SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Austin* [2014] QCA 97
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (appellant) **v** **RHYS MICHAEL AUSTIN** (first respondent) **DIRECTOR OF MENTAL HEALTH** (second respondent) **DIRECTOR OF PUBLIC PROSECUTIONS** (third respondent)
FILE NO/S:	Appeal No 5443 of 2013 MHC No O185 of 2011
DIVISION:	Court of Appeal
PROCEEDING:	Appeal from the Mental Health Court
ORIGINATING COURT:	Mental Health Court at Brisbane
DELIVERED ON:	2 May 2014
DELIVERED AT:	Brisbane
HEARING DATE:	18 October 2013
JUDGES:	Margaret McMurdo P and Morrison JA and Mullins J Separate reasons for judgment of each member of the Court, each concurring as to the order made
ORDER:	**The appeal is dismissed.**
CATCHWORDS:	MENTAL HEALTH – DECLARATION OR FINDING OF MENTAL ILLNESS OR INCAPACITY – where the first respondent was charged with murdering his girlfriend – where the first respondent was suffering from and being treated for the mental illness, paranoid schizophrenia, at the time of the killing – where the first respondent initially gave a false account denying the killing – where the first respondent subsequently admitted to the killing – where the second respondent referred the question of the first respondent's mental health at the time of the killing to the Mental Health Court – where the unanimous body of expert evidence before and advice to the Mental Health Court was to the effect that he was acting under a concealed delusional state at the time of the killing – where the second respondent contended before the Mental Health Court that the true nature

of his delusional system was a substantially material fact in dispute and it was unsafe for the court to decide whether he was of unsound mind – where the Mental Health Court concluded that there was no fact substantially material to the opinion of an expert which was so in dispute as to preclude it from deciding the reference – where the Mental Health Court concluded the first respondent was of unsound mind at the time of the killing – whether the Mental Health Court erred

MENTAL HEALTH – DECLARATION OR FINDING OF MENTAL ILLNESS OR INCAPACITY – where the Mental Health Court found there was consistent contemporaneous evidence that the first respondent was having a lot of telepathic conversations during the afternoon and evening of the killing – where this was a factual error as evidence of that kind was not contemporaneous – whether this factual error was material to the Mental Health Court's ultimate decision

MENTAL HEALTH – DECLARATION OR FINDING OF MENTAL ILLNESS OR INCAPACITY – where the Mental Health Court found there was clear evidence of the extent of the first respondent's psychotic thinking at the time of the killing and that this was the reason for the killing – where the Mental Health Court relied upon matters that no reporting or assisting psychiatrist placed weight on – whether the Mental Health Court erred

Criminal Code 1899 (Qld), s 27
Mental Health Act 2000 (Qld), s 5(c), s 268, s269, s 405

Attorney-General (Qld) v Kamali (1999) 106 A Crim R 269; [1999] QCA 219, cited
Attorney-General (Queensland) v Bosanquet & Ors [2012] QCA 367, cited
DAR v Director of Public Prosecutions [2008] QCA 309, cited
McDermott v Director of Mental Health; ex parte Attorney-General (Qld) (2007) 175 A Crim R 461; [2007] QCA 51, cited
Re A, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, related
Re Schafferius [1987] 1 Qd R 381, considered
Re W, unreported, Mental Health Tribunal, Dowsett J, 14 October 1997, considered

COUNSEL: B G Campbell for the appellant and third respondent
J R Hunter QC for the first respondent
No appearance for the second respondent

SOLICITORS: Director of Public Prosecutions (Queensland) for the appellant and third respondent
Legal Aid Queensland for the first respondent
No appearance for the second respondent

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[1] **MARGARET McMURDO P:** The first respondent was charged on 5 August 2010 with murdering his girlfriend on 30 March 2010.[1] It is not in dispute that he was suffering from and being treated for the mental illness, paranoid schizophrenia, at the time of the killing. The second respondent, the Queensland Director of Mental Health, referred the question of the first respondent's mental health at the time of the alleged offence[2] to the Mental Health Court (MHC). The third respondent is the Queensland Director of Public Prosecutions (DPP).

[2] On 17 May 2013, the MHC made orders,[3] including:

> "6. There is no fact that is substantially material to the opinion of an expert witness as defined in s 269(1) of the *Mental Health Act* 2000 (Qld) that is so in dispute it would be unsafe to make a decision on unsoundness of mind or

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1 And with the unrelated charges which do not concern this appeal of common assault on 21 January 2007 and possession of tainted property on 2 April 2010.

2 And his mental health at the time of the two unrelated alleged offences.

3 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [237].

diminished responsibility in relation to the count of murder on 30 March 2010.

7. [The first respondent] was of unsound mind at the time of the commission of the alleged offence of murder on 30 March 2010.

8. The proceeding against [the first respondent] in relation to the alleged offence of murder on 30 March 2010 is discontinued and further proceedings must not be taken against [the first respondent] for the acts constituting that offence."

