Neutral Citation Number: [2008] EWCA Crim 3059

Case No: 200605956 C1

**IN THE SUPREME COURT OF JUDICATURE**
**COURT OF APPEAL (CRIMINAL DIVISION)**
**ON APPEAL FROM PRESTON CROWN COURT**
**HHJ OPENSHAW QC**
**200605956C1 1**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/12/2008

**Before :**

**LORD JUSTICE PILL**
**MR JUSTICE SWEENEY**
and
**SIR CHRISTOPHER HOLLAND**

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**Between :**

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| | **Peter Geoffrey Moyle** | **Appellant** |
| | **- and -** | |
| | **R** | **Respondent** |

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Lord Carlile of Berriew QC and Miss C Rimmer (instructed by Keith Park) for the Appellant
**Mr J McDermott QC** (instructed by **CPS**) for the Respondent

Hearing date : 17 October 2008

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# Judgment

**Lord Justice Pill :**

1. On 11 November 2004 in the Crown Court at Preston before HHJ Openshaw QC and a jury, Peter Geoffrey Moyle was convicted of murder. He was sentenced to life imprisonment with a minimum term of 14 years and 5 months. He appeals against conviction by leave of the full court.

2. On 6 April 2004, the deceased, David Brown, aged 67 years, was knocked to the ground outside the The George public house, Blackpool, and repeatedly kicked. He sustained catastrophic head injuries which caused his death three weeks later on 23 April 2004. He had been a regular customer at The George.

3. The prosecution case was that the appellant had inflicted the blows that caused death. In interview and evidence, the appellant admitted striking the deceased but denied that he had caused the fatal head injuries. He claimed to have been provoked by the deceased.

Thus the issues for the jury were whether the appellant had caused the injury from which the deceased died, whether he had intended either to kill the deceased or cause him really serious injury and, if so, whether he had been provoked by the deceased to act as he did.

4.Evidence was given of unpleasantness between the two men at the public house some weeks before 6 April. Before his death occurred, the deceased had been drinking in The George for several hours. The landlord saw the deceased and the appellant engaged in a struggle and saw the deceased raise his hand as if to punch the appellant. The landlord forcibly removed the deceased from the public house.

5.Through a window at the public house, the deceased was observed to be on the ground and being kicked viciously by the appellant. One of the witnesses went outside and saw the deceased lying on the ground. The appellant was two to three feet away and grinning. The appellant then walked away casually. Another regular at the public house pursued the appellant and took hold of him; the appellant grinned, laughed and ran off. Blood staining was present on the front part of the right instep of the appellant's shoe and the blood was found to be that of the deceased.

6.In evidence, the appellant said that he had drunk six cans of lager, a pint of lager and two double whiskies before entering The George. He said that he had been drunk, but not excessively so, and he had been aware of his actions.

7.When he had been in the public house for only a few minutes, the deceased crossed the room and punched him in the face. He said he was ushered from the premises by the landlord and the deceased followed about two minutes later. The deceased staggered over to him and fell to the ground, the back of his head hitting the pavement. The appellant stood over him and punched him with his fist about three times. He was angry about what had happened in the public house. He denied that he had kicked the deceased. He did not know how the blood spots came to be on his trainers.

8.The appellant accepted that he had told the police in interview that he had punched the deceased to the ground. He said that was untrue. He had told that untruth because he thought it sounded better than the truth which was that he had punched the deceased while the deceased was already on the ground.

9.It is now claimed on behalf of the appellant that he was unfit to plead at the time of the trial in November 2004. It is further submitted that, if he was fit to plead, he was, at the time of the alleged offence, suffering from such abnormality of mind as substantially impaired his mental responsibility for his acts in being a party to the killing and that, by virtue of section 2 of the Homicide Act 1957, any conviction should have been for manslaughter. Neither issue was raised at the hearing before Judge Openshaw. The appellant was represented at the trial by leading and junior counsel as well as solicitors. A medical report, dated 1 September 2004, had been obtained from Dr T.J. O'Hare, consultant psychiatrist.

