Psychiatric Diagnosis as Newly Discovered Evidence in Ireland

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This article considers how courts in Ireland have responded to newly discovered evidence that a defendant was suffering from a mental disorder at the time of the offence. Where such evidence was not known to the jury, there is a risk that a wrongful conviction may have occurred. When psychiatrists examine a defendant for the purposes of criminal proceedings, they may only have had limited time to study and diagnose the defendant. Sometimes, the defendant's subsequent symptoms and presentation can lead to a psychiatrist revising their original diagnosis. In Ireland, a defendant can make an application arguing that this newly discovered fact shows that there has been a miscarriage of justice in relation to the original conviction. It appears that Irish courts will only accept such applications in exceptional circumstances. This article discusses the recent Court of Appeal decisions in People (DPP) v Abdi (no 2) and People (DPP) v McGinley. It analyses the reasoning of the judgments and seeks to identify what general principles can be derived from the decisions that can be used to inform future applications.

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I Introduction

In Ireland, a special verdict of insanity can only be returned after hearing evidence from a consultant psychiatrist relating to the mental condition of the defendant.[1] This evidence is to assist the tribunal of fact and not supplant its role as the ultimate decision maker.[2] Having a condition that qualifies as a mental disorder[3] is an essential element of the defences of insanity[4] and diminished responsibility;[5] however, the tribunal of fact will lack the necessary expertise to diagnose the defendant and will be reliant on the consultant psychiatrist's diagnosis to help them establish if the defendant satisfies this criterion.

A psychiatrist's diagnosis is a subjective opinion based upon their expertise and experience and is not capable of being scientifically certain.[6] Occasionally, psychiatrists in an insanity trial will differ slightly on the diagnosis but still agree that the defendant should not be held criminally responsible.[7] On rarer occasions, they might agree on the actual diagnosis, but differ on the issue of whether the defendant was legally insane.[8] Sometimes, the opposing psychiatrists will not be in agreement on either aspect of the defence. When either of the latter two scenarios represent the psychiatric evidence at trial, the defence almost always fails.[9]

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[1] *Criminal Law (Insanity) Act*, IR 2006, s 5(1).

[2] *DPP v. Abdi, (no 1)*,2004 IECCA 47 [*Abdi (no 1)*].

[3] A mental disorder is defined as including "mental illness, mental disability, dementia or any disease of the mind but … [excluding] … intoxication"; *Criminal Law (Insanity) Act, supra* note 1 at s 1.

[4] The tribunal of fact must also be satisfied that, in addition to suffering from a mental disorder, the defendant did not know the nature and quality of the act (cognitive limb), or did not know the act was wrong (evaluative limb), or was unable to refrain from committing the act (volitional limb); *Criminal Law (Insanity) Act, supra* note 1 at s 5(1)(b).

[5] The tribunal of fact must also be satisfied that, in addition to suffering from a mental disorder, "the mental disorder was not such as to justify finding him or her not guilty by reason of insanity but was such as to diminish substantially his or her responsibility for the act"; *Criminal Law (Insanity) Act, supra* note 1 at s 6(1)(c).

[6] See Murrah J's comments in *Wion v. United States:* "[s]anity and insanity are concepts of incertitude … no expert can speak with scientific certainty and no jury can or does act on the assumption that some of the experts in the case have done so"; *Wion v. United States,* 1963 325 F 2d 420 (1963) at 427–428. Also see *Leland v. Oregon,* 1952 343 US 790 (1952) 803 .

[7] See for example, *DPP v. Alchimionek,* 2019 IECA 49 where the defence psychiatrist diagnosed the defendant with Schizophrenia, and the prosecution's psychiatrist had diagnosed with psychotic depression. Despite the differing diagnoses, it was not regarded as a "major clash" and both were of the opinion that the defendant was insane.

[8] See for example, *DPP v. McKenna,* where the defence and prosecution psychiatrists agreed on the diagnosis, but differed on whether it was responsible for her behaviour; Natasha Reid, "'I sliced her like a goat': woman guilty of attempted murder despite insanity plea", *Court News Ireland* (3 May 2019), online: <https://courtsnewsireland.ie/sliced-like-goat-woman-guilty-attempted-murder-despite-insanity-plea/2019/03/05/>.

[9] In the last twenty years, only one trial could be identified where the prosecution psychiatrist testified that the defendant was not insane, but the jury still returned the special verdict: Eoin Reynolds, "Man not

If the convicted defendant had not had previous contact with psychiatric services prior to the commission of the offence, the amount of time to study his behaviour and condition prior to trial might be limited. An extended time period after a defendant's trial could provide further insight into his condition, and perhaps evidence suggesting a different diagnosis might emerge that was either not known, or in dispute, at the time of the original trial. In the cases of *DPP v Abdi (no 2)*[10] and *DPP v McGinley*,[11] the Court of Appeal had to consider whether a subsequent diagnosis of a psychiatrist was enough to constitute a new or newly discovered fact under section 2 of the *Criminal Procedure Act 1993* allowing the Court of Appeal to declare the conviction a miscarriage of justice.

This article will analyse the judgments in *Abdi* and *McGinley* and discuss the implications that the Court of Appeal judgments might have on the defences of insanity and diminished responsibility in the future.

II Newly Discovered Evidence

A. The Test for Admissibility of Newly Discovered Evidence

Section 2(1) of the *Criminal Procedure Act 1993* provides that a person who has been convicted of a criminal offence and alleges that a "new or newly-discovered fact shows that there has been a miscarriage of justice in relation to the conviction" can apply to the Court of Appeal for an order quashing the conviction if the court has previously rejected an appeal or application for leave to appeal. Demonstrated or actual innocence is not required for an order to be made, as it is based on the "administration in a given case of the justice system itself ".[12] Prior to the Act's enactment, the only recourse available to a convict was to petition the President for a pardon.[13]

The Act makes a distinction between new facts and newly discovered facts. A new fact is one which was known to the defendant at the time of the earlier proceedings but not adduced as evidence. There must be a reasonable explanation for the defence's failure to adduce this evidence previously.[14] A newly discovered fact is a fact not known to the defendant at the time of the relevant proceedings, or alternatively a fact which was known to the defendant, but its significance was not appreciated.[15]

In *DPP v. Willoughby*, the Court of Criminal Appeal established a four-tier test which must be satisfied before newly discovered facts could be admitted into evidence. Firstly, there must

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guilty of partner's attempted murder by reason of insanity", *The Irish Times* (27 April 2018), online: <https://www.irishtimes.com/news/crime-and-law/courts/criminal-court/man-not-guilty-of-partner-s-attempted-murder-by-reason-of-insanity-1.3476580>.

[10] *DPP v. Abdi (no 2),* 2019 IECA 38 [*Abdi*].

