**Appeal (fresh evidence)** – *R. v Foy* [2020] EWCA Crim 270, unreported, 27 February 2020, CA.

The appellant fatally stabbed the victim on the streets of London. The victim, a French tourist, was unknown to the appellant, who was suffering from 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. Consideration had been given to running a partial defence of diminished responsibility under section 2 of the *Homicide Act* 1957, but that was not supported by the appellant’s psychiatric expert. The appellant was convicted of murder. He appealed, seeking to rely on fresh evidence, namely the report of a different psychiatric expert, which was said to support a defence of diminished responsibility.

(1) The case was not one where a potential defence of diminished responsibility was overlooked. There had not been any legal error or oversight. The instructed expert, of acknowledged expertise, did not overlook or misunderstand relevant information, fail diligently to examine the relevant materials, or fail to reach a proper conclusion reasonably open to him. The case was not one where important new facts, materials or other developments had emerged since trial. It was, in its fundamentals, one where, following conviction, an attempt was made to instruct a new expert with a view to securing an opinion on diminished responsibility different from that of the previous expert instructed before trial. That amounted to expert shopping. Applying the general principles outlined in *R. v Erskine*; *R. v Williams*, CLW/09/28/1, [2009] EWCA Crim 1425, [2010] 1 W.L.R. 183, CA, *R. v Evans (John Derek)*, CLW/10/19/2,([2009] EWCA Crim 2243, [2010] Crim.L.R. 491, CA, and *R. v Challen*, CLW/19/38/1, [2019] EWCA Crim 916, [2019] Crim.L.R. 980, CA, the case was not one in which it was appropriate to give permission to adduce this evidence.

(2) In any event, the proposed fresh evidence did not afford a viable defence of diminished responsibility that a jury, properly directed, could accept on the balance of probabilities. Reviewing the proposed evidence and excluding, as one must, the involvement of the voluntarily ingested alcohol and cocaine, there was no solid basis for asserting that the abnormality of mental functioning (the psychotic episode) arose from a recognised medical condition (it being common ground that the appellant did not suffer from alcohol or intoxicant dependency syndrome or paranoid schizophrenia) that substantially impaired the appellant’s ability in the relevant respects and that provided an explanation (in the sense of the 1957 Act, s.2) for his acts.

**Key cases cited**: Considered – *R. v Dietschmann*, CLW/03/09/5, [2003] UKHL 10, [2003] 1 A.C. 1209, HL; *R. v Dowds*, CLW/12/09/2, [2012] EWCA Crim 281, [2012] 1 W.L.R. 2576, CA; *R. v Golds*, CLW/16/44/2, [2016] UKSC 61, [2016] 1 W.L.R. 5231, SC; *R. v Kay (Robert)*; *R. v Joyce (Trevor)*, CLW/17/28/5, [2017] EWCA Crim 647, [2017] 4 W.L.R. 121, CA. Kay

**Comment:**

In addition to affirming the well-established rule that voluntary intoxication is irrelevant on a charge of murder save where it goes to the issue of intent (*R v Dietschmann* [2003] UKHL 10; *R v Dowds* [2012] EWCA Crim 281; *R v Kay; R v Joyce* [2017] EWCA Crim 647), this case highlights the risks and limitations of psychiatric opinion in addressing questions of law.

To establish a defence of diminished responsibility under s.2 of the Homicide Act 1957 (as amended by the Coroners and Justice Act 2009), the defendant must prove that he was suffering from an abnormality of mental functioning which:

(a) arose from a recognised medical condition;

(b) substantially impaired his ability understand the nature of his conduct, form a rational judgment or exercise self-control; and

(c) provides an explanation for his acts and omissions in doing or being a party to the killing.

The “recognised medical condition” requirement was introduced in an effort to ensure that defences would be “grounded in a valid medical diagnosis linked to the accepted classificatory systems which together encompass the recognised psychiatric and psychological conditions” (Ministry of Justice, *Murder, Manslaughter and Infanticide* Consultation Paper, July 2008, para. 49). The “classificatory systems” currently in use in the UK are the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*,Fourth Edition, American Psychiatric Association 2013) and the ICD-10 (*International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision, World Health Organisation 2004). These systems classify presentations and are designed for use in clinical assessment and treatment; they have never been determinative of legal issues concerning mental disorder (*DL-H v Devon Partnership Trust* [2010] UKUT 102 (AAC)). Indeed, the DSM-5 is prefaced by a warning that it is not designed for use in forensic settings, where “there is a risk that diagnostic information will be misused or misunderstood” due to the “imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis” (DSM-5, p.25).