10.Dr O'Hare's report was based on detailed information he had been given about the appellant's medical history, a two hour interview with the appellant and a discussion

with Mr A. Bates, the appellant's Community Mental Health Nurse.

11. Dr O'Hare described the appellant's family and personal history, summarised his medical history and referred to the optimism which had been felt in the early part of 2004 about the appellant's future. Dr O'Hare considered, in detail, the circumstances of the alleged offence. He considered that he had established a good rapport with the appellant. The appellant had mentioned lack of intent and diminished responsibility due to alcohol and paranoia as possible defences to the charge of murder.

12. Dr O'Hare stated:

> "All the available information indicates that over the next few months [in early 2004], his mental state and functioning improved substantially. However, it is my opinion that, by the time of the alleged offence, he had not fully recovered from his illness, and although the florid psychotic symptoms had resolved, he was continuing to report paranoid feelings, felt suspicious of the motives of others towards himself, and avoided crowded situations. These symptoms have evidently persisted during his remand."

13. In the doctor's opinion, the disinhibiting effect of alcohol had been a significant factor in the appellant's behaviour. He did not consider that a defence of insanity was applicable. As to diminished responsibility, he stated:

> "I will now attempt to address the issue of whether his responsibility was substantially diminished. I have no doubt that Peter Moyle suffers from paranoid schizophrenia, a severe mental illness within the meaning of the Mental Health Act 1983. He was evidently very unwell at the time of his admission to hospital in December 2003. However, by the time of the alleged offence, his mental state and functioning were much improved but he continued to experience symptoms, as previously described. While he was not frankly psychotic or "out of touch with reality", my opinion is that these symptoms are likely to have influenced his perception of situations and to have made him mistrustful of the motives of others. If a person is experiencing such symptoms on a regular basis, they are likely to feel under stress and this is likely to impair their ability to tolerate additional stress such as being subject to an assault. My impression is that this reduced tolerance to stress, as a result of residual symptoms of his schizophrenia, combined with alcohol intoxication, contributed to his violent behaviour. I think it unlikely that he was acting under the direct influence of psychotic symptoms (as, for example, when a person suffering from delusions of persecution attacks their supposed persecutor; another example would be a person who carries out an assault in response to auditory hallucinations, believing them to be instructions from God).
>
> I therefore think it is reasonable to infer that Peter Moyle's responsibility for his actions was, to some extent, impaired by

> illness. However, on the basis of the information available to me, I do not feel able to state that the impairment of his responsibility was "substantial"."

14. As to fitness to plead, Dr O'Hare stated:

> "At the time of my assessment, Peter Moyle was able to understand the nature of the evidence; plead with understanding; instruct his legal representatives; challenge a juror and follow Court proceedings. He was therefore fit to plead. However, he told me that he had not taken antipsychotic medication for the past month and that there had been a recent deterioration in his mental state. I therefore recommend that his fitness to plead be reassessed nearer the time of his trial: I assume that the Crown Prosecution Service will be requesting a report from a Psychiatrist."

No further report was obtained, the appellant declining to co-operate with the psychiatrist appointed (Dr Plunkett).

15. In addition to the report of Dr O'Hare, this court had available medical reports from four consultant psychiatrists who have examined him post-conviction. Three of them gave oral evidence.

Fitness to Plead

16. The test was stated by Alderson B in *Pritchard* (1836) 7 C&P 303:

> "There are three points to be enquired into:- first, whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of the proceedings in the trial so as to make a proper defence - to know that he might challenge any of you [the jury] to whom he may object - and to comprehend the details of the evidence, which in a case of this nature must constitute a minute investigation.'"

17. The test for fitness to plead was considered in this court in *Padola* [1959] 43 Cr App R 220 (a five judge constitution) and *Robertson* [1968] 52 Cr App R 690. The *Pritchard* test was approved. In *Padola*, Lord Parker CJ stated, at page 239:

> "In our judgment the direction given by Alderson B. is not intended to cover and does not cover a case where the prisoner can plead to the indictment and has the physical and mental capacity to know that he has the right of challenge and to understand the case as it proceeds."