[11] *DPP v. McGinley,* 2022 IECA 239 [*McGinley*].

[12] *DPP v. Meleady (No 3),* 2001 4 IR 16 (CCA) 33.

[13] Constitution of Ireland, Art 13.6.

[14] *Criminal Procedure Act 1993,* s 3.

[15] *Ibid* at s 4.

be exceptional circumstances established, particularly in the case of expert testimony, as the public interest requires that a defendant submits his entire case at trial and a multitude of expertise is available at this time.[16] Secondly, the evidence must be credible and it must be such that it might have an important and material influence on the result of the case.[17] Thirdly, the materiality and credibility is to be assessed by reference to the other evidence at the trial and not in insolation. Finally, the evidence must also not have been known at the time of trial and the circumstances must be such that it could not have been reasonably known or required at that time.[18]

B. When can Opinion Evidence be regarded as Newly Discovered Evidence?

The 1993 Act allows for only newly discovered facts to be admitted. It does not expressly allow for the introduction of new opinion evidence. In *People (DPP) v Kelly,* the Court of Criminal Appeal adopted the Concise Oxford Dictionary definition of a fact as being "a thing that is indisputably the case" and contrasted it with an opinion which is "not necessarily based on fact or knowledge".[19] Opinion Evidence was held to be incapable of constituting a newly discovered fact. Kearns J held that allowing the admissibility of new opinion evidence would:

> …have the effect of rendering virtually every conviction … open to later challenge if a further or new expert could be found to offer an opinion which went further than a defence expert had done at trial, or which tended to contradict or undermine experts called on behalf of the prosecution at trial.[20]

However, Kearns J went on to state that in limited circumstances opinion evidence may be admissible where it is necessary to properly interpret new facts. This may include cases where scientific knowledge at the time of trial has been cast into doubt by new scientific research, and where an original expert testimony is shown to have been rendered unreliable by bias, dishonesty or incompetence.[21]

For psychiatric testimony, the decision in *Kelly* indicates that expert psychiatric testimony would only be admissible if needed to interpret a new fact that had come to light. Thus, if a new psychiatrist diagnosed the defendant with a different mental disorder after the trial, this diagnosis alone would still be an opinion and inadmissible, unless it was based on a fact that was only discovered after the trial. Under the *Willoughby* criteria, this fact must also not have been capable of being reasonably known or discovered at the time. This sets a very high threshold for a defendant who wishes to argue that their claim of insanity or diminished responsibility should be reconsidered due to a new diagnosis.

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[16] *DPP v. Willoughby*, 2005 IECCA 4 approved by the Supreme Court in *DPP v. O'Regan,* 2007 IESC 38 at para 69.

[17] *Ibid.*

[18] *Ibid.*

[19] *DPP v. Kelly*, 2008 IECCA 7, 2008 3 IR 697 at para 34.

[20] *Ibid* at para 41.

[21] *Ibid* at para 44.

III The Decision in People (DPP) v Abdi (No 2)

A. Summary of the Case

Mr Abdi was convicted on 28 May 2003 in the Central Criminal Court for the murder of his 20-month-old son by a majority 10-2 jury verdict. His defence at trial was that he was insane at the time of committing the act.

His wife, Ms Bailey, gave evidence that the defendant had begun to display paranoid behaviour three months after their son's birth following an altercation between Mr Abdi and members of the Gardaí, for which Abdi was convicted of assault and sentenced to community service.[22] The defendant's mental state worsened after he returned from a trip to Kenya and his paranoia began to be directed towards his wife, culminating in a physical assault on 21 February 2001. It is not clear exactly when Ms Bailey left the family home, but on 17 April 2001 she met with Mr Abdi so he could spend time with his son. Ms Bailey and their son stayed in Mr Abdi's house that night in the bedroom, whilst the defendant slept in the living room. At around 4:20 am Mr Abdi collected his son from the bedroom and brought him into the living room.[23] The defendant locked the door and then swung his son by his legs into the wall several times. After praying for some time, he moved his son's body to the sofa and called an ambulance.

The defendant's explanation for his son's death was revised several times. He originally told Gardaí and ambulance attendants at the scene that his son suffered the injuries in a fall. Later, in an interview with Gardaí, he stated that he could not remember the events.[24] When he was first admitted to the Central Mental Hospital in October 2001, he claimed that he was sleepwalking at the time of the crime.[25] Later in 2001, he told psychiatrists that he had been hearing voices, and explained that he had not mentioned it earlier because he had not trusted them.[26] At trial, Mr Abdi described feeling like a "zombie or possessed" and alleged that a voice in Bajuni commanded him to hit the child.

Two consultant psychiatrists for the defence, Dr McCaffrey and Dr Washington-Burke, testified that Mr Abdi was suffering from schizophrenia. Dr McCaffrey based his diagnosis on the defendant's self-reported olfactory hallucinations and paranoid behaviour, believing that the only credible explanation was schizophrenia. Both psychiatrists also felt that the defendant's reaction to the treatment he was given in the Central Mental Hospital was suggestive of schizophrenia.[27]

Dr Mohan from the Central Mental Hospital, testifying for the prosecution, disagreed. He believed that Abdi's actions were motivated by the prospect of losing custody of his son and being unable to raise him in his own religious faith, and also partly provoked by racial abuse and taunts that he had been subjected to earlier that evening. He testified that there was no objective or

[22] *Abdi, supra* note 10 at para 17.
[23] *Ibid* at para 21.
[24] *Ibid* at para 41.
[25] *Ibid* at para 28.
[26] *Ibid* at para 23.
[27] *Ibid* at para 26.

professional evidence which confirms that the defendant was suffering from a psychotic mental disorder, although there was evidence of depression and PTSD. Dr Mohan pointed to the defendant's activities that day, and his action of locking the door to the living room before the murder as evidence that he knew, and was in control of, what he was doing.

