Neutral Citation Number: [2020] EWCA Crim 270

Case No: 201802368 C3

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CENTRAL CRIMINAL COURT
HHJ MUNRO QC
T20177316

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/02/2020

Before :

LORD JUSTICE DAVIS
MR JUSTICE SPENCER
and
MR JUSTICE GRIFFITHS

- -

Between :

REGINA	**Respondent**
- and -	
NICHOLAS JOHN FOY	**Appellant**

- -
- -

Mr Orlando Pownall QC (instructed by **Bark & Co**) for the **Appellant**
Mr Oliver Glasgow QC (instructed by **the Crown Prosecution Service**) for the **Respondent**

Hearing date: Wednesday 5 February 2020

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Approved Judgment

LORD JUSTICE DAVIS:

Introduction

1. On the evening of 11 August 2017, Nicholas Foy (the appellant in this appeal) fatally stabbed Laurent Volpe in a street in South-East London. The two were complete strangers to each other. Mr Volpe was in fact a tourist from France. He was returning to his temporary accommodation from a shop. As for the appellant, he was indisputably experiencing a psychotic episode at the time. On his own admission, he had been voluntarily ingesting huge quantities of alcohol and cocaine in the period before the killing. The sole defence advanced at trial to the charge of murder was lack of the necessary intent to kill or to cause really serious injury. The appellant gave evidence. The jury rejected that defence and, on 12 February 2018 at the Central Criminal Court, convicted the appellant of murder.

2. The present appeal is founded solely on fresh evidence which the appellant now seeks leave to adduce. That evidence – primarily in the form of expert psychiatric evidence – is to the effect that a defence of diminished responsibility was available. It is one feature of this appeal that a defence of diminished responsibility had in fact been carefully considered in this case before the trial. But it had not been pursued at trial: because the report of the expert psychiatrist instructed on behalf of the appellant was adverse to such a defence.

3. So this appeal raises two principal questions. First, should this proposed fresh evidence be admitted at all, given that the issue of diminished responsibility had been expressly considered and (on the basis of expert psychiatric evidence) not pursued at trial? Second, is the proposed fresh evidence, even if otherwise admissible, such that the conviction is to be adjudged unsafe? The issues raised also necessarily involve some consideration of some of the vexed questions that can arise where a killing occurs in the context of a combination of voluntary intoxication and mental health issues on the part of the killer.

4. Before us, the appellant was represented by Mr Orlando Pownall QC. The respondent Crown was represented by Mr Oliver Glasgow QC. Both had appeared at the trial below. We are grateful to them for their arguments.

Background Facts

5. The appellant was born in 1979. He has a partner, Victoria O'Connor, and three sons. Latterly, he had been living in the Eltham area of South-East London. He ran a local courier company.

6. The appellant's adult life has been marked by a proclivity to alcohol. He would very frequently drink to excess. Further, when in drink he would also sometimes resort to consuming large quantities of cocaine: he would periodically go on binges in that respect. It is to be emphasised, however, that it has never been said – and as was accepted before us at the appeal hearing – that he suffered from an addiction to intoxicants sufficient to amount to a disease or recognised medical condition.

7. It is not disputed that over the years the appellant has suffered from depression, anxiety and paranoia. There were, in fact, some indications that he would tend to resort to drink to counter his feelings of anxiety and depression. He had from time to time been prescribed anti-depressants. He was, however, never prescribed anti-psychotic drugs nor had it been thought necessary to refer him to a psychiatrist. He has never been sectioned or attended any mental health hospital.

8. In the weeks before the date of the killing, the appellant had been on holiday in Spain with his family. In evidence sought to be adduced before us, Ms O'Connor and the couple's son Harry described aspects of the appellant's bizarre and paranoid behaviour in that time. For example, before leaving on holiday he had taken various items round to his father's address and had put a table against the door as a barricade. According to Ms O'Connor, when on holiday he was fearful of intruders, was withdrawn and in low spirits and would not interact with his family; sometimes he also would say that he was hearing things. She gave a number of examples of his paranoid behaviour. His son Harry also described him as worried about intruders; and, for instance, on the way to the airport he kept looking behind him as though concerned that he was being followed. It is, we add, clear that he was drinking heavily throughout much of the holiday.

9. On return from Spain on 6 August 2017, the appellant went to stay at his parents' home. He did not immediately return to work.

10. On 10 August 2017, on his own account, he met up with his brother and some friends in a pub. They drank a good deal of lager. He was offered some cocaine. When he went home that night, he drank further and also took some more cocaine.

11. The following day, 11 August 2017, he went to his place of work briefly in the morning. He arranged to be dropped off at his home (his partner and children in fact being out). He then consumed yet more alcohol and cocaine. He was to state in his evidence at the trial that, in addition to what he had previously drunk, during the 11 August 2017 he consumed, he estimated, half a litre of Jack Daniels bourbon whisky and half a litre of rum. He also said that he had taken, he estimated, in the region of 4 grams of cocaine (the Defence Statement put it at 4.5 grams).

12. By the afternoon the appellant was, on any view, behaving in an extremely disordered way and having wholly disordered thoughts. He was observed to go out into the street wearing only pink shorts. According to him, he had been feeling endangered. He had started hallucinating; and eventually was convinced that he had a lump on his foot which he thought was a bomb. He took a knife from the kitchen and went outside to cut the bomb away from his foot. A number of neighbours observed him in the street, gouging at his foot with the knife (in fact, subsequent medical investigation revealed quite serious damage to his foot). One neighbour shouted out to him in order to challenge his bizarre behaviour.

13. Laurent Volpe, a French national, was on holiday with his family in London. They were staying in a house in Eltham. The family had been sight-seeing during the day. On returning home, Mr Volpe went to a local shop to buy some provisions. He then set out to return to the house, carrying his shopping. The appellant, according to unchallenged eye-witness evidence, then ran quickly down the street in the direction of Mr Volpe. He stabbed him once in the stomach with the knife which the appellant

had been using to gouge at his foot. Mr Volpe, unsurprisingly, had been wholly oblivious as to what was about to happen and was in no position to try to ward off the attack. Sadly, the stabbing proved to be fatal.

14. After that, the appellant was observed to carry on running. At one stage, he waved the knife shouting out to by-standers words to the effect "Do you want some?" or "Do you want to be next?". He then ran into another street.