*Robertson* was a case in which there had been a finding of disability before arraignment. The defendant submitted that he should have been tried. Lord Parker referred to medical

evidence that "[the defendant's] delusional thinking might cause him to use his challenges wrongly or unwisely and that his "delusional thinking", from which he suffers, might cause him to act otherwise than in his own best interest; in other words unwisely, and so on." The finding of disability was quashed, the court accepting the submission on behalf of the defendant that:

> "On the evidence here [he] appears to have had a complete understanding of the legal proceedings and all that is involved and, although he suffers from delusions which at any moment might interfere with a proper action on his part, that is not a matter which should deprive him of his right of being tried."

18. A finding of disability was also quashed in *Berry* [1978] 66 Cr App R 156, Lord Lane, CJ, presiding. Lord Lane found the direction to the jury inadequate stating, at page 158:

> "It may very well be that the jury may come to the conclusion that a defendant is highly abnormal, but a high degree of abnormality does not mean that the man is incapable of following a trial or giving evidence or instructing counsel and so on."

19. Giving the judgment of this court in *M* [2003] EWCA Crim 3452, Keene LJ referred to the authorities mentioned above and stated, at paragraph 31, that they "clearly establish the law on this topic in this jurisdiction."

20. In submitting that the appellant was unfit to plead at the time of his trial in September 2004, Lord Carlile QC, who did not appear at the trial, seeks to rely on the evidence of the three consultant forensic psychiatrists called before the court. In May 2005, the appellant was transferred from HMP Preston to Guild Lodge Medium Secure Unit under section 47/49 of the Mental Health Act 1983 because his mental state had deteriorated to an extent that he required hospital care. He has remained an inpatient at Guild Lodge and, since his transfer, Dr R Abdur has been the Responsible Medical Officer ("RMO"). He first met the appellant in January 2005 as visiting psychiatrist at the prison and reviewed his case in February and again in April 2005. He has since interviewed the appellant regularly.

21. In his report, Dr Abdur refers in great detail to the hospital notes. His opinion, as expressed in his report of 18 April 2006, was that the appellant "suffers from a serious enduring mental illness called Paranoid Schizophrenia." The prognosis is poor and confirmed in a further report dated 23 September 2008. That opinion is shared by Dr M Ventresss in his report of 19 March 2008. In his opinion, the appellant has had symptoms of the illness since around 2002 but that these have "preoccupied him to greater or lesser extents and he has chosen, or been able, to conceal these for significant periods." Dr J McKenna (9 October 2006) and Professor D Grubin (19 July 2008) share that opinion.

22. In his oral evidence, Dr Abdur stated that the appellant has been concealing his symptoms. Asked why the appellant had refused to see Dr Plunkett, Dr Abdur stated:

> "My opinion is that this was based on his delusions. He felt that Dr Plunkett was part of a larger conspiracy that involved the

courts, the police, the prison system. He was under the impression that the court case was already mapped out before the trial and that he would be hung, drawn and quartered anyway."

23. Dr Abdur accepted that the appellant "can go about his day to day living activities without any problems but it is his inner belief system that is psychotic." Dr Abdur added:

> ". . . I have known him for about three years now, my Lord. On a day to day basis Mr Moyle can go about his daily business, he engages in activities on the wards. But underneath it all there is always the psychosis present and you only need to scratch the surface and the delusions come out."

24. We set out further extracts from Dr Abdur's oral evidence:

> "Psychotic patients sometimes do not talk about their symptoms because they feel so vulnerable as a result of the symptoms that if they were to disclose these symptoms something catastrophic might happen. This was reported to me by Mr Moyle later, that during the trial he felt that if he were to disclose his psychotic symptoms to the doctors then he would be convicted of witchcraft and he would be executed. His way of protecting himself was not to disclose his symptoms. Even at the best of times Mr Moyle does not talk about his symptoms very openly. . . "

> "Because of the nature of the illness, Mr Moyle does not live in a real world. He is not in touch with reality, even at the best of times. I think at that time, because of his psychotic presentation, this would have had a profound effect on how he perceived what was going on around him. Some of the delusions that would have hampered his understanding of the trial process would have been his belief that there was a conspiracy involving the courts, the police, the prison system, and even the mental health professionals. He also believed that if he were to disclose his psychiatric symptoms then he would be persecuted even more for it."