He also gave evidence of the defendant's treatment in the Central Mental Hospital from October 2001 to June 2003. Mr Abdi was prescribed Risperidone to help sedate him and reduce the risk of suicidal behaviour, although an initial assessment had expressed a suspicion that he was exaggerating his symptoms. Throughout 2002, he continued to display paranoid behaviour and reported hearing voices. After Professor Kennedy concluded that the medication had led to no obvious improvement in the defendant's condition, it was stopped in November 2002. According to Dr Mohan, there was an "instant deterioration" when the medication was withdrawn in circumstances where the relapse would have been expected to occur over a week or two. Additionally, improvement was immediate when the defendant was given the drugs again. This compounded the suspicion that his alleged symptoms were not genuine. In May 2003, after further observation, the treatment team held a case conference and concluded that the applicant was not suffering from schizophrenia. Coincidently that same evening, the defendant made suicidal threats, and the decision was made to keep him at the Central Mental Hospital until his trial.[28] In June 2003, he was transferred to prison after his conviction with a diagnosis of depression.[29]

B. Events after the Conviction

Mr Abdi sought leave to appeal the verdict on the grounds that evidence from Dr Mohan regarding motive was improperly admitted as his testimony was only relevant to the accused's psychiatric condition, and that the trial judge compounded the error by referring to this evidence in his charge to the jury. This was rejected by the Court of Criminal Appeal, holding that Dr Mohan's view was rebutting opinion evidence given by the defence psychiatrists, such as Dr McCaffrey's argument that "only a person in an acute psychotic state could perform the crime".[30]

On 3 June 2005, approximately six months after his appeal had been dismissed, Mr Abdi was admitted to the Central Mental Hospital, primarily due to suicidal behaviour.[31] He also alleged he was being poisoned and was hearing voices. At the time of admittance, Dr Ferguson was of the view that Mr Abdi was malingering at least some of his symptoms. Mr Abdi was returned to prison on 8 September 2005, and prescribed 10 mgs of Olanzapine.[32]

On 25 May 2007, Mr Abdi assaulted a prison officer and was admitted to the Central Mental Hospital for a third time.[33] He claimed that he was hearing voices which ordered him to hurt other people, that he had cancer, and he also engaged in self-harming behaviour. At the time of the admittance, Dr Linehan's opinion was that the "subjective complaints are not supported by

[28] *Ibid* at para 29.

[29] *Ibid* at para 30.

[30] *Abdi (No 1), supra* note 2.

[31] *Abdi, supra* note 10 at para 49.

[32] *Ibid* at para 50.

[33] *Ibid* at para 51.

objective observations that would be consistent with a psychotic illness".[34] Mr Abdi was returned to prison on 12 September 2007, and prescribed Venlafaxine, and Olanzapine.[35]

On 20 May 2013, Mr Abdi was admitted to the Central Mental Hospital for a fourth time, claiming he was hearing voices and that he had been raped by prison officers. During this admission, he was diagnosed with paranoid schizophrenia and antisocial personality disorder. This was the first time a psychiatrist providing in-patient care had given him a diagnosis of schizophrenia. He was discharged in October 2013 and has been on increased doses of Risperidone since his return to prison. Dr O'Connell from the Central Mental Hospital examined the defendant in 2016 and also concluded that schizophrenia was an appropriate diagnosis.[36] There have been no further incidents of violence to third parties, although the defendant's suicidal behaviour has continued.[37]

C. The Application under section 2 of the 1993 Act

Following his diagnosis of schizophrenia, Mr Abdi applied to the Court of Appeal to have his conviction quashed on the grounds of newly discovered facts which render the trial verdict a possible miscarriage of justice. The applicant argued that his psychiatric history, symptoms and presentation after his trial were newly discovered facts. Whilst his condition itself was not new, the changed diagnosis was based on more extensive evidence than was available at the time of the first trial.[38] The applicant further argued that this subsequent history establishes that the diagnosis made by Dr Mohan was wrong.[39]

Counsel for the Director of Public Prosecutions (DPP) argued that the diagnosis was an opinion. It drew a distinction between the diagnosis taking place, which was a fact, and the actual diagnosis itself, which was an opinion. The evidence sought to be adduced was not that a diagnosis had taken place, but the actual content of that diagnosis.[40] They further argued that the diagnosis of schizophrenia was not a newly discovered matter, it was the same diagnosis advanced by the defendant at his original trial.[41] Essentially, the defence was merely seeking to introduce another opinion which was already expressed by the defence psychiatrists. The fact that more experts are on one side than the other, the DPP argued, does not mean that a miscarriage of justice has occurred.[42]

For the purposes of the appeal, two reports were submitted which reviewed the entire psychiatric history of the applicant. Both reports concluded that the evidence established that Mr Abdi had been suffering from schizophrenia at the time of the killing. The first was by one of the

[34] *Ibid* at para 33.
[35] *Ibid* at para 51.
[36] *Ibid* at para 52.
[37] *Ibid* at para 33.
[38] *Ibid* at para 64.
[39] *Ibid* at para 58.
[40] *Ibid* at para 78.
[41] *Ibid* at para 79.
[42] *Ibid* at para 80.

original defence psychiatrists, Dr Washington-Burke. The report speculated that the medication prescribed by the Central Mental Hospital during the applicant's first admission may have masked symptoms of schizophrenia which would have been obvious if he was not on the drug.[43] It urged the court to consider if it was acceptable to provide treatment for Mr Abdi in prison rather than a hospital.[44] Such a view is also present in the second report, which was compiled by Dr Quinn, who stated that he held a:

> …clear view that [the applicant] should have received a hospital disposal … [t]he issue of insanity and disposal should be considered separately. One is clear (that of hospital disposal) and the other is less so. The evidence for his mental illness is clear, corroborated and consistent over time hence the reason for my views on his disposal.[45]

Both reports seem to slightly misunderstand the law. In Ireland, a hospital order can only be directed by the Court when a special verdict of insanity has been returned by the tribunal of fact, so the suggestion that disposal and responsibility should be treated separately does not help resolve the legal issues. Provisions exist to transfer prisoners to the Central Mental Hospital when it is necessary for treatment.[46] The prisoner is only transferred back when the clinical director is of the view that in-patient care or treatment is no longer required.[47] This procedure was used for Mr Abdi four times. Even after the 2013 diagnosis, doctors at the Central Mental Hospital were of the view that the applicant did not require any care that could not be provided in a prison.

Dr Quinn's report also criticised Dr Mohan for not interviewing Mr Abdi's family and for not giving significant weight to Ms Bailey's evidence.[48] Dr Quinn attached great significance to Ms Bailey's description of how the applicant went "from a sensitive, gentle man to a paranoid, deluded and suspicious individual".[49] Dr Mohan, under cross-examination at the original trial, had noted that the behaviour of the applicant prior to the killing was unusual, but had questioned the weight that it should be given, as it did not come from independent medical professionals.[50]

Dr Quinn's report did demonstrate that the applicant is an unreliable historian. It was acknowledged by Dr Quinn, that Mr Abdi's various accounts have made it difficult to interpret his mental state at the time of the killing.[51] The applicant's accounts to Dr Quinn alone featured inconsistencies and, in parts, contradicted his trial testimony. Dr Quinn felt that it was clear that the applicant was mentally ill but concluded that: "although it is clear that the events leading to

[43] *Ibid* at para 34
[44] *Ibid*.
[45] *Ibid* at para 54.
[46] *2006 Act*, s 15.
[47] *2006 Act*, s 16.
[48] *Abdi*, *supra* note 10 at para 53.
[49] *Ibid* at para 54.
[50] *Ibid* at para 28.
[51] *Ibid* at para 54.

