ARTICLE

Miscarriages of justice and expert psychiatric evidence: lessons from criminal appeals in England and Wales*†

Nicholas Hallett, Nadine Smit & Keith Rix

SUMMARY

Miscarriages of justice occur as a result of unsafe convictions and findings and inappropriate sentences. In cases involving expert psychiatric evidence it is possible that the way evidence is presented by experts or interpreted by the courts has a direct bearing on the case. Using illustrative cases from the Criminal Division of the Court of Appeal, advice is offered to expert psychiatric witnesses on ways to reduce the likelihood of contributing to such miscarriages of justice and on how they may assist in rectifying such miscarriages, should they occur.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the place of criminal appeals in the criminal justice system in England and Wales
- understand what may go wrong in the provision of psychiatric evidence and how expert psychiatric evidence can assist in the administration of justice
- be able to reduce the risk of unsafe convictions and inappropriate sentences when providing expert psychiatric evidence, including for cases referred to the Court of Appeal and the Criminal Cases Review Commission.

DECLARATION OF INTEREST

None.

KEYWORDS

Expert psychiatric evidence; miscarriages of justice; criminal appeals; Criminal Cases Review Commission.

> 'It is a regrettable feature of any justice system that any miscarriages of justice occur. That is the inevitable consequence of any justice system designed and operated by human beings […] The task […] is to develop mechanisms designed to minimise miscarriages of justice.'
>
> (Lord Justice Treacy, Keynote Speech, Criminal Cases Review Commission Stakeholder Event, London, 2014)

Miscarriages of justice occur not only when innocent people are found guilty or guilty people are found innocent but when people are convicted or sentenced without the correct legal safeguards or processes in place. In this article we are concerned only with unsafe findings and convictions and the inappropriate sentencing of those whose guilt is found or upheld. We use the term 'miscarriages of justice' to refer to the cases of persons who are found on appeal to have been unsafely convicted or to have been wrongly given what ultimately is regarded as an inappropriate sentence or to have been the subject of a wrong finding. We use the term 'unsafe conviction' rather than 'wrongful conviction' because what is assessed in the process of criminal appeal is the safety of the conviction; it is important to recognise that a finding that a conviction was unsafe does not mean that the person was innocent. Often it is the process that goes wrong.

The criminal appeal process in England and Wales

In England and Wales anyone convicted of an offence in the magistrates' court can appeal to the Crown Court against conviction or for a review of sentence or both, and anyone convicted and sentenced, or found unfit to plead or not guilty by reason of insanity, in the Crown Court can appeal to the Criminal Division of the Court of Appeal. In addition, the Criminal Cases Review Commission has the authority to review cases and refer them to the Court of Appeal. These are mechanisms designed to minimise miscarriages of justice and with which expert psychiatric witnesses need to be familiar.

Appeal against a magistrates' court conviction or sentence

A person who is convicted of an offence in the magistrates' court has 21 days within which to give a notice of appeal, although the Crown Court can extend this period by giving what is known as 'leave to appeal out of time'. An appeal against conviction is heard

Nicholas Hallett is a specialist registrar (ST6) in forensic psychiatry with Essex Partnership University NHS Foundation Trust, UK. He has an LLM (Distinction) in Mental Health Law from the University of Northumbria. **Nadine Smit**, PhD, is a researcher at University College London (UCL), UK. She has an MSc and MRes (Distinction) from the Department of Security and Crime Science at UCL. **Keith Rix** is a forensic psychiatrist with Norfolk and Suffolk NHS Foundation Trust, and Visiting Professor of Medical Jurisprudence at the University of Chester, UK. He is an elected Honorary Fellow of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians and author of *Expert Psychiatric Evidence*, of which the second edition is to be published shortly.
Correspondence Dr Nicholas Hallett, Brockfield House, Kemble Way, Runwell, Wickford SS11 7FE, UK. Email: nickhallett@doctors.org.uk

First received 13 Dec 2018
Final revision 8 Feb 2019
Accepted 15 Feb 2019

Copyright and usage
© The Royal College of Psychiatrists 2019

*Based in part on a presentation by N.S. at the 17th Annual Grange Conference, Ripley Castle, Harrogate, UK, in September 2018.

†See commentary, this issue.

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

by a judge, who sits with two magistrates. There is no jury. The case is heard anew. Either the conviction is upheld or there is an acquittal. An appeal against sentence is heard by a judge who sits alone. The judge may confirm the sentence or substitute one of their own, which may be more or less severe, but only within the range available to magistrates.

Appeal against a Crown Court conviction or sentence

A person who is convicted and sentenced in the Crown Court can appeal, or apply to appeal, to the Criminal Division of the Court of Appeal against conviction or sentence or both. A successful application to appeal may lead to a hearing of the appeal at the same sitting before the same court or at a later date before a possibly differently constituted court. The Court of Appeal is situated in the Royal Courts of Justice in The Strand, London, and the Court comprises the Lord Chief Justice and Lord Justices of Appeal, assisted by High Court judges and, occasionally, circuit judges. Appeals are heard by a bench comprising an uneven number of judges, usually three but five or seven in more important cases or where there have been conflicting decisions of the Court of Appeal on the same point. The Court may set aside or 'quash' a conviction. It may set aside a sentence and impose any sentence that had been available to the Crown Court, except that it may not deal with the person more severely than they were in the Crown Court. Finally, the Supreme Court hears appeals from the Court of Appeal, Criminal Division.

The role of the Criminal Cases Review Commission

The Criminal Appeal Act 1995 established the Criminal Cases Review Commission (CCRC) to review possible miscarriages of justice in England, Wales and Northern Ireland. It represents the last resort in the criminal appeal process because, other than in rare exceptions, it considers only cases that have exhausted all other appeal processes. The CCRC does not of itself overturn convictions or sentences. Where appropriate, it refers the case to the relevant court, which is usually the Court of Appeal. The statutory threshold for referring a case is that there is a 'real possibility' that the conviction, verdict or finding or the sentence will not be upheld. The CCRC considers 'not […] innocence or guilt, but whether there is new evidence or argument that may cast doubt on the safety of an original decision' (Naughton 2011).

Grounds for appeal

In an appeal against conviction, the principal question is whether the Court considers the conviction to be unsafe. This is because section 2 of the Criminal Appeal Act 1968 states:

'the Court of Appeal:

(a) shall allow an appeal against conviction if they think that the conviction is unsafe; and
(b) shall dismiss such an appeal in any other case.'

In a case where there is 'fresh evidence', which means evidence that was not available at the time of the trial, the Court has to decide whether that evidence causes it to doubt the safety of the guilty verdict or finding. Safety may also be called into question as a result of errors and irregularities; for example: the wrongful admission or exclusion of evidence; conduct on the part of lawyers resulting in identifiable errors or irregularities in the trial; inconsistent verdicts and jury irregularities; the conduct of the judge; and errors in the judge's summing up to the jury, such as misdirection on law, wrongful withdrawal of issues from the jury, misdirection on facts, comment on the failure of the accused to testify and inappropriate direction as to the accused's character.

Commonly occurring grounds for an appeal against sentence include the following: the sentence was wrong in law; the sentence was wrong in principle or manifestly excessive (but mere severity is an insufficient ground); irrelevant factors were taken into consideration by the judge; there were procedural errors; and for no apparent good reason there was a serious disparity between the sentences of the co-accused.