> ". . . he can go about his day to day living activities without any problems but it is his inner belief system that is psychotic."

> ". . . Again, most of the information I have gathered in retrospect is considered in hindsight. I am not sure if everything would be accurate, but from what I gather from Mr Moyle he told me that at the time he did not trust his own solicitor and he could not see how he could have a fair trial. Because of his delusions, his own description of the index offence has changed over time. It has always been in disturbing delusional terms, about how the victim died. It was either the Queen of Sheba, which is one of the characters of his delusions, who killed the victim or it was somebody else or some other spirits. His account often changed

over time. Based on that I wonder if he was, at the time, in the state of mind where he could actually instruct his counsel."

". . . In terms of understanding the charges, Mr Moyle has always given the impression that he understood the charge, which was murder, but he does not agree with the fact that he should have been charged with the offence of murder because according to him he only punched the victim a few times. He believes that somebody else finished the victim off. So he understands the charges but he does not agree with what was the cause. I think that was very delusional."

". . . Mr Moyle, when he is stressed, one of his coping strategies is to withdraw into his own space."

25. Questioned by the court, Dr Abdur accepted that the appellant had always been able to give a rational explanation of the tragic events outside the public house on 6 April 2004:

"In terms of the particular scuffle, he can talk about it in a more or less rational way but any further then he becomes all embroiled in his delusions. As I said, his account has changed over time depending on the course of his illness."

". . . I have to be careful, because on one hand he could try to exculpate himself from the guilt and always say that somebody else finished him off or kicked him when the victim was lying on the floor. That could be normal. That might be delusional but it might not be as well because that might be an explanation that anybody would give, that "I only punched him so I do not know how he died. Somebody else must have come and inflicted more injury"."

Dr Abdur added that the appellant had always and consistently denied that he kicked the victim. He had given different accounts of his punching.

26. On remand, the appellant had been in a general psychiatric hospital which he found very unpleasant. He made it clear to Dr Abdur that he did not want to return there, saying to Dr Abdur, that "he did not want to go back to a "nut house.""

27. In his report of 9 October 2006, Dr McKenna stated that it was now difficult to reconstruct with certainty the appellant's likely mental state at the time of the trial. The appellant told the doctor that, when he was facing trial, he felt that he could not trust anybody sufficiently to disclose his experiences. Dr McKenna considered that in terms of the appellant's global intellectual abilities, including comprehension and memory, there was little doubt that he would have been able to understand the nature of the charge he faced and the significance of entering a plea of guilty or not guilty. His history did, however, raise concern about whether or not mental disorder might have affected his ability correctly to appraise, believe, weigh up and validly use information relating to the legal proceedings. Dr McKenna added:

"There is also very strong evidence, in my view, that the

> particular symptoms of his mental disorder had strong and direct relevance to the Court proceedings and their background. Mr Moyle has stated that while he was in prison, God told him that he was innocent, and he also came to incorporate or assimilate the fact of the victim's death into his extensive persecutory delusional system (for example, maintaining that meningitis was induced by the Queen of Sheba). At interview, he suggested to me that he had felt that if he had disclosed his beliefs at the time, he would have been hanged, for witchcraft. He also appears to have believed, or at least suspected, that the legal proceedings were in some way 'set up', and that the outcome was preordained (he saw imprisonment in a comparable light, believing that it was something that had been deliberately engineered to suit the purposes of his putative persecutors).
>
> It seems very likely that at the relevant time Mr Moyle, and as part of the effects of active illness, was preoccupied with his internal experiences, mistrustful of others, and deluded about the criminal justice system, the legal proceedings, the background to his charge, and about those involved in them. On balance, and on reviewing the evidence that is now available, I believe that there are strong grounds to suspect that Mr Moyle's psychotic disorder significantly impaired his ability to take a proper or valid part in his trial, and significantly affected his capacity to be properly defended in legal proceedings."