15. Police swiftly attended. The appellant, when challenged, dropped the knife. He was then tasered, twice. But he was able to get to his feet and there was then a violent attack on the police officers. The appellant punched and kicked one of them and was shouting out aggressively, saying things such as "You want to have it, do you?" Having been tasered again, he was overpowered and handcuffed. Much of the incident was caught and recorded on the police officers' body cameras.

16. The appellant eventually was calmed down. He nevertheless continued to make bizarre remarks. At one stage, for example, he invited the police to "put a bullet in my back." One of the police officers described his behaviour as erratic and said that he came across as "very paranoid." It was also noted that he had traces of white powder under his nose.

17. The appellant was subsequently taken to hospital. There were some instances of violence there and a number of attempts to escape. Toxicology samples were taken, this being done some two hours after the stabbing. His blood alcohol was estimated at the time to have been around at least twice the drink-driving limit. No actual traces of cocaine were found in his blood, but the concentration of benzoylecgonine in the blood was indicative of relatively recent use. The cautious toxicological view expressed was that it was "possible" that the appellant was experiencing the effects of cocaine at the time of the incident.

18. The appellant was interviewed under caution at the police station on 15 August 2017. He made no comment to questions asked.

Preparation of Defence Case before Trial

19. The appellant had a very experienced legal team acting on his behalf.

20. Given the circumstances, it was inevitable that a psychiatric evaluation was needed and it was inevitable that the question of whether that was available, among other possible defences, a defence of diminished responsibility should be explored. In fact, the Defence Statement dated 12 December 2017 raised the issue of diminished responsibility, as well as raising the issue of intent.

21. The defence of diminished responsibility is available in the circumstances set out in in s.2 of the Homicide Act 1957 (as amended by s.52 of the Coroners and Justice Act 2009). That section provides in the relevant respects as follows:

> ""(1) A person ("D") who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—
>
> (a) arose from a recognised medical condition,

> (b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and
>
> (c) provides an explanation for D's acts and omissions in doing or being a party to the killing.
>
> (1A) Those things are—
>
> (a) to understand the nature of D's conduct;
>
> (b) to form a rational judgment;
>
> (c) to exercise self-control.
>
> (1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct."

22. An approach was initially made by the defence legal team to Dr Philip Joseph, a most experienced forensic psychiatrist. In the event, Dr Joseph was not instructed (it is said in the Grounds of Appeal that the Legal Aid authorities would not agree his fee). Instead, Dr Michael Isaac, also a very experienced consultant psychiatrist, was instructed. No dispute whatsoever is, or could be, raised as to his qualifications, competence and expertise.

23. The report of Dr Isaac, which was provided to us, was on its face a very thorough and detailed evaluation. It extends to 122 paragraphs, and was conveniently divided into separate sections. Dr Isaac had seen the medical records of the appellant and had interviewed him. He made clear, however, that he had not at that time seen all his inmate medical records from HMP Belmarsh (where he was remanded). Nevertheless, Dr Isaac had been made aware, and noted in his report, that the appellant was describing continuing paranoid symptoms in prison; and was made aware that the appellant was receiving antipsychotic medication in the form of Aripiprazole and Quetiapine. Dr Isaac said that neither was a "particularly potent" antipsychotic medication and that both could be effective for treating mood disorders as well as for detoxification from prolonged substance abuse.

24. Dr Isaac set out very fully the circumstances of the incident and the appellant's own account and explanations. He recorded that the appellant had, among other things, said to him that he was "obliterated-drunk" and had been "drinking and snorting" throughout that day. The appellant had given a full account of his paranoid feelings that day and had also said that the medication since given to him in prison had meant that he "was not getting as paranoid now". The report also set out a very full account of the appellant's background, as recounted by him. This included saying that he had "21 years of getting paranoid". His attraction to alcohol and cocaine also featured strongly. Dr Isaac also carefully considered the medical records. In addition, he had studied the body camera transcript, when the police apprehended the appellant.

25. His opinion was that what the appellant described was a substance-induced psychotic disorder, with severe cocaine-use disorder and moderate alcohol-use disorder. He said

that the "clinical pattern is typical of the paranoid psychosis associated with cocaine and clearly caused impaired function."

26. Dr Isaac considered, as a possible alternative, schizophreniform disorder: which connotes a psychosis with a duration of at least a month. But on the materials available to him the symptoms and diagnosis were, in his opinion, not "sufficiently serious or prominent" as to show a psychosis of that order. But he qualified that by saying that he had not seen the inmate prison medical records. In expressing his overall conclusions on diminished responsibility, Dr Isaac among other things stated of the appellant's psychotic episode: "…for me, it is highly likely that it was caused by a combination of cocaine and alcohol." Dr Isaac also ruled out insanity; and confirmed that the appellant was fit to plead.

27. Dr Isaac ended his report by saying that the appellant did not require inpatient psychiatric treatment. He strongly counselled that his substance abuse problems should be vigorously addressed. If the appellant used cocaine and alcohol to the same level again, he would be at a high risk of offending again; and, conversely, if he kept off cocaine and alcohol he "presents little or no special risk."

28. Plainly such a report, as it stood, and given the law as to voluntary consumption of intoxicants, would not have sustained a defence of diminished responsibility: the burden of proof (on the balance of probabilities) being on the defence.

29. It will be noted, however, that Dr Isaac had, understandably, qualified his report in saying that he had not seen the inmate prison records. These the defence solicitors duly obtained, along with certain other materials. These were (as was accepted before us) then provided to Dr Isaac.

30. The inmate records – which we have seen – present a rather mixed picture. They record, for example, on 2 October 2017 "psychsis (sic) very paranoid and suspicious, feels he is being watched and food poisoned….". Another entry (on 5 October 2017) states of the appellant "very determined to convince me he has psychosis." In December 2017 it was being reported that there was nil evidence of acute psychotic symptoms. There had been evidence of one violent episode in prison: but the records show that that was linked to unauthorised use by the appellant of the synthetic drug Spice whilst in prison.