Potential outcomes of appeal

In addition to quashing a conviction, the Criminal Appeal Act 1968 allows the Court of Appeal to substitute a verdict of not guilty by reason of insanity or of the defendant having been unfit to plead but having done the acts or omissions charged. Appeals can be made against a verdict of insanity or finding of unfitness if the verdict or finding respectively is considered unsafe.

Appeals against sentence can include appeals against hospital disposals. Although the Court of Appeal cannot deal with the appellant more severely than he or she was dealt with by the original court, a hospital disposal is not a punishment and is generally not considered more severe, even with a restriction order. This is the case even if it results in a longer period of detention (*R v Bennett* [1968]).

Misleading evidence in unsafe rulings in England and Wales

One of us (N.S.) has carried out a systematic analysis of misleading evidence in unsafe rulings in England and Wales (Smit 2018). This research explored the reasons for unsafe rulings in all cases where a conviction or acquittal was quashed or overturned by the Criminal Division of the Court of Appeal

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

between January 2010 and December 2016. In total, 218 such cases involving evidence were identified and analysed according to the type of misleading evidence and the reason for it being misleading. Many of these related to the nature of the forensic or witness evidence and the way in which it was presented, including its relevance, probative value and scientific validity. Although there were cases where new evidence, including new psychiatric evidence not available at the time of the original hearing, was presented, the majority of unsafe convictions related to the reinterpretation of the original evidence. This suggests that the way an expert witness presents their evidence or the way that the court interprets it can potentially mislead the court and lead to unsafe convictions or inappropriate sentences.

This analysis exposes the potential for misleading psychiatric evidence, especially since a large part of expert psychiatric evidence is opinion evidence, which may go unchallenged. Although misleading evidence does not always result in an unsafe conviction, wrong finding or inappropriate sentencing, there is a danger that it can. In combination with further analysis of cases prior to 2010 and after 2016 where psychiatric evidence has played a role in the Court of Appeal reviewing findings, convictions or sentences, this research has identified a number of important cases that illustrate the potential for misleading psychiatric evidence. There are lessons from these Court of Appeal cases that may be applied in preparing psychiatric evidence for courts of first instance, as well as insights into how expert psychiatric evidence can assist the appellate courts.

Illustrative cases

Appeals based on new psychiatric evidence

Under section 23 of the Criminal Appeal Act 1968 new psychiatric evidence can only be admitted if there is a reasonable explanation for it not having been received at the original hearing. Retrospective psychiatric evidence obtained long after the original hearing will generally be viewed with scepticism by the courts (*R v Andrews* [2003]). Nevertheless, many of the appeals based on new psychiatric evidence identified by N.S. turned on evidence that the appellant had a mental disorder that was unrecognised at the time of the original hearing and had a bearing on the case. Sometimes this was not the failure of a psychiatrist to diagnose the mental disorder, but the absence of any psychiatric assessment at the relevant time.

One of the ways that an undiagnosed mental disorder might affect a hearing could relate to fitness to plead, as discussed below. However, even though a defendant may be fit to plead, their mental disorder may have had an impact on their decisions about how to plead such that the court considers it a reasonable explanation for a particular defence not having been advanced during the original hearing and therefore admitting it on appeal. This was the case in *R v Erskine* [2009] (Box 1) and *R v Moyle* [2008]. In both cases the defendants' murder convictions were substituted for manslaughter on grounds of diminished responsibility because their reasons for not advancing the defences at trial were related to their psychoses rather than being tactical decisions. This may appear inconsistent with the finding that they had been fit to plead but making the best defence or choosing whether to plead diminished responsibility are not technically part of fitness to plead. This is to do with a 'reasonable explanation' for an argument not having been advanced in the original hearing (and therefore appropriate for an appeal), which is different from not having been fit to plead.

Psychiatrists giving evidence in appeal cases may therefore be asked about the impact of mental disorder on decisions to plead, although it is still possible that the court may consider that a defendant's decisions were tactical (*R v Diamond* [2008]). If there is evidence that a defendant's reasons for pleading are related to mental disorder, this should be made clear, even if this does not amount to unfitness to plead.

The admissibility of expert evidence and the reliability of witnesses

Psychiatrists giving evidence in criminal cases must comply with the Criminal Procedure Rules 2015 (SI 2015/1490: http://www.legislation.gov.uk/uksi/2015/1490/contents/made) and give objective unbiased opinion within their area of expertise. Such evidence is only admissible if it is outside the experience and knowledge of a judge or jury and relevant to the case (*R v Turner* [1975]). It must be necessary to assist the court. The witness should

BOX 1 *R v Erskine* [2009]

The appellant had been convicted of seven counts of murder but had not advanced the partial defence of manslaughter on the grounds of diminished responsibility at trial, despite psychiatric evidence at the time that the defence would have been available to him. He appealed against conviction, on the basis of new psychiatric evidence that he had not originally advanced the defence because of his delusional beliefs about being executed rather than any tactical decisions. Although the court held that his decision not to advance the defence was irremediably flawed, in the light of contemporaneous evidence that his mental acuity was reduced, this was not held to amount to unfitness to plead. His murder conviction was quashed, verdicts of manslaughter on the grounds of diminished responsibility were substituted and he was made the subject of a hospital order with restrictions on discharge.

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

have the necessary knowledge or experience, be impartial and their evidence should be underpinned by a reliable body of knowledge or experience (*Kennedy v Cordia LLP* [2016]).

Psychiatrists should be aware that commenting directly on the truthfulness of a defendant (*R v Turner* [1975]) or on the intention of a defendant at the time of the alleged offence (*R v Chard* (1972)) is not admissible because this is an 'ultimate issue': a legal issue which must be made by the court. Similarly, the ability of a witness to remember events would normally be within the experience of a jury. However, psychological evidence that childhood memories described in unrealistic detail might be unreliable was admitted in *R v H* [2005]. Nevertheless, in *R v Weightman* (1991) evidence of histrionic personality disorder in relation to truthfulness was not considered outside the experience of a jury.

Section 77 of the Police and Criminal Evidence Act 1984 (PACE) (discussed below) establishes that evidence of being 'mentally handicapped' (which is defined in law as 'a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning' and which practitioners would be likely to equate with what is now known as 'intellectual disability') may be admissible in relation to confession evidence. However, it is not admissible in relation to evidence of intention, even if the defendant's IQ is considered to be abnormally low (*R v Henry* [2005]).

R v H [2014] (Box 2) demonstrates the potential dangers for experts in giving evidence that is either unscientific or gives a direct view on the credibility of a witness.

Although experts must not comment directly on the credibility of witnesses, evidence that is outside the knowledge of the jury relating to potential unreliability may be admissible (*R v O'Brien* [2000]). The effects of psychosis and cognitive deficits on the potential reliability of a witness may be admissible (*R v Mulindwa* [2017]). In *R v Bryant* [2016] (Box 3) evidence of suspected personality disorder and chronic lying from general practitioner records was admitted on appeal and the defendant's conviction was ruled unsafe. In contrast, in *R v Pluck* [2010] (Box 4) being dishonest and manipulative was not admissible psychiatric evidence because it was considered not to relate to any mental disorder. Psychiatric experts must tread carefully in commenting on potential unreliability and, if they give evidence, it must usually relate to a diagnosable mental disorder. The case of *Pora v The Queen* [2015] (see below), heard by the Appellate Committee of the Privy Council[a] on appeal from the Court of Appeal of New Zealand, is the most authoritative statement of the law on this matter:

> 'It is the duty of an expert witness to provide material on which a court can form its own conclusions on relevant issues. On occasions that may involve the witness expressing an opinion about whether, for instance, an individual suffered from a particular condition or vulnerability. The expert witness should be careful to recognise, however, the need to avoid supplanting the court's role as the ultimate decision-maker on matters that are central to the outcome of the case […] It is for the court to decide if the confessions are reliable and to reach conclusions on any reasons for their possible falsity.'

