at the State Hospital. She spoke to her reports of 9 July 1997 and 3 April 1998 (*supra*).

[36] Dr Campbell produced an extremely detailed report dated 17 September 2009. She recorded in this that the reason for the appellant's move from Cromarty Ward was because of the assault on another patient. She described the appellant's lack of capacity to understand situations other than the immediate and his failure to think through the implications of his actions. He was a person who could become extremely aroused and violent very quickly, especially when drink and drugs were involved. Even in the context of a twelve bedded ward with four staff, he found it difficult to deal with minor things that might upset him. The concern about the immediacy and seriousness of the risk which the appellant posed to others in terms of violent and sexual crime was such that his case was "quite unusual". He was currently detained solely because of his personality disorder.

[37] If the appellant had pled guilty to culpable homicide today, Dr Campbell's view was that her recommendation would depend upon whether she had had access to the detailed information which she had presented in her report. The report continued:

> "Without that knowledge, I would probably recommend that he be dealt with in the prison system as I did in 1997. Given that I would have considerable doubts about his ability to benefit from treatment I would certainly not be immediately recommending a Compulsion Order and Restriction Order. However, after a lengthy period of assessment in terms of the *interim* Compulsion Order I might have felt it appropriate to recommend the imposition of a Hospital Direction which would allow treatment in hospital but return to the prison system if appropriate. ...
>
> Despite his wish to be transferred to prison he is in my professional opinion more appropriately placed in the State Hospital, both in terms of receiving appropriate treatment and for the protection of the public".

[38] Dr Campbell explained that the activities at the State Hospital kept the appellant occupied. He had an enormous input from the nursing staff, in a setting which had an exceptionally high staff:patient ratio. The nurses were able to anticipate and intervene when the appellant's disorder manifested itself. Although she could not say that this regime had produced a wonderful improvement in his condition, there had been small changes and he was less violent and aggressive. She did not agree that he should be kept in a prison setting.

[39] A supplementary report dated 28 February 2013 (Pro 33/2) recorded in its conclusions that the appellant's "sole diagnosis" was one of "personality disorder", which had become the mental disorder justifying his continued detention. Whilst mainly described as dissocial, the appellant also met the criteria for a number of other personality disorders, including the paranoid, borderline obsessive, compulsive and avoidant. However, the report continues:

> "[The appellant] has now been in the State Hospital for 15 years. Initially diagnosed as learning disabled he has consistently been assessed as in the borderline range of intelligence in recent years. He has been described as functioning in the lowest 2% of the population intellectually. In addition he has other specific deficits particularly poor memory for verbal material, difficulty recognising the emotions of others from facial expressions and deafness. He can participate well in a one to one conversation in a quiet area but finds situations with a lot of noise around much more difficult. He has a low threshold for discharge of aggression and his response to relatively trivial events in grossly disproportionate. His anger escalates extremely rapidly".

In her conclusion, Dr Campbell expressed the view that treatment was available within the State Hospital to prevent deterioration in the appellant's condition. It was her opinion that this treatment was alleviating his condition, albeit slowly. There had been some improvement in his presentation and at interview she had found him to be more reflective and insightful than previously. The treatment programmes available in prison would be unable to address his particular needs. Despite his wish to be transferred to prison, he was more appropriately placed in the State Hospital, since treatment was necessary in the interests of his own health, safety and welfare and for the safety of others. The appellant had had multiple disadvantages in life and had problems in understanding the world around him now. The original diagnosis had been one of mental impairment, which could be a combination of borderline IQ together with difficulties in social functioning. The conditions for mental impairment had applied at the time of sentencing. On this basis, although others now thought that he did not meet the relevant criteria, the combination of IQ and difficulties in social functioning had made the Hospital Order an appropriate disposal.

Dr Baird

[40] Dr Baird spoke to his earlier reports from 1990, 1991, 1997 and 1998 (*supra*).
In evidence at the Appeal Hearing, he confirmed his view that at the time the better disposal had been one to the State Hospital. He was referred to his testimony at the sentencing diet and confirmed that he was not cross-examined, nor referred to any reports. There was no

reference in his testimony to the case being a marginal one. Dr Baird recalled that there was uncertainty until the position of the State Hospital (ie Dr Gray) had become clear. The case remained a marginal/borderline one. Nevertheless Dr Baird considered that there was benefit in a Hospital Order. Once the State Hospital's position had become known, a way ahead for the case had opened out "more smoothly" than had been the case previously.