31. The principal responsible clinician for the appellant in prison appears to have been Dr Daly, a consultant psychiatrist. As the records show, she had diagnosed acute transient psychotic disorder. She prescribed anti-psychotic medication, at relatively low levels. The findings and treatment are set out in the prison records. We add that in a subsequent witness statement dated 22 November 2019, reflecting a previous report by her, which was shown to us - although not, it would seem, accompanied by a form W - Dr Daly, basing herself on the inmate prison records, reported an initial diagnosis of paranoid psychosis illness, from which there was subsequently marked improvement. She also said that it appeared that the "underlying paranoid illness" was likely to have been exacerbated by misuse of cocaine. (It might be added that on transfer of the appellant to HMP Whitemoor in early 2019 the new treating psychiatrist decreased the dose of anti-psychotic medication and then removed the appellant from anti-psychotic medication altogether: his diagnosis being one of paranoid personality disorder.)

32. At all events, Dr Isaac was further instructed prior to trial. In this regard we have seen a commendably detailed and thorough Advice on Evidence dated 3 January 2018 and prepared by junior counsel, Mr Leon Kazakos. This was provided to Dr Isaac.

33. That document indicates that there had been ongoing discussions between the defence legal team and Dr Isaac. That document also confirms that Dr Isaac had been provided with the inmate prison records from HMP Belmarsh. Dr Isaac's conclusion expressed in correspondence, as recorded by counsel, was that "causation by cocaine and alcohol is overwhelmingly likely". The material available did not show psychotic symptoms lasting long enough to warrant a diagnosis of schizophreniform disorder, as was recorded in the Advice. That being so, as counsel observed (citing in detail from the case of *Kay and Joyce*, to which we will come): "we presently do not have sufficient grounds to establish diminished responsibility".

34. Counsel then set out at length numerous examples of the appellant's mental state in the absence of drugs and alcohol, as reported by his family, evidencing his bizarre and paranoid behaviour and thoughts over the years (as well as during the recent family holiday to Spain). Dr Isaac was asked to consider this material and further to consider whether diminished responsibility in terms of the provisions of s.2 of the Homicide Act 1957 – which counsel set out – could be made out on the balance of probabilities. A copy of the case of *Kay and Joyce* was also provided to Dr Isaac.

35. Dr Isaac responded by a lengthy email. He accepted that these reports from the family, if correct, were suggestive of some sort of paranoid process. But paranoid thoughts are not necessarily psychotic, he pointed out; and he also pointed out that there was no recorded instance of the appellant being violent in the absence of copious amounts of cocaine and alcohol. Dr Isaac went on to say this:

> "However, Mr Foy's account (and the third party information such as the police camera) is so characteristic of cocaine psychosis that it cannot be ignored … without the cocaine and alcohol I think it very unlikely that he would [have] behaved similarly in any event."

He went on:

> "It is therefore conceivable (and I cannot go to more likely than not) that at the time of the killing, Mr Foy was suffering from an abnormality of mental functioning which arose from an abnormality of mental functioning [sic] that arose from a recognised medical condition – a paranoid psychosis – that (substantially? not sure) impaired his ability to form a rational judgment or, as he had apparently shown in the past, to exercise self control, but without the cocaine and alcohol he had been voluntarily ingesting pretty well continuously for many hours, I cannot see that in itself it would have *substantially* [Dr Isaac's emphasis] impaired his responsibility. "

Dr Isaac concluded his e-mail by saying that he was available for further discussion.

36. Clearly this evidence would not establish a defence of diminished responsibility on the balance of probabilities. No further psychiatric report was obtained from any other psychiatrist. In such circumstances, the legal team for the defence were not in a position to advance such a defence at trial. The trial proceeded accordingly, the only issue being that of intent. No psychiatric evidence of any kind was adduced at trial. The report of Dr Isaac was not served on the prosecution before trial; but it was placed before the judge when she subsequently came to pass sentence (that sentence being life imprisonment with a specified minimum of 17 years).

The Trial

37. The prosecution evidence at trial was effectively unchallenged. When the appellant gave evidence, he described in detail the amounts of alcohol and cocaine he had taken. He accepted that it was his choice to do so. In his evidence in chief, when asked what the effect on him was when taking alcohol and cocaine in combination, he said: "more often than not it made me very paranoid." He followed that by agreeing that he could be aggressive when he consumed alcohol and cocaine. A little later, when asked over what period of time he had felt such feelings of paranoia, he answered: "when I used to drink and take cocaine, I didn't always used to get to the same level of paranoia, sometimes it would be a lot lower but there would be the occasion when the paranoia was extreme. I mean I've been taking it since the age of 17…" He further accepted in cross-examination that, from incidents in the past, he knew that under the combined influence of alcohol and cocaine he could become violent and dangerous:

> "Q: …you agree, don't you, that when you take alcohol and cocaine together you end up being violent and dangerous?
>
> A: I can do, yes.
>
> ….
>
> Q: And you have done in the past?
>
> A: Yes".

He also accepted in cross-examination that on that day he knew that he had a knife in his hand, knew that there was someone in front of him and knew that he was moving his knife hand forward. He accepted also that, just a few minutes later, he had been deliberately violent and aggressive towards the police officers trying to apprehend him.

38. No one criticizes, or could criticize, the fairness or legal accuracy of the summing up of the trial judge (HHJ Sarah Munro QC). She made clear in her directions on the law that there was no dispute but that the appellant had stabbed Mr Volpe deliberately and unlawfully. The only issue was intent. The judge gave conventional directions in that regard, to the effect that an intoxicated intent can still be an intent; and that the real issue was whether the appellant was or may have been so intoxicated by alcohol and cocaine that he had not been able to form a particular intent to kill or cause really serious injury.

39. In the result, the jury convicted.

The Fresh Evidence

40. It is to be gathered that the family of the appellant were and are (understandably) distraught at this outcome. Funds were raised by them and a new psychiatric expert was instructed to consider the matter. That expert was Dr Philip Joseph: the same psychiatrist who had initially first been approached by the defence team before trial.

41. Dr Joseph interviewed the appellant at length. He also considered the medical notes and inmate prison records. In addition, he had seen recently obtained witness statements of Ms O'Connor and of the appellant's son, Harry, in effect setting out examples of the appellant's previous behaviour corresponding (as was accepted before us) to those described in junior counsel's advice provided to Dr Isaac. He of course considered the report, and follow up report, of Dr Isaac. But he reached a different conclusion from that of Dr Isaac. In Dr Joseph's opinion, a defence of diminished responsibility was available.