[a] The Judicial Committee of the Privy Council is the highest court of appeal for certain Commonwealth countries. It consists of UK Supreme Court justices and other senior judges from the Commonwealth, who sit as the Appellate Committee of the Privy Council in Westminster.

BOX 2 *R v H* [2014]

The applicant, a general practitioner, appealed against his convictions of multiple sexual offences against his daughter. He appealed on the basis of psychiatric evidence from a retired psychiatrist and psychotherapist, stating that his daughter had 'false memory syndrome' and therefore was not reliable. The trial judge refused to admit this evidence and the Court of Appeal agreed. The evidence for false memory syndrome was lacking and the psychotherapist had not interviewed the daughter. The Court found that she had usurped the function of the jury in pronouncing on the credibility of what the daughter had reported and had acted in a wholly inappropriate way for an expert witness. The Court was even more concerned that she had given similar evidence in other cases 10 years previously and her evidence had been excluded then for similar reasons. The appeal was dismissed.

BOX 3 *R v Bryant* [2016]

The appellant Mr Bryant had been convicted of buggery and had been sentenced to imprisonment in addition to being made subject to orders under legislation relating to sex offenders. He appealed against conviction, on the basis of new psychiatric evidence relating to the reliability of the main complainant, Mr Day. Unknown to the jury at the time, Mr Day's general practice records showed a 10-year history of chronic lying and a suspected personality disorder. Mr Bryant argued that had the jury known of these facts they would not have convicted him. The Court of Appeal did not regard the psychiatric evidence as admissible but accepted that the fact of his history of lying might reasonably have resulted in the jury acquitting the appellant and that the conviction was therefore unsafe. It therefore quashed the conviction and acquitted Mr Bryant.

Fitness for interview by the police and false confessions

Psychiatrists, as well as forensic physicians, may be asked to give expert evidence in relation to detained persons in police custody after arrest but prior to police interview as to their fitness to be interviewed (Ventress 2008). Unsafe convictions may result from incorrect procedures or a failure to implement safeguards.

BJPsych Advances (2019), vol. 25, 251–264 doi: 10.1192/bja.2019.11

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

BOX 4 *R v Pluck* [2010]

The appellant appealed against his conviction for two murders on referral by the Criminal Cases Review Commission. This was in part based on fresh DNA evidence although this was not found to make the conviction unsafe. A psychiatric report suggesting that one of the witnesses was manipulative and dishonest was not admitted at the original trial. The Court of Appeal found that new psychiatric evidence relating to a potential personality disorder as evidence of unreliability of this witness was also inadmissible because it was his dishonesty rather than any mental disorder that had made him unreliable in the jury's eyes. The appeal was dismissed.

The importance of the 'appropriate adult'

The interviewing of detained persons is governed by the Police and Criminal Evidence Act 1984 (PACE) and revised Code C of its Code of Practice (Home Office 2018). Section 77 of PACE requires a judge to caution a jury where a confession is made by a person who is 'mentally handicapped' (see definition above) without the presence of an independent person if the case against them is substantially based on their confession. Their confession will not be admissible unless the prosecution can prove beyond reasonable doubt that it was not obtained by oppression or in consequences of anything said or done that was likely to render any confession unreliable. However, in *R v Gill and Others* [2004], where a defendant with an IQ of 63 was considered to be 'mentally handicapped', the absence of an appropriate adult did not render the confession unreliable. This was because he had planned his confession in anticipation of his arrest and it was held that if an appropriate adult had been present, it would not have made any difference to the confession.

Guidance in Annex G of Code C of the PACE (Home Office 2018) suggests that fitness for police interview should depend on: (a) how the detainee's physical or mental state might affect their ability to understand the nature and purpose of the interview, to comprehend what is being asked and to appreciate the significance of any answers given and make rational decisions about whether they want to say anything; (b) the extent to which the detainee's replies may be affected by their physical or mental condition rather than representing a rational and accurate explanation of their involvement in the offence; and (c) how the nature of the interview, which could include particularly probing questions, might affect the detainee.

It is the custody officer who will decide whether to proceed with the interview in the light of the medical assessment. However, even if someone is fit to be interviewed, the Code also requires anyone who is vulnerable to be offered an appropriate adult to safeguard their rights, entitlements and welfare. If this is not done it may lead to an unsafe conviction. In *R v Aspinall* [1999], where a detained person with schizophrenia was interviewed without an appropriate adult present, his conviction was quashed. An appropriate adult should advise the detained person, facilitate communication and observe whether the interview is conducted fairly. A psychiatrist should therefore comment both on the need for an appropriate adult to be present and whether the detained person is fit for police interview. This is particularly important if there is any suspicion of intellectual disability, as in *R v Brown* [2011] (Box 5), or autism spectrum disorder, as in *L & R v R* [2011] (Box 6).

False confessions

False confessions almost always lead to unsafe convictions but they can be difficult to spot. Readers should consult *The Psychology of Interrogations and Confessions* (Gudjonsson 2003) and *The Psychology of False Confessions* (Gudjonsson 2018) for more treatment of this subject. Although the truthfulness of a defendant is an ultimate issue for the court, a psychiatrist should make clear whether mental health problems may affect the reliability not only of their evidence in general but also of any confessions in particular. Mental disorders such as personality disorder and intellectual disability may at times lead to false confessions, but high levels of suggestibility or compliance can also make defendants particularly vulnerable during police interviews.

In *R v Lawless* [2009] (Box 7) the defendant was assessed in custody by a psychiatrist, who did not consider him to have any mental disorder. As later evidence showed, he was in fact highly compliant and prone to make up stories to gain attention. This demonstrates the importance of considering the presence of suggestibility and compliance particularly in people with personality disorder. Nevertheless, as *Pora v The Queen* [2015] (Box 8) demonstrates,

BOX 5 *R v Brown* [2011]

The appellant Mr Brown appealed against conviction for murder on the basis that new psychological evidence showed that he had very low intellectual functioning and that evidence from his police interviews should be excluded as he had had no appropriate adult with him. Psychological evidence was deemed admissible in principle because its absence could have led to an unsafe conviction. However, in this case it did not make any difference to the appeal. The Court of Appeal held that the jury could make its own mind up about Mr Brown's abilities. His solicitor was present during the police interviews and Mr Brown had refused to have an appropriate adult with him. The appeal was dismissed.

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

BOX 6 *L & R v R* [2011]

Two appellants were convicted of a number of assaults against a baby but appealed against conviction on the grounds that one of the police interviews should be excluded as one of the defendants had not had an appropriate adult or solicitor present. Psychiatric evidence of autism spectrum disorder and suggestibility led the court to exclude the police interview and quash the convictions on appeal.

BOX 7 *R v Lawless* [2009]

The appellant appealed against his conviction for murder via the Criminal Cases Review Commission on the basis that new psychiatric evidence showed his confessions to be unreliable. Psychiatric evidence at the time discounted any mental disorder. New psychological evidence showed that he was emotionally unstable, had high levels of compliance, had a pathological dependency on others and that it would be unsafe to rely on his self-incriminating comments. The Court of Appeal agreed and the conviction was quashed.