28. There was strong evidence, the doctor stated, that the appellant had been reluctant to disclose the nature and depths of his active symptomatology:

> "While on the one hand it is possible to see such behaviour is as straightforwardly understandable (i.e. as a tactic to avoid clear negative consequences from his point of view, such as hospitalisation or medication), I would also suggest that for people suffering in the way that Mr Moyle was, the issue can be closer to, from their own perspective, one of trying to maintain physical and psychological survival. In other words, non-disclosure is not necessarily due to lack of co-operation or malice."

29. Dr McKenna also considered that the appellant's suspiciousness was important:

> "If you are suspicious of other peoples' motives, or indeed their true identity, you are much less likely to be open with them."

The appellant was trying to protect himself psychologically and regarded the experiences he was undergoing as "an assault on his physical and psychological integrity."

30. In his oral evidence, Dr McKenna stated that what struck him about the fatal incident was that the appellant "gave an account of his behaviour which was completely at odds with the account provided by people at the scene . . . He can certainly understand, for example, what was being said in court on an, if you like, grammatical level, but at a

more distal level the way that he would interpret that and manipulate that information and make use of it, I think, was almost certainly corrupted by his illness." Dr McKenna concluded that the appellant "lacked the capacity to be properly defended and that he was unfit to plead." Asked about the evidence the appellant gave, Dr McKenna said that the appellant claims only to have punched the victim as opposed to kicking him and said that it "could either be part of his delusional thought process or it could simply be guile." In Dr McKenna's opinion, the appellant's delusions "have contaminated his understanding of how the victim actually died." There had been a previous assault in November 2003 when he attacked his uncle. In that case too, the appellant had given an account of his behaviour which was completely at odds with the account given by people at the scene, Dr McKenna said.

31. In his report of 19 March 2008, Dr Ventress also expressed the view that, "on balance, the appellant would not have been fit to plead at the time of his trial. He had a delusional fear that he might be executed which would have had at least some preoccupying or distracting effect on him." Dr Ventress also recorded the appellant's statement that, during the trial: "I was so embarrassed and ashamed of how my life had turned out."

32. Dr Ventress believed that the appellant was masking or concealing his symptoms from the professionals. The appellant believed that people were talking about him. Dr Ventress said in oral evidence:

> "My view is that where somebody feels that the integrity of their own mind or thinking has been breached and that the thoughts are available to others, it adversely affects their capacity to take part in a trial because I think it is likely that they would monitor the things that they were thinking, feeling that they might be available to the jury, that they might be available to the prosecution and to others. It is a fundamental breach of a person's integrity . . ."

The appellant told Dr Ventress that, when preparing for the plea and directions hearing, he was setting up a game plan in his mind and "as part of his game plan considered how many spirits the members of the court had in their minds." The appellant believed that the court had a power to execute him and that "probably would affect whether or not he could enter a plea." He might also have been influenced by his belief that the court and the jury were under the influence of Satan.

33. In his oral evidence, Dr Ventress recalled further statements noted in his report:

> "He said that at the time he interpreted this as meaning God was listening and paying attention. He recalled the proceedings and said that the judge had been nice and had not raised his voice at Mr Moyle. He said that he had not had specific concerns about individuals in the jury but went on 'I still believed Satan had all the court and jury under his influence. He'd set me up by sticking the boot in. I thought they were possessed'."

34. Dr Ventress concluded, in cross-examination, with the opinion:

> "I think he would have had quite a marked difficulty in following what would have been a very involved process in the context, as I have mentioned, of a very stressful experience for somebody who is already suffering from a severe mental illness."