42. The views of Dr Joseph are expressed in three reports: the last of which is in response to a report of an expert psychiatrist, Dr Nigel Blackwood, obtained by the Crown for purposes of this appeal.

43. In the first report, Dr Joseph among other things stated, after reviewing the appellant's history, "as a result of that abnormal personality structure, he has suffered transient psychotic episodes, when not under the influence of alcohol or drugs, in which he has felt very paranoid and anxious about the intentions of others". Dr Joseph noted that whilst in prison the appellant's anxiety and paranoia apparently had persisted and noted that he had been placed by Dr Daly on anti-psychotic medication. The principal elements of his conclusion were expressed as follows:

> "39. Taking all these matters into account, I conclude that at the time of the killing the defendant was suffering from an abnormality of mental functioning caused by the recognised medical condition of an acute transient psychotic episode, possibly exacerbated by the abuse of cocaine. His abnormality in mental functioning was extremely severe and I am confident that it substantially impaired his ability to form a rational judgement and exercise self-control. It may also have impaired his ability to understand the nature of his conduct. The abnormality of mental functioning provides an explanation for his conduct at the same time of the killing. If the effects of alcohol and cocaine are discounted, the remaining abnormality of mental functioning was in my opinion a significant contributory factor causing the appellant to carry out the killing.
>
> ....
>
> 41. In conclusion, I am of the opinion that despite probable intoxication with cocaine and to a lesser extent alcohol at the time of the killing, the defendant was suffering from an acute

> transient psychotic episode, independent of drug and alcohol abuse, which substantially impaired his mental responsibility for the killing. I conclude therefore that he has a defence to murder of manslaughter on the grounds of diminished responsibility."

44. In his second report, Dr Joseph maintained that view. However, he also drew attention to the toxicological evidence, which he suggested might indicate that the amounts of alcohol and cocaine ingested were in fact lower than described by the appellant in his evidence. If that was so, that would strengthen the defence of diminished responsibility: albeit Dr Joseph made clear that his opinion remained the same even if the appellant had accurately described the quantities consumed.

45. In his third report, he said that he disagreed with Dr Blackwood's diagnosis of paranoid personality disorder. Dr Joseph also took exception to Dr Blackwood casting doubt (as Dr Joseph took it) on the reliability and objectivity of Ms O'Connor's evidence, Dr Joseph – who had seen her – holding, and expressing, the view that she was a credible witness. He also criticised Dr Blackwood for not having considered the appellant's progress in prison or taken into account the prison medical records or Dr Daly's views.

46. As to the reports of Dr Blackwood, obtained by the Crown on this appeal, Dr Blackwood in essence shared the ultimate view of Dr Isaac. Dr Blackwood in fact diagnosed the appellant as developing features of a paranoid personality disorder. He firmly rejected the notion of an acute transient psychotic episode, independent of, even if exacerbated by, substance misuse. The psychotic episode of 11 August 2017 was, he said, the product of voluntary consumption of drink and drugs, and did not endure. That the appellant also had a paranoid personality disorder did not displace that. Dr Blackwood expressed his conclusion, at the end of his lengthy report, as follows:

> "To conclude, I hold that the index offence occurred in the context of voluntary intoxication with (at least) alcohol and cocaine, to the point of a psychotic state which informed his actions on that day but which did not endure. It is impossible to separate out a psychotic disorder emerging independently from substance misuse from one arising in the context of substance misuse when such substance misuse clearly occurred at the material time. There is no evidence of an enduring mental illness of a nature or degree which requires treatment in a psychiatric setting…."

47. He maintained that conclusion in his second report, saying that the toxicology report did not undermine it. In his third report, he indignantly rebutted Dr Joseph's assertion that he had not taken into account Dr Daly's views, pointing out that he had expressly referred to them in his first report. As to the full prison inmate records, he had now been supplied with them. He analysed them closely. He said that they did not displace his previously expressed view and they did not evidence an enduring psychotic illness. None of the materials provided, he said, supported the contention that it was possible to separate out an emerging psychotic disorder independently from substance misuse: which is what Dr Joseph had stated.

48. We think it only right to record that each of Dr Joseph and Dr Blackwood informed us that they considered, in their respective interviews with the appellant, that he was genuinely trying to assist and not trying to mislead in any way.

The Application to Adduce the Fresh Evidence

49. The position, so far as this court is concerned, in deciding whether the proposed fresh evidence should formally be admitted into evidence, is governed by s.23 of the Criminal Appeal Act 1968. While the four matters set out in s.23 (2) are required to be taken into account, the overarching consideration is by reference to what is necessary or expedient in the interests of justice: s.23 (1).

50. One core principle relating to the good administration of justice is the need for finality in litigation. It is ordinarily the obligation of a party to advance his whole case at trial: and an appeal cannot simply be treated as a means of having a second go. There may be some exceptions to this general approach: but that remains the general approach. Were it otherwise, the whole trial process would stand to be subverted.

51. In the present case, there is no question of any legal oversight or legal error at trial. On the contrary, the issue of diminished responsibility was fully examined; the opinion of a reputable psychiatrist obtained; and the legal view that, in the light of that opinion, a defence of diminished responsibility could not be made out was correct. It was correct because it is well-established that there must be appropriate evidence adduced to support such a defence: and self-evidently the opinion of Dr Isaac, so far from supporting it, rebutted such a defence.

52. So ultimately what we now have is one expert (Dr Joseph) taking a different view, instructed after trial, from that of another expert (Dr Isaac), instructed before trial. Moreover, their views were expressed on essentially the same material. In granting permission to appeal, following refusal by the single judge, the Full Court (whilst expressly leaving open the issue of whether permission to adduce the fresh evidence should be given) had raised concerns that Dr Isaac may not have considered the prison diagnosis of Dr Daly or the prison inmate medical records. But that concern has been shown to be misplaced. It was, as we have said, accepted before us that Dr Isaac had indeed been aware of and considered such matters. In fact, in his oral evidence to us Dr Joseph himself very fairly accepted that Dr Isaac had before him all the information that he needed to make an informed diagnosis and judgment; he accepted that Dr Isaac was not missing anything which might be important; and he agreed with the proposition put to him by Mr Glasgow that having had access to the same information the two had reached different conclusions. He also in terms accepted that the opinion of Dr Isaac (as also the opinion of Dr Blackwood) was an opinion that could reasonably be held by a responsible expert psychiatrist.