BOX 8 *Pora v The Queen* [2015]

The appellant had been convicted of murder and rape and appealed on the basis that his confession evidence had been unreliable. New expert evidence of fetal alcohol spectrum disorder and associated impulsivity and executive function impairment led the appellant's convictions to be quashed. However, one of the experts was criticised for straying beyond his role in giving an opinion that the appellant's confessions were unreliable, given that this was an ultimate issue for the court.

BOX 9 *R v B* [2012]

The appellant, who had been convicted of a sexual assault, appealed against conviction on the basis that psychiatric evidence of 'learning disability' meant that he had not been fit to be interviewed by police. Two psychiatrists gave evidence that he was not fit to plead but also that he would not have been fit for police interview. Based on these psychiatric opinions, the court quashed his conviction.

experts must be careful not to usurp the court's role in pronouncing on the actual reliability of the defendant; they should only comment on the way in which mental disorder could make a confession unreliable.

Fitness to plead

Psychiatrists are often asked to give evidence in relation to fitness to plead, which is determined by the court without a jury. Although this should be distinguished from fitness for police interview, in *R v B* [2012] (Box 9) being unfit to plead was considered inconsistent with having been able to understand the police caution and be interviewed. If psychiatrists are of the opinion that the evidence for a defendant having been unfit for police interview is overwhelming, it may be useful to make such observations when assessing fitness to plead even if they have not directly been asked to comment on it. The same is true if a defendant has already been convicted but the evidence for them having been unfit to plead during the trial is overwhelming. Psychiatric evidence relating to previous unfitness can lead to the quashing of a conviction, as demonstrated in *R v Chitolie* [2016] (Box 10) and *R v Shulman* [2010] (Wood 2016). The latter is a case in which study of the transcripts of the defendant's evidence and his interruptions of court proceedings, along with notes of his conferences with counsel, revealed evidence of schizophrenic thought disorder and this, along with evidence of his delusions about the female complainant, who alleged rape, false imprisonment and assault, persuaded the Court of Appeal to quash his convictions and make a finding of unfitness to plead.

In the Crown Court fitness to plead is governed by the Criminal Procedure (Insanity) Act 1964, which was amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. Since the Domestic Violence, Crime and Victims Act 2004, fitness to plead is determined by a judge rather than a jury. If raised by the defence, unfitness must be determined on the balance of probabilities, but if raised by the prosecution, it must be proved beyond reasonable doubt (*R v Robertson* [1968]).

Disposals if found unfit to plead

A defendant found to be unfit to plead is described as being under a disability and cannot be convicted of an offence unless they become fit in the future. If they are found to have done the act or made the omission charged, the court can make an order for admission to hospital (with or without restrictions), a supervision order or an absolute discharge. This is

BOX 10 *R v Chitolie* [2016]

The appellant appealed against conviction for breach of a restraining order on the grounds that he had been unfit to plead. He was unrepresented and walked out of the dock, whereupon his trial took place in his absence. After being found guilty, psychiatric reports were ordered and these stated that he had delusional disorder or schizophrenia. All three psychiatrists were of the opinion that he had not been fit to plead and all recommended a hospital order. On the basis of the new psychiatric evidence the Court of Appeal found him unfit and quashed his conviction. It found that he had done the acts charged and imposed an order for admission to hospital with a restriction order.

BJPsych Advances (2019), vol. 25, 251–264 doi: 10.1192/bja.2019.11

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

unless the charge is murder and they are given a hospital disposal, in which case they must also be given a restriction order. Expert psychiatric evidence is therefore essential for a finding of unfitness to plead and the court must obtain evidence from at least two registered medical practitioners (RMPs), of whom at least one must be an approved medical practitioner (AMP), i.e. approved under section 12 of the Mental Health Act 1983.

The Pritchard criteria, the six abilities and their implications

The legal test for fitness to plead is defined in case law by the Pritchard criteria (*R v Pritchard* (1836)) in the light of more recent case law such as *R v M* (*John*) [2003]. *R v M* (*John*) [2003] clarified the six abilities needed to be fit to plead:

- understand the charges
- decide whether to plead guilty or not guilty
- exercise the right to challenge a juror
- instruct solicitors and counsel
- follow the course of the proceedings
- give evidence in your own defence.

Following the course of proceedings does not mean understanding every legal point but only requires a grasp of the essential issues (*JD v R* [2013]).

R v Marcantonio [2016] (Box 11), which quoted *R v M (John)* [2003] at length, clarified that fitness to plead remained a unitary legal test despite sympathy with the view that a distinction should be made between fitness to plead and fitness to stand trial. Despite having dementia, schizophrenia and depression the defendant was still found to be fit to plead, which serves as reminder that the issue to be determined is not the diagnosis, or the number of diagnoses, but the effect, if any, on the specific six abilities. When considering fitness to plead, psychiatrists should also consider the importance of effective participation, in order to comply with the right to a fair trial under Article 6 of the European Convention on Human Rights (*R v Central Devon Magistrates' Court* [2003]; *R v West London Youth Court* [2005]).

A number of important cases have demonstrated that having a psychiatric disorder does not necessarily make someone unfit to plead. It does not follow that someone is unfit to plead merely because of having amnesia for the alleged offences (*R v Podola* [1960]), memory impairment (*R v Marcantonio* [2016]), being deluded about the court process (*R v Robertson* [1968]), having delusional beliefs that the jury members are possessed by evil (*R v Moyle* [2008]), not being able to act in one's best interests (*R v Robertson* [1968]) or giving instructions that are implausible, unbelievable or unreliable (*R v M (John)* [2003]). In addition, concern about the mental fragility or suicidality of a defendant is not a reason to find a defendant unfit to plead (*R v Lederman* [2015]).

If a defendant becomes unfit during their trial, then the unfitness procedure must be followed (*R v Orr* [2016]). Psychiatrists should therefore raise any new concerns about fitness to plead during a trial process. *R v Walls* [2011] (Box 12) illustrates how psychiatrists may be severely criticised if they fail to address the Pritchard criteria.

Psychiatrists are sometimes asked to give evidence in relation to the undesirability of a defendant to give evidence under section 35 of the Criminal Justice and Public Order Act 1994. This is only relevant if a defendant is fit to plead but their mental or physical condition means that giving evidence may be undesirable: in such a case the jury could draw an adverse inference from their failure to give evidence. This must be clearly distinguished from being unfit to plead (*R v Orr* [2016]).

BOX 11 *R v Marcantonio* [2016]

The appellant appealed against conviction for burglary on the basis that he had been unfit to plead. Although he had mentioned that he suffered from dementia at the time of the original hearing, he pleaded guilty and his solicitor did not consider fitness to plead to be an issue. New psychiatric evidence showed that at the time of conviction the appellant had dementia, schizophrenia and depression, which resulted in deficits in his decision-making abilities. Three psychiatrists giving evidence were of the opinion that he would have been unfit to plead at the time of his original hearing. One psychiatrist thought that he might have been exaggerating his symptoms and been fit to plead despite having mild cognitive impairment. The Court of Appeal found that he had been fit to plead and his appeal was dismissed.

Insanity

Psychiatrists are often asked to give evidence in relation to the defence of insanity, which is a common law defence to any criminal charge (*Loake v Crown Prosecution Service* [2017]). If successful the defendant is given the special verdict of not guilty by reason of insanity and, like someone found unfit to plead, can be given an order for admission to hospital (with or without restrictions), a supervision order or an absolute discharge under the Criminal Procedure (Insanity) Act 1964.