[41] Dr Baird produced a further report dated 25 April 2007 (App 1/24). This was a detailed assessment of all the records. It concluded, as follows:

> "I consider that [the appellant] is suffering from mental disorder and that this is the same mental disorder from which he was suffering in 1998. I am unable to support his appeal. I am aware in this case that medical opinion is divided and I remain of the view, as I was in 1998, that this is a marginal case. Arguments could be put forward with some conviction both for and against [the appellant] suffering from a mental disorder and I do not consider that either position could be presented in terms which were overwhelming. My reasons for concluding that he does suffer from mental disorder and for being unable to support the appeal are as follows.
>
> While there could be extensive and detailed argument as to whether his level of intellectual functioning is sufficiently below average to constitute learning disability, there does not appear to me to be any disagreement over the fact that his level of intellectual functioning is significantly below average.
>
> There is agreement that he suffers from a severe personality disorder.
>
> There is evidence that within the State Hospital he has been deemed suitable to participate in, he has co-operated with and has benefitted from, a range of sophisticated and complex psychological therapies which have been administered both individually and in a group setting. From my knowledge of services within Scotland at the present time, I am not aware of any other setting, apart from the State Hospital, where therapies of this kind would be available at this level of intensity. I am aware that a range of psychological and behavioural interventions are provided within the Scottish Prison Service, but not of the same level of complexity or within the same capacity to respond to individual need. ...
>
> ... I agree with those opinions expressed by colleagues to the effect that the degree of learning disability present does not constitute a mental disorder and to the effect that severe personality disorder of this kind would not be deemed to be a mental disorder requiring treatment and would not result in a recommendation for hospital committal. However, I take the view that while each of these conditions on its own is below the threshold for hospital committal, when they are combined, as they are in this case, they do reach the necessary threshold and were I to be challenged on this point I would cite the psychological therapies which have been provided for him since 1998 and the general agreement ... that there has been progress and improvement, albeit slowly, as a result of those treatments".

[42] Dr Baird explained the effect on psychiatric services of the escape of Messrs Mone and McCulloch in 1976. "Personality disorder" became a diagnosis of exclusion, which suggested that psychiatric services should have no role. The episode had had a "hugely serious impact" on Scottish forensic psychiatry. The effect of the incident had been so serious that therapeutic optimism had significantly diminished and only in the last ten years had the view re-emerged that personality disorders do respond to treatment even if they are much better dealt with within the prison system in the form of programmes and offence focussed work. The prison system was much more robust, tangible and generally better than it had been in 1998. The programmes were not as intense as in hospital. They were more straightforward in their approach, compared to those within the "fluffy" hospital atmosphere. If the appellant's only problem had been his level of intellectual functioning, that would not have been grounds for a hospital order. However, when that was set alongside his emotional vulnerability and behavioural problems, his condition did constitute a mental disorder. The whole was greater than the sum of the parts.

[43] Dr Baird produced yet another report dated 8 July 2009 (App 2/1). This set out that the appellant had an "antisocial personality disorder and probable diagnosis of paranoid personality disorder". The report stated, again, that the appellant's case was "marginal". Dr Baird mentioned that it was now recognised that individuals, who in the past had been deemed to be learning disabled, appeared to improve as they grew older. The report ended as follows:

> "... if [the appellant] were to be convicted today of the culpable homicide of which he was convicted in 1998, then I consider that it is very likely that the recommendations to the court would be in different terms and a mental health disposal would not be proposed.
>
> Regarding the specific matter of the treatment of personality disorder, I consider that this is a potentially confusing area. The cognitive limitations which are associated with personality disorder, and the behavioural consequences of the disorder, are managed and contained both within the prison and the hospital system. [The appellant] has received in hospital specific interventions directed towards his personality disorder and similar interventions, albeit of a less intensive nature, are available for him in prison. ...".

[44] In a letter dated 14 April 2012 (Pro. 20) Dr Baird re-stated his position as follows:

> "I consider it a relatively straightforward matter that if I were to be assessing [the appellant] in 2010, in the circumstances in which I was asked to assess him in 1998, then I would not recommend a mental health disposal. It is a different matter,

> however, to consider whether my recommendation in 1998 was wrong. This has to be considered against the background of prevailing practice and opinion at that time, and because of this consideration I find it difficult to express a firm opinion either way. I want to emphasise, however, that I am not merely defending my 1998 opinion for the sake of doing so. All I think that I can say is that it is certainly possible that I was wrong. I put it in these terms because I consider that revisiting earlier decisions and judging them by the practice of another time is an exercise which in my opinion should be undertaken with considerable caution".