35. We have also considered the report of Professor Grubin, dated 19 July 2008, who was unable to attend to give evidence. Professor Grubin was not asked to express an opinion as to the appellant's fitness to plead at the time of trial. He has, however, expressed an opinion as to current fitness to plead in a situation in which the state of the appellant's health has not changed significantly since the trial. Professor Grubin considered alternative scenarios. With respect to fitness to plead to a defence of diminished responsibility, Professor Grubin stated:

> "If the matter came to trial, his understanding of the evidence and his comprehension of court proceedings would almost certainly be sufficient given the issue to be determined."

Given a contest in relation to the killing itself, Professor Grubin stated:

> "Again, I would not foresee problems in respect of his being able to understand the evidence or comprehending court proceedings if the matter at hand is his mental state at the time of the incident."

36. As to diminished responsibility, Professor Grubin was firmly of the opinion that, at the time of the killing, the appellant's mental state: "will have been such that his ability to control his physical acts in accordance with rational judgment will have been substantially impaired, consistent with a defence of manslaughter on the grounds of diminished responsibility."

Fitness to Plead

37. It does not follow, and Lord Carlile does not suggest, that a person whose case comes within section 2 of the Homicide Act 1957 by reason of diminished responsibility is thereby unfit to plead. Nor can there be a proposition of law that a person suffering from delusions is thereby necessarily unfit to plead. Lord Carlile submits that the court should accept the evidence of three consultant forensic psychiatrists each of whom formed the view, from their own standpoint, that the appellant was unfit to plead. He submits that the appellant's approach to the trial was so coloured by delusions that he was unfit to plead.

38. We are unable to accede to that submission. The analysis must start with the fundamental principle that a person must be tried for and convicted of an offence, according to law, before a custodial order is made. That is fundamental, both in the public interest and in the interests of defendants, to the rule of law. While the law may make provision for custodial orders where defendants are unable to avail themselves of that fundamental right, the circumstances must be circumscribed in the manner

prescribed in the authorities already considered. Each case, of course, depends on its own facts but delusions as to the court's powers of sentence, or as to the objectivity of the court, or as to the evil influences which are thought to be present in the proceedings, do not necessarily require a finding that a person is unable to give instructions and to understand the proceedings.

39. In concluding that the appellant was, in November 2004, fit to plead, the court has regard to the following factors, not set out in any order of importance:

(a) The appellant was represented at trial by leading and junior counsel and a solicitor. Notwithstanding the evidence available from Dr O'Hare, they found no reason to query, or investigate further, the appellant's fitness to plead. The trial was conducted by a judge experienced in criminal cases, who allowed it to proceed. Given the appellant's instructions, the plea and the issues raised were entirely appropriate.

(b) The appellant gave evidence at his trial and did so in a way which does not create doubts about his ability to understand questions put to him and to give the answers he saw fit to give. The trial involved a consideration of the events on the evening of 6 April 2004 and the appellant's part in them. There is no indication that he failed to understand the evidence given or to respond to it with his own account, albeit an account which the jury disbelieved.

(c) There is no reason to doubt that the appellant understood that the proceedings were serious proceedings, that he was being tried for a serious offence and that the aim of the trial was to determine whether he was guilty of wrongdoing.

(d) The appellant's evidence did demonstrate a tactical awareness difficult to reconcile with unfitness to plead as understood in the authorities. For example, he gave evidence about the timing of his punching the victim which was inconsistent with an account given to the police. He gave a reason for having told the police what in evidence he claimed to be an untruth.

(e) The medical witnesses acknowledged the possibility of guile by the appellant in his approach to the case. Their main concern was that the appellant's delusions were such as to impede his communication with his legal advisers and his understanding of proceedings.

(f) The appellant's embarrassment at his predicament and his inability to accept that his conduct was the cause of death were reactions not uncommon in those charged with serious crime and certainly not supportive of unfitness to plead.

(g) Clearly, beliefs, one hopes always delusional, that the court is biased cannot extinguish a person's right to be tried or the public's right to have that person tried. A false belief about the punishment liable to be inflicted does not impair the defendant's ability to be tried.

(h) Even if, at times during the trial, the appellant was not acting in his own best interests, in the evidence and instructions he gave, that does not, in itself, create, or contribute, to a finding of unfitness to plead.