the killing of Nathan were in large part driven by psychosis it is difficult to be quite so certain that they would reach the high bar set for insanity."[52]

D. The Court of Appeal Decision

The court concluded that the circumstances of the case were exceptional but did not fall under either of the exceptions suggested by Kearns J in *Kelly*.[53] However, Edwards J, delivering the Court of Appeal judgment, determined that the instances mentioned were not intended to be exhaustive, but offered as helpful examples.[54]

Edwards J went on to state that the new diagnosis took account of the extensive psychiatric history that had occurred since the trial, and this was not the same evidence that the opinions offered at trial were based upon.[55] The court also placed emphasis that this new diagnosis was provided by a doctor who was treating him, rather than preparing an opinion for court proceedings.[56] The court also felt that Dr Quinn's report, which was based on interpreting the defendant's behaviour before the offence to the present, was a newly discovered fact, in that it placed evidence heard at trial into a new context.[57]

The court admitted that a medical diagnosis was an opinion of the doctor but stated the existence of that diagnosis is a fact, and a diagnosis cannot easily be divorced from the investigation or history which led to it. If the symptoms and history were not the same in each investigation, then each diagnosis is different regardless of the conclusion.[58] The court concluded that the current diagnosis was a newly discovered fact.[59] They also declared that the fact that doctors at the same hospital as Dr Mohan and Professor Kennedy regard their diagnosis as incorrect is a newly discovered fact.[60] The court also felt that the symptoms, presentation and treatment experienced by the defendant also qualified as newly discovered facts.

The court then considered whether a miscarriage of justice had occurred. They considered a scenario where the 2003 trial had been postponed until 2013 due to a hypothetical series of events. They considered whether the evidence between 2003 and 2013 would have been relevant at trial and concluded that the fact the defendant's diagnosis changed in 2013 was a relevant issue for the jury to consider.[61] The newly discovered facts were held to have the potential to influence the outcome.[62] The jury verdict was quashed and a re-trial was ordered.[63]

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[52] *Ibid* at para 54.
[53] *Ibid* at para 83.
[54] *Ibid* at para 84.
[55] *Ibid* at para 85.
[56] *Ibid* at para 87.
[57] *Ibid* at para 88.
[58] *Ibid* at para 89.
[59] *Ibid* at para 90.
[60] *Ibid.*
[61] *Ibid* at para 93.
[62] *Ibid* at para 94.
[63] *Ibid* at para 97.

E. Analysis of the Court's Decision

Edward J's view that *Kelly* did not provide for an exhaustive list of circumstances where opinion evidence could be considered is a reasonable interpretation of the case. However, it could be argued that he appears to put little emphasis on the context of the remarks. Kearns J does not seem to be providing examples of when opinion evidence was capable of being a newly discovered fact, he appears to be discussing circumstances where new opinion evidence may be admissible to aid in the interpretation of a fact. As such, the conclusion that Dr Quinn's report was a newly discovered fact seems to be possibly inconsistent with *Kelly*. It could be strongly argued that it is opinion evidence. The same applies to the view that the 2013 diagnosis is a newly discovered fact. The fact that a new diagnosis was made is indeed a factual occurrence, but only in the same way that anybody offering a new opinion is something that factually happened. This fact of occurrence is meaningless on its own without knowing the actual opinion. It's an attempt to disguise opinion as fact just because the opinion was expressed.

Furthermore, parts of the court's reasoning are not explained as clearly as it could have been. The court's view that the 2013 doctor felt that the original diagnosis offered by Dr Mohan and Professor Kennedy was incorrect and was a newly discovered fact also seems to be opinion evidence. Additionally, it appeared to be without foundation. There did not seem to be any evidence before the court to state that this was the doctor's opinion. The evidence that the court discussed was that he diagnosed the defendant with schizophrenia in 2013, but there was nothing to suggest that he felt that the diagnosis made by his colleagues 10-years earlier was incorrect.

Kelly does not permit a new diagnosis to be admissible, unless it is based on newly discovered facts. That the applicant was eventually able to find another psychiatrist who would diagnose him with schizophrenia is neither surprising nor grounds for quashing the jury verdict. Applying *Kelly* correctly involves considering if the symptoms, treatment or presentation of the defendant between 2003 and 2018 were capable of being regarded as newly discovered facts. In summary, there are two distinct steps to be taken. The first is to determine if new facts exist, and if so, whether the opinion evidence is admissible to aid in the interpretation of the new facts. The second is to determine if these new facts themselves meet the threshold for admissibility to declare that there has been a miscarriage of justice.

If the applicant displayed new symptoms which were not evident or discussed at the time of trial then this would be a newly discovered fact. However, it could be argued that in Mr Abdi's case, there was not really any significant new symptoms or behaviour. Hearing voices, suicidal behaviour, delusions, paranoia and violent behaviour were all symptoms that the defendant displayed prior to his trial and were discussed in the psychiatric testimony at that time. Effectively, the issue to be determined is whether the fact that these symptoms continued to recur makes them capable of constituting a newly discovered fact, thus making the 2013 diagnosis relevant and admissible.

This is a difficult matter to resolve because of the unique circumstances of the case. The prosecution's case at trial was that the applicant's complaints were malingering, and this is the version of events that seemed to be accepted by the jury. Psychiatrists in 2005 and 2007 had also reached the same conclusion. It should be considered if the fact that the applicant continued to

complain of the same symptoms make it less likely that he was being dishonest. The mere fact that a defendant might continue to stick to his story after his conviction does not necessarily make his narrative any more believable, nor would a jury likely be surprised to learn of it.

The applicant's case seemed to rely on the 2013 diagnosis providing context as to why his continuation of symptoms is a newly discovered fact. However, this would only be the case if the psychiatrist in 2013 believed the defendant was likely suffering from schizophrenia in 2001. There does not appear to be any evidence introduced in the course of the appeal that the Central Mental Hospital doctors who examined the applicant in 2013 and 2016 were of this opinion. Studies have found that persons with a traumatic stress disorder have an increased risk of developing schizophrenia, and this risk increases with time.[64] This means that it is perfectly conceivable that Dr Mohan's diagnosis of PTSD in 2003 was accurate, and the applicant subsequently developed schizophrenia. As such it must be concluded that the 2013 diagnosis on its own should not have been considered admissible. It does not provide the necessary information that allows the subsequent psychiatric behaviour of the applicant to be considered as a newly discovered fact.