In expanding upon the use of the word "wrong", Dr Baird explained that, if someone were to say that he should have come down on the other side, he could not give powerful reasons for not having done so. Nevertheless, he remained of the view that "I made the best opinion I could at the time in good faith".

[45] Finally, in relation to Dr Baird, a report dated 27 February 2013 (Pro 34) noted the following:

> "For a substantial period now the opinion is that [the appellant] is not suffering from mental illness, nor is he learning disabled, but he does have a personality disorder. Following the administration of an International Personality Disorder Examination (IPDE), he was found to meet the threshold of antisocial personality disorder and to have a number of the traits of paranoid personality disorder. In addition he is considered to be psychopathic".

The nursing staff were of the view that anything which the appellant might require in the way of support or input could be provided for him in prison. His level of intellectual functioning was "clearly within the normal range". The report concluded, in slightly different terms to the previous one, as follows:

> "While I find it difficult to review an opinion retrospectively against a background which did not prevail at that time, if that exercise is undertaken in [the appellant's] case then my recommendation would be viewed by today's standards as having been wrong".

Dr Gray

[46] Dr Gray was referred to his report of 2 February 1998 and explained that he did not at that time view a Hospital Order as appropriate because, although the appellant had mental impairment, he would not have met the treatability test. After his report there had been an adjournment of the trial diet from 9 February to 30 March to allow a further assessment to take place. Under reference to his report of 1 April 2008 (App 1/27), Dr Gray said that he had ceased to be the appellant's RMO after sentencing as, at that point, the appellant had been

put into the LDS ward, although he had not remained there. The report mentions the letter of 10 May 2000 from Dr White to Dr Young asking Dr Young to reconsider whether the appellant's needs might be best met by a return to the LDS ward. Dr White had concluded that the appellant was not mentally impaired. In the conclusions Dr Gray stated that, having regard to the measurements of the appellant's IQ:

> "In April 1998 there was a reasonable consensus of professional opinion that [the appellant] suffered from a mental disorder that placed him in the category of mental impairment ... I concluded that the impairment of his intelligence was significant. It was recognised that he additionally presented personality disorder and this contributed to placing him in the legal category of mental impairment. The degree of the impairment of his social functioning is not categorical, but linear and a matter of judgment.
>
> After taking my view of this matter and the treatability of [the appellant's] disorder into consideration, I revised my opinion and gave the oral evidence ...
>
> I remain of the view that those recommendations were appropriate. [The appellant] was still having his detention in hospital justified on the grounds of mental impairment three years after his hospital disposal. He has required psychological treatments adapted for those with limited intelligence and he is said to have shown some improvement. His progress since 9 April 1998 does not cause me to believe that the recommendations given to the court at that time were inappropriate or out of keeping with contemporaneous practice".

[47] In a letter of 16 February 2010 (Pro. 18), Dr Gray commented on his doubts on whether the appellant would have been able to cope with prolonged imprisonment. This was so, albeit that he accepted that the prison service coped with individuals similar to the appellant. His opinion, in this letter, was:

> "I have seen no new material that leads me to conclude that the disposal of this case in 1998 was inappropriate or out of keeping with practice at that time".

In a report dated 17 Jun 2013 (Pro. 35) Dr Gray explained that, on the day prior to his giving evidence, he was, unusually, approached by the advocate depute and defence counsel. It was put to him that the appellant could be treated in hospital and that perhaps he should think again about his conclusion. Following upon this, he returned to the State Hospital and consulted with Dr Young, who was an expert on learning disability. They discussed other cases and the similarities between them. Dr Young was less pessimistic than Dr Gray had been on the subject of treatment and, by the following day and in light of the discussion, Dr Gray was able to state that he had revised his opinion and was able to make the

recommendation which he did make in his testimony that the appellant's condition was treatable. The report expresses Dr Gray's opinion as follows:

> "Had I been aware in 1998 of the course that [the appellant's] case would take I would have been unlikely to recommend a hospital disposal. He has shown little underlying change or shown genuine response to treatment. His detention in hospital has prevented his behaviour from escalating in the most dangerous ways, but this has not been an effect of specific treatment. Clinical practice has changed in the intervening years".

Psychiatrists now took a stricter view on learning disability. In 1998 the practice had been to take a broader view and that, although a person might be slightly above the IQ level of 70, treatment might still be recommended.