53. Mr Pownall observed that had, in response to the initial approach, Dr Joseph provided his written report before trial then a defence of diminished responsibility would have been available in this case to be deployed before the jury. But that sort of consideration cannot, of itself, displace the ordinary approach required to be taken by the courts in assessing applications to adduce fresh evidence. Besides, in the present case the family have proved to have been in a position, following conviction, to raise funds privately to commission a report from Dr Joseph. If there was dissatisfaction or dismay at the time with the conclusion of Dr Isaac before trial then it was open to

them at that time to raise funds to seek to commission a further report at that stage: and doubtless an adjournment, if needed, would have been granted for that purpose. But it is not, in our opinion, acceptable to wait upon the outcome of the trial: and then, and only then, when the defence of lack of intent was disproved and the appellant convicted, seek to resurrect a defence of diminished responsibility by commissioning a fresh psychiatric report from a different psychiatrist. We do not say that by way of criticism of anybody for not obtaining a further report before trial. But it is an answer to Mr Pownall's point.

54. Whilst all such cases ultimately are fact specific, numerous authorities illustrate the rigorous approach which is generally taken by the courts in a context such as the present.

55. Thus in *Erskine and Williams* [2009] EWCA Crim 1425, [2009] 2 Cr. App. R 29 it was emphasised, following a lengthy review of the authorities, that it would be exceptional to permit a defence to be advanced or fresh evidence adduced on appeal when it could and should have been advanced at trial: otherwise the trial process is subverted. It may be noted that in the actual case of *Williams*, the appellant had elected to plead guilty to murder, following a close examination by experts of the issue of a possible defence of diminished responsibility which had concluded that such defence was not available. The court in the circumstances of that case, and notwithstanding an attempt to advance fresh psychiatric evidence, upheld the safety of the conviction on the appellant's guilty plea at trial.

56. This general approach was followed and endorsed in *Evans* [2009] EWCA Crim 2243, [2010] Crim. L R 491. That was a case where a defendant had pleaded guilty to murder, in circumstances where two expert psychiatrists at the time had concluded that there was no sufficient evidence on which a defence of diminished responsibility could be left to a jury. The appellate court refused to admit fresh psychiatric evidence, served many years later, seeking to advance a defence of diminished responsibility. Thomas LJ, giving the judgment of the court, said this at paragraph 71:

> "The approach to the admission of fresh evidence in these circumstances is set out in *R v Erskine [2009] EWCA Crim 1425*. We are entirely satisfied that the issue of diminished responsibility was most carefully examined in 1997 and 1998 by Dr Higgins and Dr Boyd and firm and unimpeachable conclusions reached; they did not fall into error. The issue was thoroughly investigated by the conscientious and experienced legal team that represented the appellant; they left no avenue unexplored. Dr Somekh, Professor Eastman and Professor Kopelman have put forward a new opinion, but there is nothing in what they say that was not investigated at the time by the two highly experienced psychiatrists who had the benefit of a contemporaneous examination of the appellant. The significance of the contemporaneous examination is underlined by the consideration that aspects of what the appellant told Professor Eastman many years later are at variance with what he told those who examined him within months of the killing. Psychiatrists often differ in their conclusions; such a difference can be resolved by the trial process. As in this case there is no

> basis for contending that Dr Higgins and Dr Boyd fell into error or did not reach a conclusion reasonably open to them it is not permissible many years later to allow other psychiatrists by expressing different opinions to reopen the issue that was diligently investigated and resolved at the time."

57. It is true that those observations were made in the context of a prior guilty plea and when the fresh evidence was sought to be adduced many years after the event. But, as we see it, those observations are of general application and so are equally capable of application where there has been a contested trial or where the fresh evidence is sought to be adduced relatively swiftly after conviction. Those observations are directly in point in the present case. Indeed, the present case seems to share all the features identified in *Evans* at paragraph 71 of the judgment.

58. Again, in *Challen* [2019] EWCA Crim 916, Hallett LJ, Vice President, observed in the course of her judgment:

> "…As a general rule, it is not open to a defendant to run one defence at trial and, when unsuccessful, to run an alternative defence on appeal relying on evidence that could have been available at trial. This court has set its face against what has been called expert shopping…."

Challen in fact was a case in which it was emphasised that there were unusual circumstances, whereby the court was prepared to admit fresh psychiatric evidence.

59. Whilst we of course accept that what is necessary or expedient in the interests of justice will depend on the particular circumstances of each particular case, our conclusion is that these general principles as outlined in the authorities apply in this case: and apply, given the circumstances, in a way that is wholly adverse to the appellant's application for permission to adduce this fresh evidence.

60. This is not a case where a potential defence of diminished responsibility was overlooked. This is not a case where there was any legal error or oversight. This is not a case where the instructed expert, of acknowledged expertise, has overlooked or misunderstood relevant information or did not have access to relevant information. This is not a case where the expert failed diligently to examine the relevant materials or failed to reach a proper conclusion reasonably open to him. This is not a case where important new facts or materials or other developments have emerged since trial. In truth, this case is, in its fundamentals, a case where, following conviction, an attempt has been made to instruct a new expert with a view to securing – as has happened – an opinion on diminished responsibility different from that of the previous expert instructed before trial. It is, bluntly, expert shopping.

61. All this is wholly against this being an appropriate case to give permission to adduce this evidence. But there is also this extra consideration, if more were needed: a consideration which is reflected in the general approach taken by the courts, as revealed in the authorities. It is this.