However, the reports submitted by Dr Washington-Burke and Dr Quinn, particularly the latter, are a different matter. Both reports are opinion evidence but contained the critical conclusion that the 2013 diagnosis when considered in context with the applicant's displayed symptoms since 2001, made it likely that he was suffering from a mental disorder at the time of the 2001 killing. Their analysis was based on fifteen years more observation of Mr Abdi's symptoms than was available at the time of the original trial. As their opinion evidence provided the necessary interpretation for why the applicant's subsequent psychiatric history should be considered as a newly discovered fact, both reports are admissible.

The second question is whether the newly discovered facts (as interpreted by the opinion evidence in the reports) meet the threshold for admissibility. There are no grounds for doubting the credibility of Dr Quinn's report, and it was not possible to have known what the applicant's subsequent psychiatric history would have been at the time of the trial. Thus, under the *Willoughby* rules, admissibility depends on the effect that this information might have had on the outcome of the original trial. It is particularly noteworthy that no evidence was introduced by counsel for the DPP which contradicted the view of Dr Quinn (who was their own expert). The court had two reports which believed the applicant had been suffering from schizophrenia at the time of the offence, and nothing to contradict these views. However, the issue is not whether the applicant was suffering from a mental disorder at the time, but rather whether he was legally insane. Although both reports do conclude that the applicant was likely insane at the time of the offence, Dr Quinn's report is not as definitive:

> If the account he gave to me were to be considered truthful, however, I would be of the view that he would have met the criteria for insanity under M'Naghten's Principles now enshrined under Irish law in the 2006 Insanity Act. Although he knew the nature of the

[64] See for example, Niels Okkels et al, "Traumatic Stress Disorders and Risk of Subsequent Schizophrenia Spectrum Disorder or Bipolar Disorder: A Nationwide Cohort Study" (2017) 43:1 Schizophrenia Bull at 180.

> act, he describes acting under an irresistible impulse, and given that he thought that his son was possessed by some sort of Jin or devil that was trying to harm him and take his life, he would not have known that what he was doing was wrong.[65]

The DPP could have argued that there was insufficient reason to suspect that either of these reports would be enough to influence the jury if the prosecution's witnesses continued to assert that he did not satisfy the test of legal insanity at the time of the killing, however they chose not to argue this point. In the absence of such evidence, it is difficult to argue that the Court of Appeal had no option but to order a re-trial. It is noteworthy that Dr. Mohan testified in the subsequent re-trial that, with the benefit of subsequent psychiatric history of the accused, he now agreed that the applicant had schizophrenia at the time of the offence and that he "was unable to refrain from committing the act".[66] At the re-trial, which was uncontested by the prosecution, the jury unanimously found the defendant not guilty by reason of insanity after just 17 minutes of deliberation.[67]

One issue that was not fully clarified is the threshold for a miscarriage of justice in cases of insanity. The court cited Keane J in *People (DPP) v Meleady & Grogan,* who stated that the provision is "intended to afford relief to those who could point to materials which, if they had been available at the trial, might — not necessarily would — have raised a reasonable doubt in the mind of the jury".[68] This was the threshold that counsel for the applicant also argued in their submissions. One could argue that because the burden of proving insanity is on the defence to a standard of a balance of probabilities, the test of the new evidence potentially raising a reasonable doubt should be different where the issue is insanity. The Court of Appeal did not directly address whether the threshold was different but seemed to indicate the possibility by stating that the newly discovered facts "at least [have] the potential to influence the outcome".[69] Because it was so clear in *Abdi* that the threshold had been met regardless, the point did not need to be decided. However, it may be an issue that needs to be clarified in a future case.

IV The Decision in People (DPP) v McGinley

A. Summary of the Case

In *People (DPP) v McGinley*, the applicant was convicted by a jury of murder on 3 April 2014 and was sentenced to life imprisonment.[70] He had offered to plead guilty to manslaughter, but the plea was not accepted by the prosecution. His defence at trial was that this was a "robbery

[65] *Abdi, supra* note 10 at para 54 .

[66] "Psychiatrist now agrees that man jailed for 16 years for murder had mental disorder", *Court News Ireland* (12 December 2019), online: <courtsnewsireland.ie>.

[67] "Man who spent 16 years in jail for murdering infant son is found not guilty by reason of insanity", *Court News Ireland,* (13 December 2019), online: <courtsnewsireland.ie>.

[68] *DPP v Meleady & Grogan,* 1995 2 IR 517.

[69] *Abdi, supra* note 10 at para 94.

[70] He had also pled guilty to burglary and false imprisonment; "McGinley guilty of murdering Sligo pensioner", *Court News Ireland* (3 April 2014), online: <courtsnewsireland.ie>.

gone wrong" and that he had not intended to kill the victim.[71] The applicant admitted punching the victim a few times and tying him up using shoelaces on 19 September 2012.[72] He also admitted stealing approximately €60.[73] At trial, evidence was heard that the victim had suffered severe injuries, including a fractured skull and jaw.[74] In addition, had he lived, he would have lost the use of one of his hands because they had been bound so tightly.[75]

After the burglary, the applicant burned the clothes that he was wearing.[76] The following day, he called the emergency services with details of the victims address and informed them that the victim had been tied up.[77] Gardai went to an incorrect address and the victim was found two days later by relatives.[78] The victim died on 22 September 2012 in hospital from "bronchial pneumonia due to coma due to blunt force trauma".[79]

Prior to the murder conviction, the applicant had 21 previous convictions,[80] and was sentenced to a term of imprisonment for various offences of assault causing harm in 2005, 2006,[81] and 2007.[82] At the time of the murder, he was also signing on at the local Garda Station due to an unconnected burglary charge.[83] The applicant also had a history of drug and alcohol abuse. In the twelve months prior to the murder, he reported that he was drinking 7.5-10 litres of beer every day, smoking up to 20 joints of cannabis, as well as regular daily consumption of vodka, whiskey, diazepam, cocaine, and ecstasy.[84] He had also used heroin in the past.[85] On the day of the murder, the applicant admitted to having consumed both diazepam and cannabis.[86]

There was no attempt at trial to introduce either the insanity defence or the partial defence of diminished responsibility. However, the applicant was on antipsychotic medication at the time of the murder and the trial. The applicant's medical records demonstrate a history of mental illness

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[71] *Ibid*.
[72] *McGinley*, *supra* note 11 at para 41.
[73] *Ibid* at para 60.
[74] Aine Hegarty "His gentle soul was terrorised and savaged by anger and violence", *Irish Mirror,* (3 April 2014), online: <www.irishmirror.ie>.
[75] *Ibid*.
[76] *McGinley*, *supra* note 11 at para 60.
[77] *Ibid* at para 41.
[78] "Sligo man sentenced to life for murder", *Irish Times,* (4 April 2014), online: <https://www.irishtimes.com/>.
[79] Hegarty, *supra* note 74.
[80] *Ibid*.
[81] *McGinley*, *supra* note 11 at para 40.
[82] "Stabber is jailed for three years", *Irish Independent,* (25 March 2009), online: <https://www.independent.ie/regionals/sligo/news/stabber-is-jailed-for-three-years/27563600.html>.
[83] *McGinley*, *supra* note 11 at para 60.
[84] *Ibid* at para 41.
[85] *Ibid* at para 39.
[86] *Ibid* at para 41.