Dr Dewar

[48] Dr Ian Dewar is a consultant forensic psychiatrist at the State Hospital. He had been the RMO for the appellant since 2009 and prepared a report, dated 6 October 2009 (Pro. 16). This noted Dr White's conclusion, in 1994, that there was no evidence of major mental illness, nor of learning disability. Although the appellant's IQ fell just within the normal range, he did not have deficits warranting detention by virtue of mental impairment. Dr Dewar's involvement with the appellant had begun in 2007, when consideration was being given to the appellant's security status. He had spent some considerable time with the appellant and had formed the view that his IQ was "towards the lower end of normal". It was "borderline". The term "mental impairment" was a legal one which was no longer in psychiatric use, nor had it been by this time. Dr Dewar confirmed that too much emphasis should not be put on the precise IQ level. A person's overall social functioning had to be looked at. Dr Dewar was of the view that the appellant did not have a learning disability, but he accepted that different clinicians might reach a different view.

[49] There was very little that the State Hospital could do for the appellant. On balance, medical treatment was not of benefit to him. What he did benefit from was a drug and alcohol free environment. The appellant had a great many difficulties. He required to be in a secure environment, as he was at high risk of causing harm. Nevertheless, he did not need to be in psychiatric in-patient care, although detention remained appropriate because of the public safety test. Were the appellant to be in prison, he would not stand out from the rest of the population. Psychiatric hospitals were designed to deal with persons with mental

illnesses. That having been said, the appellant had an unusual history and the conclusions of Drs Gray and Baird were understandable and not out of line with normal psychiatric practice at the time. Dr Dewar did not think that their opinions were unjustifiable.

[50] In a final report dated 25 February 2013 (Pro. 31), Dr Dewar confirmed that there had been no change in his opinion on the appellant. The appellant did not suffer from mental illness. Although he was of lower than average intelligence, his level of intellectual functioning was within the normal range and he did not have a learning disability. In this respect, his position was similar to that of Alexander Reid (*supra*). The appellant was better placed within the criminal justice, rather than the mental health, system.

Submissions

Appellant

[51] According to the appellant, the issue for the court was the "appropriateness" of the making of the Hospital Order and Restriction Order in 1998. That was to be assessed on the basis of the circumstances which were before the court at the time and those which were not. In that regard, there was no need to apply the test for "fresh" evidence under section 106(3)(a) because the court could take into account circumstances which had not been before the sentencing judge in terms of section 104(1)(c). This was so even although in *Reid* v *HM Advocate* 2013 SLT 65 (at para [14]), the court had said that the issue of the appropriateness of the earlier disposal was a matter for the court to assess on the basis of the fresh evidence presented (see also *R* v *Hempston* [2006] EWCA Crim 2869, May LJ at para 13). Thus the content of the various reports produced after 1998 could be taken into account in determining whether the Hospital Order had been appropriately made. Both the Crown and the defence had reports which suggested that, at the time, a Hospital Order had not been appropriate. Dr Baird had said the case was marginal and Dr Gray had based his view on the advice of Dr Young, which had not been borne out. Subsequent events could then be taken into account and it was sufficient that, if the matter were considered today, a Hospital Order would not be imposed (see *Jackson* v *HM Advocate* 1998 SCCR 539; *Baikie* v *HM Advocate* 2000 SCCR 119; and *Graham* v *HM Advocate* 2005 SCCR 544). The approach in *Reid* v *HM Advocate* 2008 SLT 293 (Lord Johnston at paras [17] - [18], Lord Eassie at paras [41] - [43]) had been too restrictive. Following upon the reference from the Scottish Criminal Cases Review Commission, Mr Reid's case had been re-referred to the High Court

(*Reid* v *HM Advocate* 2012 SCL 475) on the basis of fresh evidence (see para [12]). The circumstances emerging after the sentencing diet could amount to fresh evidence and entitle the court to form the view that the opinions expressed at the sentencing diet had been "wrong" (see *Reid* v *HM Advocate* 2013 SLT 65). Had the court been aware at the time of the mental health disposal that the primary diagnosis was one of personality disorder, then no order would have been made. It could not be said that at the time the appellant suffered from mental impairment. There was now a body of evidence which cast doubt on the oral testimony of Drs Baird and Gray. In any event, it was sufficient for the appellant to show that he was now inappropriately within the State Hospital. In that regard, the case was very similar to that of *Reid.* Circumstances had demonstrated that the appellant's condition did not meet the treatability test.