62. A defence of diminished responsibility is not, in itself, inconsistent with a defence of lack of intent. But the defence of lack of intent in the present case was essentially

founded on the great quantities of alcohol and cocaine said to have been ingested: whereas such evidence would potentially tell against (even if not of itself necessarily demolishing) a defence of diminished responsibility. As we gather, the appellant still strongly believes and maintains that he lacked the necessary intent. As Spencer J pointed out in argument, if this fresh evidence were admitted and if the conviction were quashed, the issue of intent necessarily would be live again at a retrial on the count of murder. Indeed, the appellant's instructions may then be positively to continue to assert such a defence of lack of intent. Thus, on the collateral basis of fresh evidence which was nothing to do with the issue of intent, he would thereby be enabled to reargue a point rejected by the jury at the first trial. If, on the other hand, the only positive defence sought to be asserted at any retrial was diminished responsibility, the appellant may then seek - in reliance on the toxicology report and the suggestions made in Dr Joseph's second report – to downplay his ingestion of drink and drugs. Either scenario, if they eventuated, would doubtless attract sustained cross-examination; and of course they might not eventuate at all. But it is precisely considerations of that sort – considerations which can potentially operate to subvert the trial process – which make the appellate courts generally so wary on applications to adduce fresh expert evidence in this kind of context.

63. In saying that, we make clear that we have no reason in the present case to think that the defence is seeking consciously to avail itself of tactical considerations of this sort: indeed, having heard Mr Pownall, we have every reason to think that it is not motivated by such considerations. But the point nevertheless remains.

64. Having considered all the circumstances of this particular case, we conclude that it would be entirely wrong, in principle and on the facts, to permit this proposed fresh evidence to be adduced. It is not in the interests of justice to do so.

65. That means that this appeal must fail. But there is a further reason why, in our judgment, this appeal must fail. That is because we consider that the proposed fresh evidence does not in any event afford a viable defence of diminished responsibility which a jury, properly directed, could accept on the balance of probabilities. We turn to that issue.

The Defence of Diminished Responsibility on the Proposed Fresh Evidence

66. As made clear to counsel at the outset of the appeal hearing, we considered the proposed written evidence and the oral evidence of Dr Joseph and Dr Blackwood in the first instance de bene esse.

(a) The legislative context

67. As is notorious, the defence of diminished responsibility under s.2 of the Homicide Act 1957 has its legal complexities. Since the defence is, in its fundamental elements, essentially psychiatric in nature it almost invariably has its evidential complexities as well. The essentially psychiatric nature of the elements of the defence at all events means that this is one of those instances where the psychiatric expert may express an opinion on the ultimate issue: although it is ordinarily for the jury, at a contested trial where the defence is before the jury, to make the final evaluation: see *Hussain* [2019] EWCA Crim 666.

68. The complexities inherent in a defence of diminished responsibility are potentially further compounded when issues of intoxication also arise – as quite often they do.

69. The current legal position appears to be this.

70. Where the killing occurs when the defendant is in a state of acute voluntary intoxication, even if that voluntary intoxication results in a psychotic episode, then there is no recognised medical condition available to found a defence of diminished responsibility: see *Dowds* [2012] EWCA Crim 281 [2012] 1 Cr. App. R 34; *Lindo* [2016] EWCA Crim 1940. This is so whether the intoxicant is alcohol or drugs or a combination of each.

71. Where, however, the consumption of the intoxicant is as a result of an addiction such as alcohol dependency syndrome, then, depending on the circumstances, there may be a recognised medical condition giving rise to an abnormality of mental functioning which can found the defence of diminished responsibility: *Dowds* (cited above); *Stewart* [2009] EWCA Crim 593, [2009] 2 Cr. App. R 30.

72. What is the position, however, where there is an abnormality of mental functioning arising from a combination of voluntary intoxication and of the existence of a recognised medical condition? What is the position, where the voluntary intoxication and the concurrent recognised medical condition are both substantially and causally operative in impairing the defendant's ability and explaining the defendant's act?

73. One principled approach might have been to say that the defence is not then available: it is not available because the defendant voluntarily chose to take the intoxicant and must take the consequences. If one consequence is that he killed someone when he would not have done so had he not been intoxicated, even if there was a concurrent operative medical cause as well, still responsibility should attach. It has always been a general principle of law, on policy grounds, that self-induced intoxication ordinarily is of itself no defence: a defendant cannot defend himself by saying: "I would never have done this had I been sober". That principle is modified where a specific intent is involved – for example, a defendant can (as here) say that he was so intoxicated that he was not capable of forming the necessary intent – but it otherwise remains the general principle (see, for example, cases such as *DPP v Majewski* [1977] AC 443). The same principle extends to sentencing: voluntary intoxication cannot be advanced as a mitigating factor, indeed it ordinarily is treated by the courts as an aggravating factor.

74. That, however, is not the course which the law has taken in cases of diminished responsibility. In *Dietschmann* [2003] UKHL 10, [2003] 2 Cr. App. R 4, the House of Lords considered this very issue, in the context of the defence being raised under the provisions of the Homicide Act 1957 in its original form. It was decided that, for the defence to be available, the abnormality of mind did not need to be the sole cause of the defendant's acts in doing the killing: even if the defendant, in that case, would not have killed had he not taken alcohol, the causative effect of the drink did not necessarily prevent an abnormality of mind from substantially impairing the mental responsibility for the fatal acts. A corresponding approach was subsequently taken by the Court of Appeal in cases such as *Stewart* (cited above).

75. Those were cases under the former legislation. But it has been decided that a corresponding approach is also to be taken under the current legislation. The relevant authority is that of a constitution of this court in *Kay and Joyce* [2017] EWCA Crim 647, [2017] 2 Cr. App. R 16. In each case which was the subject of such decision, the relevant defendant suffered from paranoid schizophrenia. Each defendant also, at the time of killing, was heavily intoxicated. Dealing with the case of *Kay*, Hallett LJ (Vice President), said this at paragraph 16:

> "…The law does not debar someone suffering from schizophrenia from relying on the partial defence of diminished responsibility where voluntary intoxication has triggered the psychotic state, but he must meet the criteria in section 2 (1). He must establish, on the balance of probabilities, that his abnormality of mental functioning (in this case psychotic state) arose from a recognised medical condition that substantially impaired his responsibility. The recognised medical condition may be schizophrenia of such severity that, absent intoxication, it substantially impaired his responsibility (as in the case of *Jenkin*); the recognised medical condition may be schizophrenia coupled with coupled with drink/drugs dependency syndrome which together substantially impair responsibility. However, if an abnormality of mental functioning arose from voluntary intoxication and not from a recognised medical condition an accused cannot avail himself of the partial defence. This is for good reason. The law is clear and well established: as a general rule voluntary intoxication cannot relieve an offender of responsibility for murder, save where it may bear on the question of intent."