The insanity defence is defined in case law by *R v M'Naghten* (1843): at the time of committing the act, the defendant must have been 'labouring under such a defect of reason, from disease of the mind, as

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

BOX 12 *R v Walls* [2011]

A defendant with intellectual disability was convicted of the sexual touching of an 11-year-old girl. He appealed against conviction, on the basis that there had been no psychiatric opinion on his fitness to plead. New psychiatric evidence from two psychiatrists was to the effect that the defendant would have been unfit to plead. However, neither mentioned the Pritchard criteria and both were asked to give oral evidence as to their reasoning. One of the psychiatrists was said to have been an unsatisfactory witness, who remained dogmatic in his view and was not able to defend it. The court found the defendant fit to plead and dismissed the appeal.

to not know the nature and quality of the act he was doing or, if he did know it, that he did not know that what he was doing was wrong'. The nature and quality of the act refers to its physical quality rather than its moral aspects (*R v Codère* (1917)). Importantly, a strict interpretation of wrong by the Court of Appeal means legally wrong rather than morally wrong (*R v Johnson* [2007]), although the Law Commission (2013) has accepted that, contrary to *Codère*, the nature of an act includes an appreciation of its moral qualities. One of us (K.R.) has published guidance on how the legal test for insanity should be approached (Rix 2016).

Although having a disease of the mind is a question of law (*Bratty v Attorney General of Northern Ireland* [1963]), psychiatrists should be aware that a state of mind caused by intoxication cannot give rise to a successful insanity defence (*R v Harris* [2013]). An insanity defence requires a jury to hear evidence from two RMPs, one of whom must be an AMP. In *R v Oye* [2013] (Box 13) the court quashed a conviction and substituted a finding of insanity based on unchallenged expert psychiatric evidence. Experts should therefore be aware of the substantial influence they may have on a jury's finding of insanity since this has profound implications for the defendant.

Diminished responsibility

Diminished responsibility is a statutory partial defence to the charge of murder under section 2 of

BOX 13 *R v Oye* [2013]

The appellant had been convicted of causing grievous bodily harm to a police officer. He had been experiencing paranoid delusions about evil spirits. He appealed against conviction, on the basis that he had a defence of self-defence but this was not successful because the court found that the amount of force used in self-defence had to be reasonable and any mistaken belief had to be a reasonable one to have been held. Having an insane delusion could not be considered reasonable. He also argued, however, that he should have been found insane on the basis of the original evidence from two psychiatrists. The Court of Appeal agreed that there was no safe or rational basis for the jury to depart from unchallenged psychiatric evidence. His conviction was quashed and a finding of not guilty by reason of insanity was made. Given his progress in prison he was given an absolute discharge.

BOX 14 *R v Brennan* [2014]

The appellant, who had a personality disorder, appealed against his conviction for murder on the grounds that he had a substantial impairment in forming a rational judgement and in exercising self-control. Uncontradicted psychiatric evidence at trial supporting the defence was rejected by the jury, who convicted him of murder. The Court of Appeal ruled that the jury had no rational basis for rejecting the psychiatric evidence because it was a purely psychiatric question, and substituted a verdict of manslaughter on the grounds of diminished responsibility.

the Homicide Act 1957, which has been amended by section 52 of the Coroners and Justice Act 2009. A successful defence requires psychiatric evidence to demonstrate an abnormality of mental functioning that arose from a recognised medical condition that substantially impaired the defendant's ability to either understand the nature of their conduct, form a rational judgement or exercise self-control. The abnormality must also provide an explanation for their acts or omissions in doing or being a party to the killing.

In *R v Brennan* [2014] (Box 14) the court described these amendments as relating to entirely psychiatric matters and advised psychiatrists to comment on all parts of the defence, including whether the impairment was substantial. In *R v Golds* [2016] (Box 15) it was pointed out that, although psychiatrists may give an opinion on whether the impairment was substantial, it is ultimately a matter for the jury. The meaning of the term 'substantial' was explored at length and psychiatrists should be familiar with its meaning. In *R v Squelch* [2017]) it was held that commenting on the ultimate issue (in this case, whether or not the defendant was found to have had diminished responsibility) may not always be appropriate. Psychiatrists should therefore be careful how they comment on this particular ultimate issue, given the danger of usurping the jury's role.

Whether a mental disorder is a recognised medical condition for the purpose of the defence is a question of law. Neither alcohol intoxication (*R v Dowds* [2012]) nor drug-induced psychosis (*R v Lindo* [2016]) is valid, although pre-existing schizophrenia triggered by acute intoxication could be (*R v Joyce* [2017]).

Substantial impairment in understanding the nature of the defendant's conduct is almost never used by psychiatrists for a diminished responsibility defence (Mackay 2017). This may be because it is similar to the insanity defence, which is a complete defence.

Substantial impairment in being able to form a rational judgement was explored in *R v Conroy*

BJPsych Advances (2019), vol. 25, 251–264 doi: 10.1192/bja.2019.11

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

BOX 15 *R v Golds* [2016]

The appellant had killed his partner by stabbing her 22 times in front of her children. He appealed against his conviction of murder on the basis that the trial judge, in considering the question of 'substantial impairment' in the potential defence of diminished responsibility, ought to have defined the term 'substantial' as 'more than merely trivial'. Although the Court of Appeal dismissed the case, the Supreme Court was asked to explore the meaning of the term substantial. Substantial was a question of degree and meant important or weighty, as in a substantial meal or a substantial salary, rather than real or not illusionary. It could also mean significant and appreciable or considerable. Nevertheless, its meaning was ultimately a matter for the jury.

BOX 17 *R v Blackman* [2017]

A Royal Marine sergeant who had been convicted by a court martial of the murder of an injured insurgent while serving in Afghanistan appealed against conviction on the basis of new psychiatric evidence. Video evidence showed what seemed to a purposeful and deliberate shooting of the insurgent but psychiatric evidence that he had had an undiagnosed adjustment disorder led the court to conclude that he had a substantial impairment in forming a rational judgement about the need to adhere to standards and the moral compass set by the armed forces. He was also found to have substantially impaired self-control. His conviction was quashed and substituted by manslaughter on the grounds of diminished responsibility.

[2017] (Box 16). It was emphasised that bad or immoral actions such as murder are not necessarily irrational because they might still be logical. In contrast, rationality in *R v Blackman* [2017] (Box 17) was associated with not being able to adhere to the moral compass set by the armed forces, which focuses more on morality than logical thought process. Given that forming a rational judgement has not been defined in law, psychiatrists should be careful about equating psychiatric symptoms with irrationality.

Distinguishing between being unable or merely unwilling to exercise self-control has always been problematic (Law Commission 2013; Appendix A, paras 74–82). In *R v Blackman* [2017] (Box 17) the defendant was found to have had substantially impaired self-control despite one psychiatrist describing the killing as a cold-blooded execution. This suggests that the lack of self-control does not have to be impulsive. This is consistent with the separate but related defence of loss of control, in which a reaction may be delayed (*R v Dawes* [2013]). In relation to a diminished responsibility defence, psychiatrists should therefore not rule out the possibility of an impairment of self-control in patients who have not acted impulsively.

BOX 16 *R v Conroy* [2017]

The appellant, who had autism spectrum disorder, had been convicted of murdering his victim in order to have sex with her. He appealed against conviction, on the basis that his ability to form a rational judgement and exercise self-control was substantially impaired. One psychiatrist argued that his desire was to have sex and he was unable to form a rational judgement as to how to go about that in the right way. Another psychiatrist argued that his judgment was rational because his actions were planned. The appeal was dismissed on the basis that his rationality remained intact despite his thought process. The court ruled that his desire to strangle his victim was not necessarily illogical or irrational, although undoubtedly wrong.