Crown

[52] The advocate depute maintained that no miscarriage of justice had occurred. The appellant's situation was readily distinguishable from that in *Reid* v *HM Advocate* (*supra*). *Reid* was a "fresh" evidence appeal involving a misdiagnosis in 1967. This case was in an entirely different category. Here, views similar to those contained in the reports of Drs Crichton, White and Darjee had all been available to the appellant at the time of his sentencing. It was the appellant's instructions to his counsel, after a discussion of the conflicting views, to accept a Hospital Order rather than imprisonment. In these circumstances, the "reasonable explanation" test for "fresh" evidence had not been met (*McIntyre* v *HM Advocate* 2005 SCCR 380 (at para [33]) ; *Mills* v *HM Advocate (No.1)* 1999 SCCR 202; and *Campbell* v *HM Advocate*1998 SCCR 214 at 242 and 270). The appellant's decision to tender a plea to culpable homicide on the basis of diminished responsibility had been made on the basis that a Hospital Order would be sought and, subject to the court's approval, made. Hence, the appellant did not call the doctors, such as Dr Campbell, who considered that the appellant should not be made the subject of such an Order.

[53] In *Reid*, it was held that no psychiatrist could have properly diagnosed Mr Reid at the time as suffering from mental impairment. However, that was quite different from the appellant's situation where a number of reports had been made available, at the time of sentencing, to the effect that he did suffer from mental impairment (now learning disability) as a result of a combination of his low IQ and limited social functioning. At the time of the

original disposal there was a complex presentation, with features of mental impairment and personality disorder manifesting itself in deficits in social functioning. That had always been the appellant's condition. Put shortly, the court's conclusion was that Mr Reid had been misdiagnosed. This appellant had not been.

Decision

[54] The only ground for an appeal against sentence now is that there has been a miscarriage of justice (1995 Act s 106(1)(b)). If the court considers that "having regard to all the circumstances", including "fresh" evidence under section 106(3)(a), the court "thinks that...a different sentence should have been passed" it can substitute that different sentence for that originally imposed (s 118(4)). In carrying out this exercise, the court "may" "take account of any circumstances ... which were not before the trial judge" (s 104(1)(c)). The direct source of these provisions is the Criminal Justice (Scotland) Act 1980 (s 33, Sch 2 paras 1 and 18; Sch 3 paras 1 and 13), which amended sections 228 and 254 of the Criminal Justice (Scotland) Act 1975, following the Thomson Committee Report recommendations. In relation to the disposal of solemn sentence appeals (as distinct from the grounds available for an appeal), the provisions are very similar to those of the 1975 Act, and indeed the Criminal Appeal Act 1926 (s 2). However, prior to the 1980 Act there was no mention of "miscarriage of justice" as a ground of appeal against sentence (cf conviction). A miscarriage of justice will have occurred where a sentence is seen by the appellate court as excessive or inappropriate. The function of the Court was described by the Lord Justice Clerk (Wheatley) in *Donaldson* v *HM Advocate* 1983 SCCR 216 (at 218) as being:

> "... not to consider as a court of review whether or not we are of the opinion that some form of sentence other than that passed by the judge in the court below should be imposed. The function of this court is to decide whether in all the circumstances the sentence imposed by the trial judge was or was not excessive. It is only if that question is answered in the affirmative that this court is called upon to determine what the appropriate sentence should be".

[55] The issue is not whether the disposal would have been different were the appellant to have been sentenced at the date of an appeal but whether, looking at the matter at the time of the sentence (albeit possibly taking into account fresh evidence or circumstances not before the sentencing court), a miscarriage of justice occurred. Thus, in J*ackson* v *HM Advocate* 1998 SCCR 539, the court quashed a life sentence and substituted a Hospital Order

in circumstances where it was demonstrated (LJG (Hope), delivering the Opinion of the Court, at 544) that, at the time of sentencing, the appellant had been suffering from a mental disorder in the form of a mental illness (schizophrenia). The same considerations applied in *Baikie* v *HM Advocate* 2000 SCCR 119 (LJG (Cullen), delivering the Opinion of the Court, at 122) and *Graham* v *HM Advocate* 2005 SCCR 544 (Lady Cosgrove, delivering the Opinion of the Court, at para [12]; see also *R* v *McDonagh* [2008] NICA 6, Campbell LJ, delivering the Opinion of the Court, at para [43]). It is an entirely different situation where, as here, the supposedly fresh evidence or new circumstances, taken as a whole, go no further than to indicate that the bulk of psychiatric opinion has altered since the date of sentencing.

[56] In determining whether a miscarriage of justice has taken place, in the context of a conviction appeal, it is clear that "fresh evidence" may result in an appellant demonstrating that, had that evidence been before the court, he ought to have been acquitted. In an appeal against sentence, the role of "fresh evidence" is perhaps rather more obscure in the normal case but it might, as indeed it did in *Reid* v *HM Advocate* 2013 SLT 65 (see 2012 SCL 475 at paras [12] and [16]), demonstrate that a particular disposal was inappropriate because the new evidence demonstrated that the criteria for a particular disposal were not met as at the date of sentence. That is not the position in the appellant's case.