76. In the event, the appeal in *Kay* failed. There was no medical evidence that his underlying mental illness, agreed to be schizophrenia, was of such a degree as to impair his responsibility substantially: once the jury rejected his defence (as it plainly had) that he was suffering from alcohol dependency syndrome, he no longer had a defence. This is to be contrasted with the case of *Joyce*, who suffered from a long-standing psychotic mental illness in the form of severe paranoid schizophrenia, independent of his drug abuse. All the experts were agreed that this was the main contributing factor to the killing and that his mental responsibility was substantially impaired. Hence a plea of guilty to manslaughter on the basis of diminished responsibility had been accepted (the appeal itself was as to sentence).

77. Finally, for present purposes, we refer to the case of *Golds* [2016] UKSC 61, [2017] 1 Cr. App. R 18, albeit that was not a case involving intoxication. In that case it was confirmed that, notwithstanding the essentially psychiatric aspects of all elements of the defence, whether the impairment was sufficiently substantial remained a matter of fact and degree for the jury. The Supreme Court rejected the notion that any impairment beyond the trivial would suffice. Aside from that, it was to be left to the jury to decide whether in any given case the impairment was of sufficient substance or importance to meet the statutory test. Although this approach has been the subject of academic criticism to the effect that it leaves so important an issue as in effect undefined for the jury, and with consequential room for the approach to be adopted to

vary from case to case, it is to be presumed that such an approach is based on pragmatic considerations in the context of jury trials. As said by Lord Judge LCJ in *Stewart* (cited above) at paragraph 35:

> "We acknowledge that this decision will rarely be easy. Indeed it is fair to say that diminished responsibility has always raised complex and difficult issues for the jury, not least because the defence usually involves conflicting medical evidence addressing legal, not medical concepts, for a jury of lay persons to decide. The jury is often called upon to confront problems relating to the operation of the mind with which they will be unfamiliar. Nevertheless the resolution of these problems continues to be the responsibility of the jury, and when addressing their responsibility they are inevitably required to make the necessary judgments not just on the basis of expert medical opinion but also by using their collective common sense and insight into the practical realities which underpin the individual case."

(b) Disposal of the issue on the proposed fresh evidence

78. Some of the problems that can arise in some of the cases do not arise in the present case.

79. First, it was and is common ground, as we have said, that the appellant did not suffer from alcohol or intoxicant dependency syndrome. Second, it was and is common ground that he did not suffer from paranoid schizophrenia: Dr Joseph himself confirmed, and Dr Blackwood agreed, that his condition did not reach that level. Third, it was and is common ground that the abnormality of mental functioning in this case was the florid psychotic episode of 17 August 2017 (and consistently with the approach taken in *Lindo* and *Kay*).

80. So, it being accepted that there was here an abnormality of mental functioning (the florid psychotic episode), the first question, by reference to the scheme of s.2 of the 1957 Act, is to ascertain from what recognised medical condition that psychotic episode arose. Second, if there was one, did the abnormality of mental functioning (absent the drink and drugs) "substantially" impair the appellant's ability in the relevant respects; and, third, did it provide an explanation for his acts?

81. On the opinion of Dr Isaac, there was no relevant recognised medical condition giving rise to the psychotic episode. To the contrary, his view was that it was the voluntary ingestion of alcohol and (in particular) cocaine which had given rise to that psychotic episode: this episode was, as he viewed it, entirely characteristic of cocaine induced psychosis. He considered, but rejected, a diagnosis of schizophreniform disorder as also having an operative causal effect for this episode (in conjunction with the drink and drugs). His final e-mailed report was to the effect that even if there was a paranoid psychosis it would not of itself have *substantially* impaired the appellant's responsibility. Dr Blackwood was, in essentials, of the like view. Whilst Dr Blackwood diagnosed the appellant as suffering from a paranoid personality disorder (which is capable of being classified as a recognised medical condition) he likewise

considered that it did not have any sufficient material contribution to the psychotic episode such as to make a defence of diminished responsibility available.

82. With all respect, we found the evidence of Dr Joseph altogether more elusive on these aspects.

83. The tone of Dr Joseph's written reports is trenchant. That of itself is not necessarily a criticism; albeit some passages do read almost as if they would acknowledge no legitimate difference of opinion from his own views. More disconcertingly, he on occasion raised unwarranted criticisms of other experts: for example, he in terms accused Dr Blackwood of not considering the appellant's progress in prison or Dr Daly's assessment, when Dr Blackwood had in fact considered those aspects in paragraph 64 of his first report (causing Dr Blackwood, not unreasonably, to refer in a later report to Dr Joseph's "haste to berate me"). Further, Dr Joseph seemed to think it open to him to comment favourably on the credibility and demeanour of Ms O'Connor (whom he had personally met) whilst reproving Dr Blackwood for not having seen her. It was also perhaps rather disconcerting that Dr Joseph regarded it as appropriate, founding himself on the tentative conclusions in the toxicology report, to propose at some length that the appellant may in fact have consumed far less alcohol and cocaine than he had specifically said in his own Defence Statement and in his own evidence at trial: Dr Joseph appreciating that the greater the quantities involved then the greater the adverse impact on a viable defence of diminished responsibility.

84. Happily, in his oral evidence matters became altogether more even handed and balanced. On the toxicology matter, for example, a further report obtained by Mr Pownall shortly before the appeal hearing confirmed that the original conclusions certainly were capable of being consistent with the appellant's own evidence. Further, Dr Joseph very fairly accepted that the opinions of Dr Isaac and of Dr Blackwood were opinions of appropriately qualified experts which were reasonably open to them; it was just that there was disagreement between them ("which is not at all unusual in psychiatry", as he frankly said of disagreement). Further, as to Ms O'Connor's (and the son's) statements, he very fairly accepted that the substance of them had previously been reported to Dr Isaac. Indeed, as we have already said, Dr Joseph – again very fairly – accepted that overall Dr Isaac essentially had ultimately had the same information as Dr Joseph himself. But it should also be recorded that Dr Blackwood in turn during his oral evidence before us accepted that Dr Joseph's opinion was tenable.

85. But, allowing for all that and allowing for Dr Joseph's very great expertise and forensic experience, there remained, as we assess the position, considerable difficulties with his evidence.