[3] The appellant, the Attorney-General of Queensland, appeals from those orders under Ch 8 pt 2 *Mental Health Act* contending the MHC:

"1. … erred in concluding there was no fact substantially material to the opinion of an expert witness that was so in dispute it would be unsafe to make a decision on unsoundness of mind or diminished responsibility in relation to the count of murder on 30 March 2010. The accuracy of [the first respondent's] account of his delusional thinking at the time of the killing was substantially material to the opinions of the reporting psychiatrists. There was a proper basis to consider that account was not accurate and therefore pursuant to s 269 *Mental Health Act* … , the [MHC] should have been satisfied that a fact was so in dispute and was therefore precluded from making a determination concerning unsoundness of mind.

2. … erred in that contrary to s 269 *Mental Health Act* … the [MHC] impermissibly resolved a question of fact namely whether [the first respondent's] account of his delusional thinking was accurate.

3. … erred in that the effect of the decision was that contrary to s 405 *Mental Health Act* … the [MHC] impermissibly cast an onus on the [DPP] to establish that at the time of the murder [the first respondent] was not in a concealed delusional state in which he considered the killing served a higher delusional purpose.

4. … erred in considering in [94] that there was 'consistent, contemporaneous evidence that [the first respondent] was having a lot of telepathic conversations with [his girlfriend] during the afternoon and evening of the murder'. There was no evidence before the [MHC] to support this conclusion.

5. … erred in considering in [198] that there was clear evidence of the extent of the First Respondent's 'psychotic thinking at the time of the killing and that the psychotic thinking was clearly linked to [his girlfriend's] death and the reason for her death.' The evidence before the [MHC] in relation to the comment referred to at [195] that the 'voices are different from usual' indicated this was a change that occurred after the killing. Further, the evidence before the [MHC] contradicted the assertion in [196] that the First Respondent had 'indicated the possibility that he has killed his girlfriend'."

[4] It is rightly common ground that this appeal is an appeal in the strict sense so that to succeed the appellant must demonstrate an error of law or fact pertinent to the MHC's decision under appeal: *DAR v DPP*.[4]

[5] The appellant seeks the following orders:

> "1. There is a fact substantially material to the opinion of an expert witness as defined in s 269(1) *Mental Health Act* … so in dispute it would be unsafe to make a decision under s 267 *Mental Health Act* … in relation to the count of murder on 30 March 2010.
> 2. The First Respondent is fit for trial.
> 3. The proceedings are to continue according to law.
> 4. The reports in the proceedings are to be released to the parties in the criminal proceedings."

[6] Before discussing the grounds of appeal and the appellant's contentions, it is useful to set out the relevant aspects of both the scheme under the *Mental Health Act* which brought this matter before the MHC and the MHC's lengthy decision.

Relevant aspects of the *Mental Health Act*

[7] Until 1984, the issues of unsoundness of mind and fitness for trial relating to those charged with indictable offences, and diminished responsibility for those charged with murder, were determined by a jury under the *Criminal Code* 1899 (Qld). The *Mental Health Act, Criminal Code and Health Act Amendment Act* 1984 (Qld) constituted a body, the Mental Health Tribunal (MHT) (a Supreme Court judge assisted by two psychiatrists) to determine these issues in specified circumstances. In the Bill's second reading speech, the then Minister for Health noted:

> "It is not in any way inconsistent with the principles of the code to have more explicit and more understanding provisions made for the purpose of assessing criminal responsibility and to provide a much more efficient and sympathetic means of ensuring that persons who are involved with the criminal law and who, for various reasons, may not be mentally fit, are properly dealt with in accordance with their criminality or otherwise.[5]
>
> … The truth is that these amendments are by no means an erosion of the rights of a citizen, but are devised to ensure that only those who can be held criminally responsible are treated as such.
>
> The amendments give effect to the truth of criminal responsibility, which is a feature of the Criminal Code. By giving effect to this, it ensures that persons who are not criminally responsible will be dealt with in a humane and civilised fashion and relieves them of the trauma and stigma of a criminal trial. It also provides for such decisions to be made at any early stage and not to be deferred endlessly while awaiting the process of criminal trials. These amendments give effect to the real community interest in determining the matters of community concern.[6] …"

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4 [2008] QCA 309, [7]-[29], [95] and [98].