that began approximately 2 years prior to the murder.[87] In early 2011, the applicant was assessed at a psychiatric unit in Sligo after he had reported being depressed.[88] He was diagnosed with "mild depressive episode with predominant anxiety symptoms"[89] and was prescribed antidepressants and benzodiazepine.[90] In August and November 2011, the applicant reported to his GP that he had been hearing voices and was having paranoid thoughts. He was prescribed Quetiapine, which is an antipsychotic drug.[91] The applicant also reported feeling paranoid in January 2012 after he had been charged with an unconnected burglary offence.[92] As a result of his condition not improving, his dose of Quetiapine was doubled.[93] The patient's history between March 2012 and September 2012 is unclear, but at the time of committal to prison in September 2012, he had a prescription for Seroquel.[94]

The applicant did not display any active symptoms of psychosis during his interactions with the Gardai. After learning that the victim had died, the applicant turned up at the local Garda Station and confessed to the offence on 28 September 2012.[95] He was described as "crying and extremely distressed".[96] The interviewing Garda believed that he was intoxicated and stated that he was "difficult at times to understand".[97] He was examined by two doctors over the next 3 hours and was deemed unfit to be interviewed. He admitted to the second doctor that he was taking Seroquel and had a prior psychiatric admission.[98]

After being charged with the murder and remanded in custody, the applicant was subsequently examined by a prison psychiatrist, who noted that he was presenting with depression and was currently taking Seroquel. The prison records incorrectly describe the drug as an anti-depressant.[99] The applicant denied experiencing any psychotic symptoms. He also denied having any prior psychiatric illness or attending a psychiatric hospital or clinic, which was untrue and contradicted what he had told the Garda doctor.[100] It is unclear if the prison psychiatrist was aware of this. On 25 October 2012, the prison psychiatrist requested a forensic assessment of the applicant, although it was noted in the written request that he did not display any symptoms of a major psychiatric disorder.[101] The same day as this letter was sent, it is noted in his prison medical

[87] There was some contact with psychiatrists in 2008 and 2009 during a period of imprisonment.
[88] *McGinley, supra* note 11 at para 42.
[89] *Ibid* at para 42 .
[90] *Ibid* at para 61.
[91] *Ibid* at para 55.
[92] *Ibid* at para 43
[93] *Ibid* at para 61.
[94] *Ibid*.
[95] *Ibid* at para 59.
[96] *Ibid*.
[97] *Ibid*.
[98] *Ibid*.
[99] *Ibid* at para 52.
[100] *Ibid*.
[101] *Ibid* at para 44.

records that a nurse observed him stating that he was hearing voices.[102] It is not clear whether the requested forensic assessment ever occurred, but the prison psychiatrist determined in November 2012 that he did not require psychiatric medication and did not renew the prescription for Seroquel.[103]

In 2013, the applicant was recorded as continuing to present as depressed. There was an incident in December 2013 where the applicant was transferred to a general hospital after consuming an "illicit substance".[104] When he returned to prison, he started to present as "delusional and paranoid".[105] He was prescribed Olanzapine by the prison psychiatrist on 16 December 2013, but the notes state "that it was not being prescribed as an antipsychotic medication".[106] As Olanzapine is an antipsychotic medication, approved for treatment for schizophrenia or manic episodes in patients with bipolar disorder, it is uncertain why it would have been otherwise prescribed.[107]

B. Events after the Conviction

Following the applicant's conviction in April 2014, he "continued to experience intermittent mood and psychotic symptoms" over the next two years and was treated with various antidepressant and antipsychotic medication.[108] In November 2015, after the applicant complained of "persecutory auditory hallucinations", a consultant psychiatrist requested his GP records. The applicant also disclosed to a nurse that he had heard voices when he was previously imprisoned in 2005.[109] In the GP record's request, the psychiatrist's initial impression was that the applicant was experiencing pseudo hallucinations rather than suffering from a psychotic illness.[110] The applicant continued to hear voices, with nurses documenting such symptoms in February, March, and April of 2016.[111] After a change of legal team, he unsuccessfully appealed the conviction to the Court of Appeal in November 2016 on a number of grounds relating to the judge's charge regarding intent.[112] Similar to the original trial, there was no evidence introduced regarding his history of mental illness.

After the appeal was rejected, the applicant's condition continued to deteriorate and by May 2017, he was claiming that "the HSE psychologist [was] communicating with him and

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[102] *Ibid* at para 52.

[103] *Ibid* at para 53.

[104] *Ibid* at para 56.

[105] *Ibid*.

[106] *Ibid*.

[107] Health Products Regulatory Authority, "Information for the user: Olanzapine", online: <https://www.hpra.ie/img/uploaded/swedocuments/670288ac-f417-4769-8809-5031c847bd64.pdf>.

[108] *McGinley, supra* note 11 at 61.

[109] *Ibid* at para 57.

[110] *Ibid* at para 45 .

[111] *Ibid* at para 58.

[112] *DPP v McGinley*, 2016 IECA 424 at para 19.

carrying his child".[113] That same month, a barrister contacted the prison governor expressing concern about the applicant's mental condition after he had appeared "distressed, paranoid and incoherent".[114] Following this letter, the applicant's antipsychotic treatment was changed in July 2017 to 10mg of olanzapine.[115]

In November 2017, the applicant was formally diagnosed with schizophrenia "with a drug related exacerbation, now much improved".[116] In 2018, consultant psychiatrist Dr Monks noted that the applicant was presenting "with chronic delusional ideas that he is possessed and controlled by an HSE psychologist operating from outside the prison".[117] Noting that cannabis use might be complicating the applicant's symptoms, Dr Monks changed his treatment from olanzapine to amisulpride and placed him on the waiting list for admission to the Central Mental Hospital.[118]

C. The Application under section 2 of the 1993 Act

In October 2018, the applicant's mother engaged the services of another new legal team and a letter of instruction was sent to the Central Mental Hospital in May 2019 requesting an examination of the applicant. The applicant was examined in January 2020 by Dr Monks. Two reports were issued by Dr Monks in June and August 2020. On the basis of these reports, the applicant sought an order quashing his conviction on the grounds that the contents of Dr Monks' report are a newly discovered fact which might have influenced the jury verdict.[119]