86. The first point was to identify the "recognised medical condition" from which he was saying that the florid psychotic episode arose. In his first report, he had referred to the appellant's "abnormal personality structure" as a result of which the appellant suffered transient psychotic episodes when not intoxicated. But, as he conceded in oral evidence, "abnormal personality structure" is not a recognised medical condition for this purpose.

87. He then went on to maintain that the abnormality of mental functioning was "caused by the recognised medical condition of an acute psychotic episode". On the face of it,

that seems tautologous – the abnormality of mental functioning here *was* the acute psychotic episode. When this was put to Dr Joseph by the court, he accepted that it was "almost tautological". Indeed, he suggested that the distinction was "slightly artificial": which approach does not seem, with all respect, to accord with the wording or structure of s.2.

88. Ultimately, as we understood him, Dr Joseph seemed to be arguing for the presence of what he called an "acute transient psychosis" as the recognised medical condition, indicating by that in effect a tendency or predisposition to psychotic episodes.

89. As we have said, Dr Blackwood accepted that Dr Joseph's opinion was tenable. In his oral evidence (and he was examined much more briefly than Dr Joseph) Dr Blackwood accepted the proposition put to him by Mr Pownall that the disagreement between the three psychiatrists was essentially as to the extent to which an underlying disfunction (absent intoxication) contributed to the stabbing of Mr Volpe. Dr Blackwood, however, maintained what he said was the impossibility of securely separating out the disorder relied on from the substance misuse in considering the act of stabbing.

90. The difficulty with Dr Joseph's opinion, in our judgment, was that, ultimately, there was no convincing evidential basis put forward to support his diagnosis other than Dr Joseph's own assertion. Nothing in the appellant's previous medical notes or records lent support to such a theory. It is true that the appellant had suggested to Dr Joseph two previous incidents when he had, as he claimed, been violent when not (so it was said) under the influence of drink and/or drugs, But police records were located for one of such incidents which show that in fact he had been at the time heavily under the influence of drugs. The clear inference – given his admitted history with regard to intoxicants – was that that was true of the other incident also.

91. The reliance by Dr Joseph on Ms O'Connor's account of incidents taken from the appellant's past history also, with respect, led nowhere. In his first report, he had said that it was on the basis of her account that he concluded that the appellant had suffered from transient paranoid psychotic episodes when sober. It is an obvious point, however that, as a matter of recollection of the past, it would have been most difficult for Ms O'Connor, going back in time, to recall precisely when intoxicants had or had not featured, especially given the regularity of the appellant's drinking. In any event, there was no real dispute but that the appellant had frequently, and independently of intoxicants, been the subject of paranoid thoughts and behaviour. But, as Dr Joseph accepted (in agreement with Dr Isaac and Dr Blackwood), a person with persistent paranoid beliefs is not necessarily psychotic.

92. Dr Joseph nevertheless sought to place reliance on the appellant's reported paranoid behaviour whilst on holiday in Spain. But not only is it difficult to discern why that behaviour, as reported, is to be assessed as psychotic, in any event the appellant had, as he had admitted in evidence, been drinking heavily on that holiday for all bar one or two days. Moreover, there was no evidence of any ingestion of drugs on that holiday and, noticeably, no evidence of any violent behaviour as such.

93. The prison records, and Dr Daly's report, are, we consider, of relatively little real value in this regard. Leaving aside the possible concerns that the appellant may have been trying whilst in prison to promote a theory of psychosis (as at least one entry

suggests) – and we observe that in his evidence at trial he had also sought during cross-examination to bring in references to psychosis before he was stopped – it is noticeable that the prescribed levels of anti-psychotic medication in prison were at a low level; that they were suitable also for dealing with anxiety and depression (as Dr Isaac and Blackwood pointed out); that at no stage was it thought necessary by Dr Daly or anyone else to refer the appellant to a separate prison or external psychiatric unit for treatment; and that, on his anti-psychotic medication being withdrawn at HMP Whitemoor, there has been no identified relapse. As to the one identified act of violence whilst in prison, that is clearly, on the prison records, linked to his consuming an illegal drug, in the form of Spice. Overall, there is not one single recorded instance of his being violent in the absence of drugs, if not drink also. Moreover, his own evidence at trial had been that a combination of alcohol and cocaine could make him violent and aggressive.

94. Further, it was rather disconcerting that, at stages in his oral evidence before us, Dr Joseph seemed to proceed on the footing that, although in his third report he had firmly rejected Dr Blackwood's suggestion of paranoid personality disorder (saying that he had seen no evidence that the appellant had developed such a disorder), nevertheless such a disorder might in fact provide an explanation for the appellant's acts. Dr Joseph was in general terms insistent that while, as he accepted, the appellant would not have killed without being (voluntarily) intoxicated, he also would not have killed without, as he put it in oral evidence, his "underlying mental health problems". At all events, at stages his oral evidence came close, as it seemed to us, to saying that because at the time the appellant was at the time intoxicated and because at the time he had some medical condition ("let's call it paranoid personality disorder, if you like", as he at one stage said) therefore a defence of diminished responsibility arose. But that simply is not tenable as a general proposition: it is wholly contrary to the wording and structure of s.2 and wholly contrary to the need for appropriate evidence for each stage of the defence, as set out in that section.

95. In our judgment, reviewing the proposed evidence and excluding, as one must, the involvement of the voluntarily ingested alcohol and cocaine, there is simply no solid basis for asserting an abnormality of mental functioning arising from a recognised medical condition which *substantially* impaired the appellant's ability in the relevant respects and which provided an *explanation* (in the sense of the statute) for his acts.

96. So for these reasons too the appeal must fail. Given the circumstances in which this fresh psychiatric evidence is now sought to be adduced, here too it is not enough for Mr Pownall to say that the appeal should be allowed because had only such evidence of Dr Joseph been adduced below the defence of diminished responsibility would have been before the jury for it to consider. To the contrary, given the present circumstances, it is the obligation of this court first to appraise for itself the proffered evidence in order to see if it is capable of giving rise to a viable defence, on the balance of probabilities, of diminished responsibility. In our assessment, it falls a long way short of doing so.

Conclusion

97. For each and both of the conclusions reached above, the application for permission to adduce fresh evidence is refused. The appeal is dismissed. The conviction for murder is safe.