The problem with relying on psychiatric nomenclature in diminished responsibility cases was illustrated shortly after the amendments to the defence were enacted. In *R v Dowds* (above) the defendant sought to argue that he had killed due to the recognised medical condition of “acute intoxication”. Acute intoxication does appear in the ICD-10, but so do numerous other “conditions” that would be problematic if relied on in a forensic context. In *Dowds* the Court of Appeal noted that ICD-10 included “'unhappiness' (R45.2), 'irritability and anger' (R45.4) 'suspiciousness and marked evasiveness' (R46.5), 'pyromania' (F63.1), 'paedophilia' (F65.4), 'sado-masochism' (F65.5) and 'kleptomania' (F63.2)”, while the DSM-4 (as it then was) included “similar conditions and also such as (*sic*) 'exhibitionism' (569) 'sexual sadism' (573) and 'intermittent explosive disorder' (663/667)” (at [31]). As their Lordships pointed out, the latter “may well be a medically useful description of something which underlies the vast majority of violent offending, but any suggestion that it could give rise to a defence, whether because it amounted to an impairment of mental functioning or otherwise, would, to say the least, demand extremely careful attention” (*Dowds* at [31]). Accordingly, the Court held that “the presence of a 'recognised medical condition' is a necessary, but not always a sufficient, condition to raise the issue of diminished responsibility” (*Dowds* at [40]).

The law does not debar a defendant who had voluntarily consumed drink or drugs at the time of killing from relying on diminished responsibility but the jury will be directed to discount the effects of the intoxication when deciding whether the defence have proved each of the s.2 criteria to the required standard (*R v Joyce; R v Kay,* above).Importantly, the question is not whether the defendant would have killed but for the intoxication. Instead, if the jury takes the view that the defendant might not have killed if he had not taken drink or drugs, then the question is whether despite the drink, his mental abnormality substantially impaired one of the specified abilities, and provides an explanation for his conduct (*Dietschmann,* above,at [41]; *Dowds*, above). Both the identification of an underlying condition and, if such a condition exists, the task of envisaging a hypothetical, sober version of the defendant, have caused difficulties in practice.

Where intoxication is a factor, the requisite condition may be related to alcohol abuse (as in *R v Stewart*, above), it may be an unrelated condition (as in *R v Joyce*, above), or it could be a combination of the two. As regards the first of these, past judgments have tended to refer to alcohol or drug “dependence” or “dependency syndrome”. Although the DSM-4 featured “alcohol dependence” and “alcohol abuse” as two distinct disorders with different diagnostic criteria, the DSM-5 integrates them into a single “alcohol use disorder” with mild, moderate and severe sub-classifications. In the present case, the psychiatrist instructed by the defence prior to trial opined that the defendant had a “severe cocaine-use disorder and moderate alcohol-use disorder” (at [25]). Nevertheless, the Court stated that it was “common ground … that the appellant did not suffer from alcohol or intoxicant dependency syndrome” (at [79]). The judgment therefore fails to clarify the application of the law to cases in which there is an underlying medical condition related to the consumption of alcohol or drugs.

The “imperfect fit” between diagnostic criteria and questions of law is further illustrated by the disagreement between the experts as to whether some other recognised medical condition existed. Both the original psychiatrist instructed by the defence and the psychiatrist instructed by the prosecution for the purposes of the appeal were of the view that the defendant had killed during a psychotic episode that was attributable to voluntary intoxication. The new defence expert, Dr Joseph, argued that it was “caused by the recognised medical condition of an acute psychotic episode”. The Court initially regarded this approach as “tautologous – the abnormality of mental functioning here *was* the acute psychotic episode” (at [87], emphasis in original). During the hearing of the appeal, the prosecution expert conceded that Dr Joseph’s view was “tenable” and the Court subsequently appears to have accepted that a tendency or predisposition to psychotic episodes is capable of amounting to a recognised medical condition. The next question was whether, discounting the effects of intoxication, the underlying condition contributed significantly to the defendant’s conduct. Dr Joseph contended that it did. The prosecution expert maintained that the entire exercise of discounting the temporary effects of voluntary intoxication, as required by *Dietschmann* was “impossible”:

“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” (at [46]).

Dr Joseph accepted that the opinions of the other two psychiatrists were “reasonably open to them; it was just that there was disagreement between them (‘which is not at all unusual in psychiatry’…)” (at [84]). All of which suggests that the Law Commission’s concerns about the diminished responsibility defence have not been addressed effectively by the terms of the revised plea: whether a defendant can find a psychiatrist who will be prepared to testify that a recognised medical condition was responsible for his behaviour remains a “lottery” (Law Com. No. 190, para. 5.43).