[57] In any event, it is a requirement that, if a party is to rely on "fresh evidence", it must have been not only not heard at the trial but also subject to a "reasonable explanation of why it was not so heard" (s 106(3A). The evidence which the appellant seeks to classify as "fresh" is testimony from psychiatrists, notably Drs Crichton and Darjee, that in their opinion (from which others may differ) the appellant was either not mentally impaired at the time of sentencing and/or did not meet the treatability test. For such evidence to be "fresh", the appellant must demonstrate that there was a reasonable explanation for it not being adduced at the trial. Where substantially the same evidence was available from one or more psychiatrists at the time of the trial diet, it cannot be said that its subsequent availability from one or more different psychiatrists renders it "fresh". If an appellant deliberately declines the opportunity to lead psychiatric evidence before a court of first instance to the effect that he was not mentally impaired and/or that his condition was not treatable in terms of the statutory provisions, he will not be able to circumvent the "reasonable explanation"

test merely by producing evidence of the same facts and circumstances from different psychiatrists instructed after the sentencing diet.

[58] That is what the appellant seeks to do. At the time of sentencing, he had material from Drs Campbell and Baird that any mental impairment which he had was "borderline". Although Dr Baird did recommend a Hospital Order with a Restriction Order, that was not the recommendation of Dr Campbell, who did not consider that his condition was treatable. Dr Antebi, citing Dr Connaughton, did not consider that the appellant met the criterion for mental impairment. Initially, Dr Gray was also of the view that the degree of disorder was not such as merited detention, although it was not clear from his report whether this referred to the extent of the impairment or its treatability.

[59] The appellant thus had the opportunity, had he elected to use it, to demonstrate that he was not suffering from mental impairment at the time of sentence and, even if he were, his condition was not treatable. There was psychiatric evidence to support that position, especially from the Crown psychiatrist Dr Antebi, from Dr Campbell, who had known the appellant from some time, and probably also from Drs Connaughton and White. There was material in Dr Gray's report which ran contrary to his ultimate view before the sentencing judge and which could have been used to challenge his testimony. It is clear from counsel's note that the appellant advisedly determined not to adduce any of that evidence but rather to adopt the contrary line that he was both mentally impaired and treatable, thus avoiding: (a) a possible conviction for murder; and (b) a sentence of imprisonment for life. There is, in a sense, a reasonable explanation for the evidence to the opposite effect not being heard; that being the appellant's deliberate tactical decision not to adduce it for fear of the consequences. The statutory provision does not, however, permit the re-introduction, as "fresh" evidence, testimony which has deliberately and reasonably not been tendered in the first place (see eg *McIntyre* v *HM Advocate* 2005 SCCR 380, LJG (Cullen) at paras [33] *et seq*). Contrary therefore to the position in *Reid* v *HM Advocate* (*supra*), the court does not consider that the "fresh" evidence test has been met.

[60] The court has no difficulty in accepting that each of the psychiatrists who gave evidence was suitably qualified as an expert in forensic psychiatry and that each testified truthfully and in good faith. The court accepts the evidence, which came from almost all of the psychiatrists, that, were the question of the appellant's mental impairment to be analysed

now, it is unlikely that modern psychiatric opinion would regard him as impaired because: (a) he has an IQ above 70; and (b) he appears to be functioning at a reasonable level, albeit in highly controlled circumstances. However, for the reasons given above, the court does not consider that this is the central consideration in the determination of whether there has been a miscarriage of justice. The court cannot alter Hospital Orders retrospectively merely on the basis of changes in the practice of psychiatric assessment. The issue is whether the Hospital and Restriction Orders were appropriate at the time when they were made, according to the practices then current, albeit perhaps analysed in light of circumstances which have occurred since sentencing.

[61] Of course, if, as in *Reid* v *HM Advocate* (*supra*), "fresh" psychiatric evidence had demonstrated that the diagnosis made at the time of sentencing had been, quite simply, wrong, a miscarriage may be seen to have occurred. If, on the other hand, the evidence is only that the diagnosis would be different if carried out today, but that it was one which was properly made at the time, it will seldom be possible to conclude that there had been a miscarriage of justice on the part of the sentencing court. As was said, albeit in a slightly different context, in *Coubrough's Executrix* v *HM Advocate* 2010 SCCR 472 (at paras [34]-[35]), although the court must apply its own modern thinking to the issue of whether a miscarriage has occurred, that does not mean that the appellate court requires to consider the question as if it were hearing the case now. The court has to have regard to the views then current in determining whether what happened at that time can be said to amount to a miscarriage of justice.