In Dr Monk's initial report in June 2020, he stated that it was possible that the applicant had schizophrenia at the time of the offence, but that it was "difficult to establish any causal nexus between mental illness and his behaviour at the material time".[120] He noted that the applicant admitted intoxication, but there was nothing else in his account to suggest that his mental capacity had been diminished.[121] Dr Monks concluded that "[a]t the very least it can be said that Mr McGinley was in a prodromal phase of schizophrenia from late 2011." He also concluded that the antipsychotic medication may have reduced the applicant's psychosis, and that the presence of psychotic symptoms "may have been attributable in part to heavy and persistent consumption of drugs and alcohol."[122]

In response to the first report, the applicant's legal team raised seven questions with Dr Monks, which were answered in a second report in August 2020. In this report, Dr Monks confirmed that in his view "prodromal schizophrenia would come under the definition of mental

[113] *McGinley, supra* note 11 at para 58.
[114] *Ibid* at para 46.
[115] *Ibid* at para 47.
[116] *Ibid* at para 48.
[117] *Ibid* at para 49.
[118] *Ibid*.
[119] *Ibid* at para 9.
[120] *Ibid* at para 54.
[121] *Ibid*.
[122] *Ibid* at para 61.

disorder as defined in section 1 of the Criminal Law (Insanity) Act 2006."[123] He also confirmed that it was probable that the applicant was also suffering from alcohol and drug dependency syndrome at the time of the offence.[124] He further stated that it was probable that the applicant was experiencing psychosis at the time of the offence, but noted that it was difficult to comment on the severity or degree of such psychosis, as there was no contemporaneous documentation of such symptoms occurring at that time.[125] He stated that "with hindsight I think it is likely that he would have met the diagnostic criteria for schizophrenia in the year before the offences".[126]

Although not mentioning diminished responsibility specifically, Dr Monks went on to state that:

> …while it doesn't appear that Mr McGinley's decision making processes at the time of the robbery and assault on Eugene Gillespie were specifically influenced by delusions or hallucinations, active psychotic illness may have impaired his reasoning, judgment and behaviour (for example impulsivity and aggression) in a more general sense. This would have relevance in addressing the question of whether Mr McGinley intended to cause serious injury to Mr Gillespie.[127]

D. The Court of Appeal Decision

The Court of Appeal dismissed the application. The court held that, even when considering the evidence of Dr Monks at its height, it still fell "far short of what would be required for a successful application pursuant to [section] 2 of the 1993 Act".[128] Ní Raifeartaigh J, in delivering the judgment of the court, acknowledged that there may be exceptional cases where a subsequent diagnosis shows that a person had a mental disorder at the time of the offence, but generally such applications "must be treated with considerable caution, and such cases will be exceptional".[129] The court agreed that *Abdi* was an exceptional case, but distinguished it on a number of grounds.

Firstly, the insanity defence had been raised at the original *Abdi* trial whereas in *McGinley*, neither insanity or diminished responsibility was raised. Secondly, there were a number of expert reports in *Abdi* which concluded that the applicant satisfied the legal test for insanity, including the original prosecution expert. In *McGinley*, there was only a single expert, and "his views are much less definitive".[130] Thirdly, the court noted that the purpose of introducing this expert evidence in *McGinley* was unclear. Counsel had not mentioned in their written submissions whether the purpose of the evidence was to support a partial defence of diminished responsibility or that the defendant lacked the *mens rea* for murder.

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[123] *Ibid* at para 55.
[124] *Ibid*.
[125] *Ibid*.
[126] *Ibid*.
[127] *Ibid*.
[128] *Ibid* at para 83.
[129] *Ibid* at para 65.
[130] *McGinley, supra* note 11 at para 66.

The court emphasised that the applicant's conduct after the offence did not raise any "alarm bells" with his legal team, the doctor who examined him at the Garda station, or prison staff.[131] The court also considered the nature of the offence. It argued that the applicant in *Abdi*'s conduct "could not in any way be described as goal-oriented behaviour".[132] In the present case, they emphasised that the offence was committed for "personal gain" and he had taken "various steps to conceal his involvement in the offence".[133] It also stated that there was a "significant question-mark [raised by Dr Monks initial report] around whether any such episode was causally connected with the offences committed".[134]

E. Analysis of the Court's Decision

The judgment avoids many of the theoretical issues that arose in *Abdi,* by immediately clarifying that that the application is based on the argument that Dr Monk's report is evidence which demonstrates that the "manifestation of the applicant's schizophrenia tells us something useful … about his mental state/illness at the time of the killing".[135] However, the decision seems to indicate a very strict approach will be taken by the court in future applications.

The court's emphasis on diminished responsibility or insanity not being raised at the original trial is problematic. The medical records establish that the applicant was on anti-psychotic medication at the time of the offence and trial, so there is no question about whether the applicant had a mental disorder at the time of the offence. These details were disclosed to a Garda doctor at the time. Whilst the public interest requires that a defendant raises his entire case at trial, it needs to be remembered that it is common for patients with conditions such as schizophrenia to lack insight into their conditions and therefore there is an argument that further details of their condition emerging should be considered as an exceptional circumstance. The applicant's medical history demonstrates that his accounts about his past psychiatric issues were not always accurate and although prior to the trial, he denied having psychotic symptoms to the prison psychiatrist, he did admit to a nurse that he was hearing voices.

Secondly, whilst it is true that there were two expert reports in *Abdi,* the judgment does not mention a report from the original prosecution expert as the court claimed. As stated previously, it is true that Dr Mohan gave such evidence at the re-trial, but not at the section 2 hearing. The evidence given by Dr Monks in the *McGinley* hearing was not contested, so it should be questioned whether the defence should really have been under an obligation to hire a second psychiatrist in these circumstances. Surely that should be the responsibility of the prosecution. In *Abdi,* one of the reports was from the DPP's witness, so it seems unfair to regard the DPP's decision not to present their own psychiatric report against the applicant in these circumstances.

The court's comment on the nature of the offense was also surprising. It seemed to adopt the view that offences committed for personal gain or acts designed to conceal the crime were

[131] *Ibid* at paras 79–80.
[132] *Ibid* at para 81.
[133] *Ibid*.
[134] *Ibid* at para 69.
[135] *Ibid* at para 64.

incompatible with the defences of diminished responsibility or insanity. However, the insanity defence has been successful in cases where there was evidence that the act was deferred until a time where it would be easier to dispose of the body,[136] and also where there has been significant evidence of planning and deliberation.[137] In both cases there was undisputed psychiatric testimony that the accused had no meaningful control over their behaviour because of a mental disorder.