Whether a defendant's abnormality of mental functioning is an explanation for their acts or omissions depends on whether it causes, or is a significant contributory factor in causing, them to carry out that conduct. Although the extent of this has not been the subject of appeal, *R v Golds* [2016] (Box 15) clarified that this is ultimately a question for the jury, although medical evidence may play a role. Psychiatrists must therefore explain how the abnormality of mental functioning is a significant contributory factor in the killing.

In *R v Williams* [2013] a psychiatrist prepared a report that did not support a plea of diminished responsibility and the defendant was convicted of murder. However, on appeal the psychiatrist was criticised for not having considered the general practice records and computed tomography (CT) scans of the brain made shortly before the killing and the court found that the psychiatrist had misunderstood the law on diminished responsibility. This shows the importance of fully considering all the medical records and understanding the relevant law.

Sentencing and mental health disposals

The purposes of sentencing according to section 142 of the Criminal Justice Act 2003 are punishment, reduction of crime, rehabilitation, protection of the public and the making of reparation. However, these purposes do not apply if an offender is given a mental health disposal (Box 18), because a hospital disposal is not a punishment (*R v Birch* (1989)).

The court must obtain a medical report before passing a sentence on a mentally disordered offender and can only make a hospital order under section 37 of the Mental Health Act 1983 if it is recommended by two RMPs, one of whom must be an AMP. The court can impose a hospital disposal on conviction of any offence punishable with imprisonment except murder, but before sentencing it must have regard to all the circumstances, including the nature of the

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

BOX 18 Mental health disposals

Disposals under the Mental Health Act 1983 include:

- Section 37: hospital order without restriction
- Section 38: interim hospital order
- Section 37/41: hospital order with restrictions
- Section 45A: hospital order with a limitation direction (a hybrid order), i.e. an initial period in hospital, with transfer to prison once treatment in hospital is complete.

offence and the character and antecedents of the offender.

In order to impose a restriction order under section 41 it must be necessary for the protection of the public from serious harm, having regard to the nature of the offence, the antecedents of the offender and the risk of the offender committing further offences if set at large. Oral evidence from at least one of the RMPs is required. Psychiatric evidence is therefore essential if the court is to make a hospital order, with or without restrictions, although the decision is ultimately a matter for the judge (*R v Reid* [2005]). Under section 45A the court can also impose a hospital disposal with a limitation direction – a 'hybrid order', in which an offender goes to hospital but is then transferred to prison to serve the rest of the sentence once treatment in hospital is complete.

Appeals against sentencing

The vast majority of appeals for mentally disordered offenders relate to sentencing. This is not surprising, given that hospital disposals and custodial sentences have very different release regimes. Deciding whether a mentally disordered offender should go to hospital or prison can be extremely difficult.

Guidance on sentencing mentally disordered offenders was given in *R v Vowles* [2015] (Box 19). Judges should consider the treatment for the mental disorder, its link with the offending, culpability requiring punishment and protection of the public. They must justify deviation from the usual course of imposing a penal sentence. The court's guidance is that a hospital order with restrictions (a section 37/41) would only be appropriate if the mental disorder is treatable, if once treated the person is not otherwise dangerous and the offending is entirely due to mental disorder.

R v Vowles [2015] has been criticised for favouring punishment rather than treatment, since it appeared to prioritise a section 45A hybrid order over a section 37/41 hospital disposal with restrictions (Ashworth 2015). However, in *R v Ahmed* [2016] (Box 20) a section 37/41 was substituted because it was considered to be a better way of protecting the public. In *R v Edwards* [2018] (Box 21) it was held that *R v Ahmed* [2016] was fact-specific and was not to be taken as meaning that a section 37/41 was necessarily always a better way to protect the public. Furthermore, it was said that *R v Vowles* [2015] had been misunderstood and did not provide a default position of imprisonment, although the usual course should be to impose a sentence with a penal element.

BOX 19 *R v Vowles* [2015]

Six appellants who had been given indeterminate sentences for public protection appealed against sentence on the basis of new psychiatric evidence recommending hospital orders with restrictions. They had all since been transferred to hospital. Three of the appellants were successful in having their sentences substituted by hospital disposals with restriction orders (under sections 37 and 41 of the Mental Health Act). All three decisions were based on hitherto undiagnosed schizophrenia or schizoaffective disorder, which with hindsight had been present at the time of the offences and contributed to them. Psychiatrists at the trials had placed too much emphasis on features of personality disorder and had not considered the possibility of a psychotic disorder carefully enough, although this was only clear with hindsight. Nevertheless, the court ruled that there should be sound reasons for departing from the usual course of a custodial sentence.

Psychiatric evidence and culpability

Although *R v Edwards* [2018] made clear that it is necessary for the judge to assess the culpability of the offender, psychiatrists were asked in cross-examination about the level of culpability. This is very concerning, given that culpability is not properly a matter for expert psychiatric opinion. Although psychiatrists can and should explain in what ways psychiatric symptoms may affect decision-making ability or behaviour, commenting directly on culpability puts them at risk of straying outside their area of expertise. The mental state of a defendant at the time of their offence does not map onto legal concepts of culpability. And even if

BOX 20 *R v Ahmed* [2016]

The appellant, who had been sentenced to life imprisonment following a conviction for manslaughter on the grounds of diminished responsibility, appealed against sentence following new psychiatric evidence. His original diagnosis of psychotic depression had not resulted in a recommendation for a hospital disposal from any of the expert psychiatric witnesses. However, one of them revised his opinion years later to that of schizoaffective disorder and recommended a hospital order with restrictions (a section 37/41). The court ruled that the original diagnosis had been incorrect. Treating his psychosis had led to a cessation of all antisocial behaviour. It was held that a section 37/41 would better protect the public because a deterioration in his mental disorder was inevitable at some point.

BJPsych Advances (2019), vol. 25, 251–264 doi: 10.1192/bja.2019.11

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

BOX 21 *R v Edwards* [2018]

Four appellants with indeterminate sentences appealed on the basis that they should have been given hospital orders with restrictions (section 37/41 orders). Two of them were successful in having their custodial sentences quashed and substituted with section 37/41 orders, which had been recommended by psychiatrists at the original hearings.

Edwards, who had schizoaffective disorder, had previously been subject to a section 37/41 and absolutely discharged only to commit another very serious offence. She was assessed as having a low-moderate culpability because she must have known that not taking medication would lead to relapse. Her appeal was rejected.

Knapper had been considered to have moderate culpability due to not taking medication and was therefore initially given a section 45A hybrid order (a period in hospital, followed by transfer to prison to serve the rest of the sentence once treatment in hospital is completed). On appeal psychiatric evidence, including new evidence about lack of insight in schizophrenia leading to non-adherence to medication and about the importance of early detection of relapse by mental health professionals, led to the imposition of a section 37/41.

Langley was found to have low culpability for his offences, given new psychiatric evidence of post-traumatic stress disorder, intellectual disability and personality disorder as being the main contributors to his offences. He was therefore given a section 37/41.

Payne, who had schizophrenia and personality disorder, appealed but this appeal was rejected. Two psychiatrists were asked in oral evidence about the level of culpability of the appellant, one arguing that it was low, the other high. The appeal did not succeed because the court placed greater emphasis on the psychiatric evidence relating to a high level of culpability and found that his high culpability made a hospital order inappropriate.

it did, it would be unethical for a psychiatrist to offer an opinion on culpability.