(i) The appellant's condition has not changed substantially since 2004. His present legal advisers have sought specific instructions from him and appear to have had no difficulty in obtaining them.

40. We do not accept that, having regard to the points already considered, the appellant's medical condition so impaired his ability to communicate with his legal advisers or understand proceedings that he was unfit to plead. We respect and attach weight to the opinion of the doctors, three of whom, though not Professor Grubin, have expressed the opinion that the appellant was unfit to plead. The appellant had serious health problems which affected his attitude to other people and his behaviour generally. They could lead to his having been distracted during the trial. However, analysis of his conduct at the time of the trial does not, read with the medical evidence, demonstrate that he was unfit to plead, as defined in law. He was able to instruct his lawyers and to understand proceedings and give evidence, notwithstanding his delusions. Our conclusion is that the appellant was fit to plead. The appeal on that ground is dismissed.

Diminished Responsibility

41. The defence of diminished responsibility was not run at trial. The evidence before the court, that of Dr O'Hare, was that the appellant's responsibility for his actions was, to some extent, impaired by illness but that the impairment was not "substantial". No further report was obtained, notwithstanding Dr O'Hare's earlier recommendation, the appellant having declined to be examined. Clear evidence is now available that, at the time of trial, the appellant, having had experience of hospital, did not want to be made subject to a hospital order, the possibility of which would have been raised had the defence been successful.

42. In such circumstances, the general principle to be applied in this court is that stated by Lord Taylor of Gosforth, CJ, in *Ahluwalia* [1993] 96 Cr App R 133:

> "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 the trial. It cannot be too strongly emphasised that this court would require much persuasion to allow such a defence [diminished responsibility] to be raised for the first time here if the option had been exercised at trial not to pursue it. Otherwise, as must be clear, defendants might be encouraged to run one defence at trial in the belief that if it fails, this court would allow a different defence to be raised and give the defendant, in effect, two opportunities to run different defences. Nothing could be further from the truth."

Applying that principle, the court declined to permit evidence of diminished

responsibility to be adduced on appeal in *Latus* [2006] EWCA Crim 3187.

43. In *Neaven* [2006] EWCA Crim 955, the court upheld the paramount and fundamental importance of the principles in favour of one trial but accepted that there may be cases, where, the evidence of mental illness and substantial impairment being clear, it may be in the interests of justice to admit it. "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" (Rix LJ at paragraph 41).

44. Having set out the medical evidence in some detail, we can deal with this issue briefly. There is now strong medical evidence, which we accept, that the appellant was, at the time he attacked Mr Brown, suffering from such abnormality of mind as substantially impaired his mental responsibility for his acts in doing the killing. All four doctors have expressly stated that the criteria in section 2 of the 1957 Act were satisfied. They also acknowledge that the appellant declined to cooperate with doctors at the time of trial, Dr McKenna, for example, stating that: "there is very strong evidence that in general, Mr Moyle has been reluctant to disclose the nature and depth of active symptomatology". He has wished "to avoid the presumed personal consequences of disclosure (particularly being returned to hospital)." The lack of co-operation may have affected the pre-trial opinion of Dr O'Hare who found impairment, but not substantial impairment, on the information available to him.

45. As in the case of *Neaven*, the appellant's decisions at the time of trial were affected by the illness itself; the sense of attack on his personal integrity leading to an unwillingness to disclose the extent of his health problems and the fear of being returned to hospital. There can be no suggestion that the appellant was holding back on a defence of diminished responsibility for tactical reasons connected with his trial.

46. For the prosecution, Mr McDermott QC accepts, and indeed asserts, that analysis. The court quashes the conviction for murder and substitutes a conviction for manslaughter on the ground of diminished responsibility. The appropriate order, as Lord Carlile readily accepts, is a hospital order under section 37 of the 1983 Act combined with a restriction order, without limit of time, under section 41. Dr Abdur has confirmed that a bed remains available at Guild Lodge where the appellant is currently an inpatient. The appeal is allowed to that extent.

47.