[62] The court notes the concerns expressed in *Reid* v *HM Advocate* 2012 SCL 475 (Lord Bonomy, delivering the Opinion of the Court, at 488) that there may be circumstances in which to apply the standards prevailing at the time at which a decision is made would perpetuate an injustice. However, as explained under reference to *Coubrough's Executrix* (*supra*), whilst it is the modern standard of miscarriage of justice that is applied by the appellate court, it is the state of psychiatric opinion applying at the time, which forms part of the analysis of whether a miscarriage has taken place. The examples given in *Reid* about blood testing and the determination of age are both classic "fresh" evidence situations in which a fact found at a trial or sentencing diet has subsequently been proved to have been wrong or incomplete. In both, had the evidence been available at the diet, a

different finding in fact would have been made. That is a different situation from that involving opinion evidence as described above.

[63] It remains important to bear in mind that the decision on whether a person is mentally impaired and treatable is one for the court to make; albeit that it must be supported by the written or oral evidence of two medical practitioners, normally psychiatrists. The Full Bench in *Reid* v *HM Advocate* 2013 SLT 65 appears not to have answered, at least directly, the question which had prompted the reference to it by the earlier court (2012 SCL 475). However, the court interprets what the Full Bench said (at para [13]) as meaning that it agreed with the proposition that the test of whether a miscarriage of justice has occurred is one to be applied as at the date of the decision under attack (ie endorsing *Reid* v *HM Advocate* 2008 SLT 293 (Lord Johnston at para [17] referring to [15], Lord Eassie at para [45]) albeit that circumstances not referred to at the diet and fresh evidence may enter that equation.

[64] It was Dr Crichton's initial position that a Hospital Order should never have been made because the degree of the appellant's mental impairment did not justify it and, in any event, his condition did not merit treatment in a hospital setting. His reasoning included what he regarded as an unexplained *volte face* by Dr Gray and the fact that the appellant was not held in a learning disablement ward after sentencing. However, Dr Crichton accepted that the IQ figure was not a rigid one and that day to day functioning played a part in the assessment of impairment, with the result that there was room for professional disagreement. In this critical area, the testimony given by the psychiatrists appears to have differed materially from that in *Reid* v *HM Advocate* 2013 SLT 65 where the court was able to conclude that, if a person's IQ exceeded 70, he could never have been classified as impaired (*ibid* at para [10]). Notwithstanding the fact that there were several common witnesses, that was not the evidence in this case. It may not even have been the understanding of the earlier benches in *Reid* (2008 SLT 293, Lord Eassie at paras [35] and [43]; 2012 SCL 475, Lord Bonomy at para [24]).

[65] Dr Crichton accepted that Dr Gray's change of mind could be explained by his having consulted an expert, namely Dr Young, in the learning disability field and that, contrary to his understanding, the appellant had been held in the LDS ward for a year after sentencing. The court considers that these features significantly undermine his opinion that the

appellant had been "wrongly" assessed as mentally impaired and treatable at the time of sentencing; an opinion which, in any event, he accepted as being one from which others could properly differ. In relation to treatability, although the criminal justice regime has advanced considerably over recent years to the stage whereby most of the treatments, which might be considered available to alleviate or prevent deterioration of the appellant's condition (including his personality disorder), may now be available in the prison setting, that is not to say that they were available, or available with the same degree of intensity, at the time of sentencing.

[66] Similar considerations underlie the approach of the court to Dr Darjee's evidence to the effect that the appellant is not, and never has been, mentally impaired and that his condition (ie a dissocial personality disorder) is, in practical terms, untreatable. Dr Darjee accepted that, even if he thought that no mental health disposal would be likely to be recommended now, that is what happened at the time. He accepted that, with a borderline IQ, a different psychiatrist could properly reach a different view on impairment based upon his assessment of the appellant's social functioning and the opinion of an expert in the treatment of learning disabilities. Although the court accepts Dr Darjee's evidence of what would happen now, or even what was "likely" to have happened in the past, it does not regard Dr Darjee's testimony as going so far as to say that, in the light of what the court knows now, a mental health disposal in 1998 would inevitably be classified as in error. In addition, the court notes that, whereas in *Reid* v *HM Advocate* (*supra*) the court appears to have formed the view that a personality disorder is an alternative diagnosis to mental impairment (*ibid* para [13]), that is not this court's understanding from the evidence presented in this case.