Given the complexity around the sentencing of mentally disordered offenders, psychiatrists should be aware of the principles in *R v Vowles* [2015] and *R v Edwards* [2018] so that if they recommend a hospital disposal, they are able to defend the reasons why it is the most appropriate disposal, if necessary under cross-examination. Although sentencing is ultimately a matter for the court, psychiatrists will be asked whether the mental disorder is treatable, whether once treated the offender would remain dangerous and to what extent the offence itself is due to the mental disorder. These may be very difficult questions to answer and psychiatrists should be honest about their limitations in predicting risk. Although psychiatrists should not comment directly on culpability, they may reasonably give opinions about whether a patient's non-adherence to medication is related to their lack of insight or part of their mental disorder, as discussed in *R v Edwards* [2018].

The difficulty in recommending s45A

There have been many successful appeals against sentence based on new psychiatric evidence which have led to hospital disposals rather than custodial sentences. Of particular interest is *R v Hoppe* [2016] (Box 22), in which one psychiatrist was criticised for being inconsistent in recommending a section 45A hybrid order but not a section 37/41 hospital disposal with restrictions. Although *R v Vowles* [2015] gives guidance on when a section 45A might be preferable to a section 37/41, the criteria for the medical recommendation elements are the same. Psychiatrists should therefore be consistent in whether they consider a defendant to meet criteria for a hospital disposal or not. Only if they do could they suggest that, on the basis of their clinical judgement of the most appropriate release regime, the court consider whether a hybrid order might be more suitable. Nevertheless, psychiatrists should not directly recommend a section 45A, as they could be accused of recommending imprisonment, which it would be unethical to do. *R v Hoppe* [2016] also suggests that if there is uncertainty about the most appropriate disposal, a section 38 interim hospital order could be recommended, even though in *R v Vowles* [2015] its use was discouraged.

Many appeal cases relating to the sentencing of mentally disordered offenders are difficult because it is a matter of individual judicial opinion whether the culpability of the defendant is low enough and the link between their mental disorder and offending strong enough to warrant a hospital disposal. As Lord Neuberger has said:

> 'The reality is that, in many cases, it is possible to reach more than one conclusion on the facts, which raises the question of what we even mean by the "right" answer. And the more difficult the case, the more true that is, and so it is scarcely surprising that one not infrequently sees sharp differences of

BOX 22 *R v Hoppe* [2016]

The appellant had been convicted of causing grievous bodily harm and sentenced to life imprisonment. She appealed against sentence, on the basis of new psychiatric evidence that she had been suffering from schizoaffective disorder and personality disorder. The court quashed her custodial sentence and gave her a hospital disposal with a restriction order (a section 37/41). One of the psychiatrists, who had initially not recommended a hospital disposal but later recommended a section 45A hybrid order (a period in hospital, followed by prison), continued to oppose a section 37/41 hospital disposal with restrictions. The court held his view to be illogical, to recommend a section 45A but not a section 37/41. It also criticised him for being unwilling to consider a hospital disposal or even an interim hospital order during the initial hearing.

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

opinion between judges in appellate courts' (Lord Neuberger 2015: para. 13).

Learning the lessons

Miscarriages of justice that involve psychiatric evidence may relate to an unsafe conviction or finding, or an inappropriate sentence. In some cases this is due to a delay in obtaining or failure to obtain psychiatric evidence in the legal process and it may only be with hindsight that a mental disorder present at the time of arrest or trial is subsequently diagnosed. Given the reluctance of appellate courts to admit new psychiatric evidence long after the original hearing, it is essential that any psychiatric issues be dealt with at the time. Sir David Latham's Working Party report *Mental Health and Fair Trial* (JUSTICE Working Party 2017) provides advice for all those working in the criminal justice system on identifying and managing individuals with mental disorders. From the investigative stage through to sentencing, a greater awareness of the effects of mental disorder, the need for mental health support and, where necessary, diversion away from the criminal justice system will reduce the likelihood of miscarriages of justice.

Where inadequate or inadmissible psychiatric evidence has led, or had the potential to lead, to a miscarriage of justice, psychiatrists acting as expert witnesses can learn lessons from the Court of Appeal cases (Box 23). Expert witnesses should comply with the Criminal Procedure Rules, which have recently included directions for the commission of medical reports (Criminal Procedure (Amendment No. 2) Rules 2018 (SI 2018/847): http://www.legislation.gov.uk/uksi/2018/847/contents/made). They should address issues within their area of expertise and not usurp the function of the court by commenting definitively on the ultimate issue. When commenting on whether someone's mental disorder could make a police interview or confession unreliable, or a witness giving evidence unreliable, psychiatrists should say that it only has the potential to make it unreliable, as reliability is an ultimate issue for the court (Box 8). Even when giving evidence in relation to fitness to plead, insanity or diminished responsibility it should be acknowledged that the ultimate issue is one for the court on the basis of all the evidence and not just the psychiatric evidence.

Expert witnesses should be familiar with and apply the correct legal tests. Fitness to plead consists of six abilities (listed above) and is one unitary legal test (Box 11). It is not sufficient to give an opinion on fitness to plead without addressing the six abilities individually (Box 12). Experts should be familiar with the tests for insanity and diminished responsibility and consider the ways in which the abilities of forming a rational judgement and exercising self-control have been interpreted by the Court of Appeal (Boxes 16 and 17).

When giving evidence in relation to sentencing, experts should be familiar with the principles in *R v Vowles* [2015] and *R v Edwards* [2018] (Boxes 18 and 20) and explain why any recommendations for a hospital order are appropriate. They should explain what the advantages and disadvantages of a section 45A hybrid order are, particularly if they consider that there may be advantages for such an order over a section 37 hospital order. However, they should not recommend one directly because it is unethical for psychiatrists to recommend punishment. Psychiatrists should not comment directly on culpability, because it is not within their expertise and would also be unethical to do so. However, they should assist the court in determining culpability by explaining how the defendant's mental state and behaviour would have been affected by their mental disorder.

BOX 23 Some take-home lessons

Do not usurp the function of the court:

- leave the ultimate issue for the court
- if commenting on reliability, describe it as only potentially being affected.

Be familiar with relevant guidance and codes of practice:

- the Criminal Procedure Rules
- Code C of the Police and Criminal Evidence Act (PACE).

Be familiar with and apply the correct tests:

- the Pritchard criteria as clarified by the six abilities in *R v M* (*John*) [2003]
- the M'Naghten Rules (described in Rix 2016)
- the diminished responsibility criteria (described in Hallett 2018).

In sentencing cases:

- be familiar with the judgments in *Vowles* and *Edwards* and any more recent judgments
- rather than directly recommending a section 45A hospital disposal with a limitation direction, explain what the advantages and disadvantages might be
- assist the court on matters relevant to culpability but make it clear that psychiatric knowledge and experience are not sufficient for giving an opinion on culpability.

Conclusions

Miscarriages of justice occur as a result of wrongful convictions or findings and inappropriate sentences. Some relate to procedural errors rather than the conviction of those who are innocent. Miscarriages of justice involving psychiatric evidence demonstrate the need for greater awareness of defendants' mental health problems among those who work in the criminal justice system and greater awareness of criminal law and procedure for those giving expert psychiatric evidence.

Psychiatrists should be aware of the relevant issues in each stage of the criminal justice process. They may assist the courts by highlighting any lack of procedural safeguards or the likelihood of previously undiagnosed mental disorders. They

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

should give objective unbiased evidence within their area of expertise. This necessitates that they do not comment directly on culpability and that they leave the ultimate issue for the court. In this way they will reduce the likelihood of miscarriages of justice occurring either directly or indirectly as a result of expert psychiatric evidence.