When drawing comparisons with *Abdi,* the court also did not seem to appreciate that the evidence establishing a causal nexus between a mental disorder and an offence is inevitably going to be much stronger in a case where insanity is pleaded rather than diminished responsibility. Unlike insanity, it should also be emphasised that the defence of diminished responsibility does not require evidence from a consultant psychiatrist before the finder of fact can consider the defence, although it would be true to say that it is unlikely to be successful without this evidence.[138]

Furthermore, there is some debate over whether there actually needs to be a causal link between the criminal act and the mental disorder in order for the defence of diminished responsibility to be successful.[139] In the academic literature, comparisons have been drawn to infanticide,[140] which requires only contemporaneity,[141] to argue that requiring a causative connection would substantially limit the scope of the defence.[142] Prendergast suggests that the words "for the act" may "provid[e] guidance on the magnitude of the mental disorder rather than its causal connection."[143] He suggests that to read a causal connection into clause (c), makes clause (b) redundant as "all the important proofs for the defence in establishing diminished responsibility are packed into clause (c)".[144] In *People (DPP) v McDonald,* the trial judge directed the jury that substantially diminishing responsibility for the act "does not mean that the mental disorder had to cause him to do what he did because if it caused him to do what he did, then we would be in the

[136] Alison O'Riordan, "Galway man who strangled brother with bungee cord found not guilty of murder by reason of insanity", *Court News Ireland* (22 April 2016), online: <courtsnewsireland.ie>.
[137] Andrew Phelan, "Man found not guilty by reason of insanity of attempting to murder pregnant sister", *Irish Independent* (12 October 2017), online: <independent.ie>.
[138] See *Criminal Law (Insanity) Act*, IR 2006, s 5(1) which states: "Where an accused person is tried for an offence and, in the case of the District Court or Special Criminal Court, the court or, in any other case, the jury finds that the accused person committed the act alleged against him or her and, having heard evidence relating to the mental condition of the accused given by a consultant psychiatrist, finds that…"
[139] Kennefick argues that "it would appear that the mental disorder must essentially amount to a significant contributory factor in causing the diminishment in responsibility"; Louise Kennefick, "Diminished responsibility in Ireland: historical reflections on the doctrine and present-day analysis of the law" (2011) 62 Northern Ireland Legal Q 269 at 285-286.
[140] *Infanticide Act 1949,* Number 16/1949, s 1(3)(c) as amended by *Criminal Law (Insanity) Act*, Number 11/2006, s 22(a).
[141] David Prendergast, "The Connection between Mental Disorder and the act of killing in the defence of diminished responsibility" (2013) 49:1 Irish Jurist 202 at 207.
[142] *Ibid* at 208.
[143] *Ibid* at 206.
[144] *Ibid*.

area of insanity".[145] The Court of Appeal in 2019 did not indicate any disapproval with that wording.[146] Furthermore, even if a causal connection is required, a weak causal connection should not preclude the defence but rather be a factor that is relevant to sentencing as suggested by O'Malley.[147]

V Conclusion

Whilst the reasoning process of the Court of Appeal in *Abdi* is open to criticism, the overall result was the correct one. It is a difficult authority to apply to future cases, because of its unique facts. However, both cases analysed in this article establish that a subsequent psychiatric diagnosis will only be a basis for a new trial in truly exceptional cases. It appears that the following will *usually* be required in order for a future application to be successful.

1. The defence must have been raised at the original trial.
2. There must be subsequent symptoms, treatment or presentation.
3. Opinion evidence by a psychiatrist must be presented to establish that these "subsequent symptoms, treatments or presentation" are a newly discovered fact because they prove that the diagnosis argued by the defence at the original trial was correct.
4. The prosecution must not contest the opinion evidence.
5. These newly discovered facts as interpreted by the opinion evidence must be such that they might have had a material impact on the jury's decision had it known about them at the time of the original trial.

Critical to the final ground would be whether the defendant's behaviour and statements at the time of the offence and first trial are inconsistent with the grounds required by the defence. In an English case, *R v Gibbons*, the defendant was diagnosed with schizophrenia a few years after his conviction for attempted murder.[148] The court accepted that the defendant was suffering from this condition at the time of the offence but still refused to overturn the conviction.[149] The court placed great weight on what the defendant said at the time of the incident, stating that

> …there has been no satisfactory explanation that a jury could accept, as to how he could have said that, if he did not appreciate what he was doing and did not have the intention to be doing that to which he referred, when he said: "I can't do this, I can't go through with it". "I can't go through with it" implies that there was something to be finished and the only possible thing to which he could have been referring was the attack … When he said [to the police]: "I tried to kill somebody tonight but I couldn't do it", he clearly then appreciated what he had physically sought to do. Both of the statements show that he appreciated that what he was doing was wrong, that he understood the nature and quality

[145] *Director of Public Prosecutions v McDonald*, 2019 IECA 298 at para 15 (CA Ireland).

[146] Note that it was not relevant to the issues raised in the appeal.

[147] Thomas O'Malley, *The Criminal Process* (Dublin: Round Hall, 2009) at paras 22-13.

[148] [2009] EWCA Crim 2988.

[149] *Ibid* at para 24.

> of what he was doing, appreciated that it was wrong and indeed that he did in fact have a specific intent.[150]

Where the defence was not argued at the original trial, the position is unclear. Providing that the other elements are present, this should not defeat a claim. Defendants may lack insight into their conditions and should not be penalised where the newly discovered evidence clearly shows that there was a relevant mental disorder at the time of the offence. In particular, where the diagnosis was not made until after the original trial as in *McGinley*, it is potentially unfair to penalise the defendant or his legal team for not raising a defence based on a diagnosis that he had not yet received.

If the prosecution decides to dispute the opinion evidence, it seems likely that it will be more difficult to convince the Court of Appeal that the newly discovered evidence will have the necessary material impact on the jury. However, even if the prosecution decides not to introduce conflicting evidence, this does not mean that the application will automatically be successful as seen in *McGinley*. Given the view of the Court of Appeal in *McGinley*, it might be wise for applicants to arrange for a second report even when the prosecution does not challenge the first report.

Some further uncertainty exists as to the appropriate threshold when the defence is diminished responsibility. Whilst the opinion evidence of Dr Monks was described as falling short, it was uncontested, and the supplemental report clearly stated that it was probable that the applicant was psychotic at the time of the offence and that psychosis may have impaired the applicant's reasoning and judgment in a general sense. The defence did not have the opportunity to examine Dr Monks in the same way that they would at a trial, and this should have been taken into account. The defence exists simply to allow a sentencing judge to consider the mental disorder rather than having to impose an automatic life sentence and should not have been ruled out simply because the Court of Appeal determined that the causal connection was too weak. In *R v Gibbons*, the English Court of Appeal refused to overturn the conviction, ruling that no reasonable jury could find the defendant insane, but did quash the life sentence, as the original sentencing judge did confirm that the evidence of the mental disorder would have affected the sentence that was imposed.[151]

[150] *Ibid* at para 26.

[151] *Ibid* at paras 29–31.