[67] The court places some not inconsiderable weight on the evidence of Dr Campbell that, at the time of sentencing, she thought that the appellant did meet the criteria for mental impairment. Although she did not testify before the sentencing court, her view on this aspect of the appellant's condition, supports the opinion of Dr Baird to the same effect and which was also made at the time. The court places emphasis on these views and considers that they outweigh assessments made with hindsight or in light of opinions formed in light of modern psychiatric practices. The court was impressed with Dr Campbell's balanced approach and noted particularly her view that, although she did not initially recommend a Hospital Order because of the treatability test, she was not prepared to assert that, after an

appropriate period of assessment, such a disposal might not have been advised. Her view in her most recent report had changed and was that: (a) the appellant was being cared for within the hospital setting; (b) his "treatment" had brought about some improvement in his condition; and (c) a Hospital Order was an appropriate disposal. The court is thus faced with respectable, but to a degree conflicting, psychiatric opinions.

[68] In turning to the views of those who gave evidence before the sentencing court, the court accepts the careful and reflective reasoning of both Dr Baird and Dr Gray, essentially to the effect that, although the appellant might be treated differently today, their decisions had been properly taken in accordance with practice prevalent at the time. Neither doctor ultimately considered that his decision had been "wrong". Rather, as Dr Baird put it, their decisions were the best that they could make, in good faith, at the time. Both eminent psychiatrists were of the view that, albeit that the position was marginal, the appellant did suffer from mental impairment as defined in section 58. His IQ was borderline but his social functioning, in 1998, was such that he was properly regarded as impaired. So far as treatment was concerned, whatever the views of the existing staff relative to the appellant's condition, at the time it was perceived that his condition could be "treated" appropriately in the secure hospital setting. Dr Gray, who explained that he had considered the appellant to be impaired, had been pessimistic on the issue of treatability. That was the reason why he had originally not made a recommendation of a mental health disposal. His explanation that he had been convinced to the contrary by the expert in the learning disability field, namely Dr Young, was entirely reasonable and the court accepts it. It is confirmed by the appellant being placed in the learning disabled ward after sentencing until an incident of violence resulted in his transfer.

[69] It seems to be relatively uncontroversial that the appellant's condition is treatable in the State Hospital in the sense of being controlled, or stabilised, by certain courses. It may be that the real benefit is the structured and drug/drink free ambiance. The prison regime has improved greatly since 1998 and it may be that it can now provide very similar courses and an equivalent ambiance. Nevertheless, the court is quite unable to conclude, particularly in the light of Dr Campbell's evidence, that Drs Baird and Gray were in error when they made their recommendations in 1998. It has taken into account the evidence of Dr Dewar in this area and, once again, accepts that a modern disposal, having regard to the current prison

system, may be different. However, the court returns to the essential point that the original disposal was entirely appropriate for the time at which it was made. Consideration of what has happened to the appellant in the hospital setting since sentencing in terms of the pragmatic section 104(1)(c) and of the content of the many and varied reports prepared both before and after the sentencing of the appellant has served only to confirm that the Hospital and Restriction Orders were appropriately made and that no miscarriage of justice occurred. [70] The appeal is accordingly refused. The court notes the general concern that the appellant may be being held in a regime which is regarded by the medical profession as being, in a sense, surplus to his needs. It may well be that, in some ways, he would be better held within a prison regime. There is no mechanism for achieving a transfer to prison within the current Hospital and Restriction Order system, as there is for a transfer of a prisoner to hospital. The court can well understand that there may be difficulties in devising a system whereby a person held under such Orders can be transferred back into the criminal justice system. Whether that is so or not, it is primarily for the Government to consider whether it can or should introduce such a system and what form it should take. It is not, however, for the court to quash validly made Hospital and Restriction Orders because psychiatric opinion has changed or because expectations have not been realised. If the Orders were appropriate at the time they were made, in the sense that they proceeded upon expert opinion properly given, they must be allowed to stand. The appellant must seek relief by adopting the provisions for release or reduced security under the same mental health regime which he was keen to come under in order to avoid the consequences of what he perceived to be a significantly worse outcome for him at the time in the form of a sentence of imprisonment for life. Indeed, but for the decision in *Reid* v *HM Advocate* 2013 SLT 65, the court would have found it difficult in any event to categorise an outcome specifically sought by an accused in such circumstances as a miscarriage of justice adverse to him.

https://www.bailii.org/scot/cases/ScotHC/2013/2013HCJAC92.html