References

Ashworth A, Mackay R (2015) Commentary on *Vowles. Crim Law Rev*, **7**: 542.

Gudjonsson G (2003) *The Psychology of Interrogations and Confessions*. Wiley & Sons.

Gudjonsson G (2018) *The Psychology of False Confessions*. Wiley-Blackwell.

Hallett N (2018) Psychiatric evidence in diminished responsibility. *J Crim Law*, **82**: 442–56.

Home Office (2018) *Police and Criminal Evidence Act (PACE): CODE C Revised. Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers*. TSO (The Stationery Office).

JUSTICE Working Party (2017) *Mental Health and Fair Trial: A Report by JUSTICE*. JUSTICE.

Law Commission (2013) *Criminal Liability: Insanity and Automatism*. Law Commission.

Lord Neuberger (2015) *'Judge not, that ye be not judged': judging judicial decision-making* (38th FA Mann Lecture, 2015). Available at: https://www.supremecourt.uk/docs/speech-150129.pdf.

Mackay R, Mitchell B (2017) The new diminished responsibility plea in operation: some initial findings. *Crim Law Rev*, **1**: 18–35.

Naughton M (ed) (2011) *The Criminal Cases Review Commission: Hope for the Innocent?* Palgrave Macmillan.

Rix KJB (2016) Towards a more just insanity defence: recovering moral wrongfulness in the M'Naghten Rules. *BJPsych Adv*, **22**: 44–52.

Smit N, Morgan RM, Lagnado DA (2018) A systematic analysis of misleading evidence in unsafe rulings in England and Wales. *Sci Justice*, **58**: 128–37.

Ventress MA, Rix KJB, Kent JH (2008) Keeping PACE: fitness to be interviewed by the police. *BJPsych Adv*, **14**: 369–81.

Wood HNW, Rix K (2016) Common psychiatric and psychological disorders explained and examined. In *Witness Testimony in Sexual Cases: Evidential, Investigative and Scientific Perspectives* (eds P Radcliffe, G Gudjonsson, A Heaton-Armstrong, et al): 309–24. Oxford University Press.

Cases

Bratty v Attorney General of Northern Ireland [1963] AC 386.

JD v R [2013] EWCA Crim 465.

Kennedy v Cordia LLP [2016] UKSC 6.

L & R v R [2011] EWCA Crim 649.

Loake v Crown Prosecution Service [2017] EWHC 2855 (Admin).

Pora v The Queen [2015] UKPC 9.

R v Ahmed [2016] EWCA Crim 670.

R v Andrews [2003] EWCA Crim 2750.

R v Aspinall [1999] 2 Cr App R 115.

R v B [2012] EWCA Crim 1799.

R v Bennett [1968] 1 WLR 988.

R v Birch (1989) 11 Cr App R (S) 202.

R v Blackman [2017] EWCA Crim 190.

R v Brennan [2014] EWCA Crim 2387.

R v Brown [2011] EWCA Crim 1606.

R v Bryant [2016] EWCA Crim 1245.

R v Central Devon Magistrates' Court [2003] EWHC 146 (Admin).

R v Chard (1972) 56 Cr App R 268.

R v Chitolie [2016] EWCA Crim 14.

R v Codère (1917) 12 Cr App R 21.

R v Conroy [2017] EWCA Crim 81.

R v Dawes [2013] EWCA Crim 322.

R v Diamond [2008] EWCA Crim 923.

R v Dowds [2012] EWCA Crim 281.

R v Edwards [2018] EWCA Crim 595.

R v Erskine [2009] EWCA Crim 1425.

R v Gill and Others [2004] EWCA Crim 3245.

R v Golds [2016] UKSC 61.

R v H [2005] EWCA Crim 1828.

R v H [2014] EWCA Crim 1555.

R v Harris [2013] EWCA Crim 223.

R v Henry [2005] EWCA Crim 1681.

R v Hoppe [2016] EWCA Crim 2258.

R v Johnson [2007] EWCA Crim 1978.

R v Joyce [2017] EWCA Crim 647.

R v Lawless [2009] EWCA Crim 1308.

R v Lederman [2015] EWCA Crim 1308.

R v Lindo [2016] EWCA Crim 1940.

R v M (John) [2003] EWCA Crim 3452.

R v Marcantonio [2016] EWCA Crim 14.

R v M'Naghten (1843) 10 Cl & F 200.

R v Moyle [2008] EWCA Crim 3059.

R v Mulindwa [2017] EWCA Crim 416.

R v O'Brien [2000] Crim LR 676.

R v Orr [2016] EWCA Crim 889.

R v Oye [2013] EWCA Crim 1725.

R v Pluck [2010] EWCA Crim 2936.

R v Podola [1960] 1 QB 325.

R v Pritchard (1836) 7 C&P 303.

R v Reid [2005] EWCA Crim 392.

R v Robertson [1968] 1 WLR 1767.

R v Squelch [2017] EWCA Crim 204.

R v Shulman [2010] EWCA Crim 1034.

R v Turner [1975] QB 834.

R v Vowles [2015] EWCA Crim 45.

R v Walls [2011] EWCA Crim 443.

R v Weightman (1991) 92 Cr App R 291.

R v West London Youth Court [2005] EWHC 2583 (Admin).

R v Williams [2013] EWCA Crim 2749.

MCQ answers
1 e 2 a 3 b 4 d 5 c

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press

MCQs

Select the single best option for each question stem

1 The Criminal Cases Review Commission:
- a abolished the Criminal Appeal Act 1995
- b is where appeals have their first hearing
- c can overturn, quash or substitute any conviction, finding or sentence
- d always refers cases to the Supreme Court
- e considers whether there is new evidence or argument that may cast doubt on the safety of an original decision.

2 Appeals based on new psychiatric evidence:
- a can only be admitted under section 23 of the Criminal Appeal Act 1968 if there is a reasonable explanation for them not having been received at the original hearing
- b are always heard, even if psychiatric evidence is produced long after the original hearing
- c cannot be heard if the appellant has already been given a hospital order
- d cannot relate to the reasons for a defendant pleading if they were considered fit to plead
- e do not consider retrospectively undiagnosed mental disorders.

3 Expert psychiatric witnesses:
- a may comment on the truthfulness of a defendant
- b should give objective unbiased opinion within their area of expertise
- c can give an opinion on whether the defendant is guilty or not
- d should never comment on whether a mental disorder could make evidence potentially unreliable
- e should make the final decision on whether a person with a mental disorder should be interviewed by police.

4 Fitness to plead:
- a is a two-part test consisting of fitness to plead and fitness to stand trial
- b is a capacity test based on the Mental Capacity Act 2005
- c is defined by abilities set out in the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991
- d consists of six abilities
- e is determined by reference to the criminal standard of beyond reasonable doubt if it is raised by the defence.

5 In the sentencing of mentally disordered offenders:
- a psychiatrists should address the culpability of the offender
- b the judge should not consider the need for punishment
- c psychiatrists should consider whether a hospital order with restrictions is the best way to protect the public
- d psychiatrists should recommend a section 45A directly if they feel it is appropriate, even though it relates to punishment
- e the judge must always hear oral evidence from an expert psychiatric witness.

BJPsych Advances (2019), vol. 25, 251–264 doi: 10.1192/bja.2019.11

https://doi.org/10.1192/bja.2019.11 Published online by Cambridge University Press