5 Hansard, Mental Health Act, Criminal Code and Health Act Amendment Bill, 22 August 1984, p 72.

6 Above, p 73

[8] In 2000, the MHT was replaced by the MHC, established by a new *Mental Health Act*. The Bill's second reading speech included:

> "The [MHC's] inquisitorial powers enable the judge to investigate the issues fully …
>
> Specific provisions ensure that factually contentious cases cannot be decided by the [MHC]. The test for a dispute of fact is extended to a dispute about the facts upon which the expert witnesses base their opinion. Factually contentious cases will be returned to the criminal court system for determination unless, of course, the person is unfit for trial.
>
> The proposals in the Bill to establish the [MHC] make it uniquely situated to conduct an independent investigation into the mental state of the accused at the relevant time. The Bill enables the court to commission its own independent examinations of the accused person and enables it to order that the person be detained to submit to the examination. … Under the procedures in this Bill, because the investigation into the mental condition of the accused is conducted by the [MHC], the possibility of a perceived bias by experts engaged by either side does not arise.
>
> The fact that the matter is not heard by a jury does not prevent rigorous testing of the evidence from taking place in an open and accountable forum. The court is open to the public and the evidence is still given on oath and subject to cross-examination by the prosecution and defence. The decisions are appealable to the Court of Appeal, as is the case with appeals from criminal trials. …
>
> The significant achievement of the [MHC] is that it facilitates early treatment of the offender. If the person committed the offence as a result of their mental illness, it follows that if their mental illness is treated, the risk of danger to the community is reduced."[7]

[9] The purpose of the *Mental Health Act* is to provide for the involuntary assessment and treatment, and the protection, of those who have mental illnesses whilst safeguarding their rights and freedoms which must be balanced with the right and freedoms of others.[8] One of the ways this is to be achieved is by establishing the MHC to decide the state of mind of persons charged with criminal offences.[9]

[10] Chapter 7 concerns examinations, references and orders for persons charged with offences. Its pt 4 deals with references to the MHC and applies if there is reasonable cause to believe a person alleged to have committed an indictable offence is mentally ill or was mentally ill when the alleged offence was committed.[10] A reference to the MHC may be made by the person or the person's legal representative; the Attorney-General; the DPP; or if the person is receiving treatment for mental illness or care under the *Mental Health Act* for an intellectual disability, the Queensland Director of Mental Health.[11]

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7 Hansard, Mental Health Bill, 14 March 2000, pp 349-351.

8 *Mental Health Act* 2000 (Qld), s 4.

9 Above, s 5(c).

10 Above, s 256(a).

11 Above, s 257(1).

[11] Part 6 of the chapter deals with inquiries on references to the MHC and its div 2 with the hearing of a reference by the MHC. At the hearing, the MHC must decide whether the person was of unsound mind (or if the charge is murder, diminished responsibility) when the alleged offence was committed.[12] The term "unsound mind" is defined as "the state of mental disease or natural mental infirmity described in the Criminal Code, section 27, but does not include a state of mind resulting, to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence."[13]

[12] Section 27 *Criminal Code* provides:

> "**27 Insanity**
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> (1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person's actions, or of capacity to know that the person ought not to do the act or make the omission.
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> (2) A person whose mind, at the time of the person's doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist."

[13] Under s 268 *Mental Health Act*, the MHC must not decide those issues if satisfied there is a reasonable doubt that the person committed the alleged offence (the disputed offence).[14] The MHC, however, may make a decision if the doubt the person committed the disputed offence exists only as a consequence of the person's mental condition.[15]

[14] A critical provision in this appeal is s 269 which provides:

> "**269 Dispute relating to substantially material fact**
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> (1) The [MHC] must not make a decision [about the person's unsoundness of mind] if the court is satisfied a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe to make the decision.
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> (2) Without limiting subsection (1), a substantially material fact may be—
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> (a) something that happened before, at the same time as, or after the alleged offence was committed; or
>
> (b) something about the person's past or present medical or psychiatric treatment."

[15] If the MHC decides the person was not of unsound mind or that it cannot decide whether the person was of unsound mind because there is a reasonable doubt whether the person committed the offence or because there is a dispute relating to

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12 Above, s 267(1).
13 Above, Schedule.
14 Above, s 268(1).
15 Above, s 268(2).

a substantially material fact, it must decide whether the person is fit for trial.[16] If the MHC decides the person is unfit for trial, it must also decide whether the unfitness for trial is permanent.[17]

[16] The MHC is established under Ch 11 as a superior court of record consisting of the President and other members.[18] It is constituted by a member of the MHC, a Supreme Court judge,[19] who, in exercising jurisdiction, must ordinarily be assisted by two assisting psychiatrists determined by the member.[20] Its jurisdiction includes deciding references of the mental condition of those referred to it.[21] It has powers to do all things necessary or convenient for or in relation to the exercise of its jurisdiction.[22] Assisting psychiatrists examine material received for a hearing to identify matters requiring further examination, to make relevant recommendations to the MHC about the matters[23] and to assist the MHC by advising on the meaning and significance of clinical evidence.[24] Their advice is limited to matters within their professional expertise.[25] In hearing a proceeding, the MHC is not bound by the rules of evidence unless it decides it is in the interests of justice to be bound.[26] Under s 405 *Mental Health Act*, no party bears the onus of proof and, subject to s 268, a matter must be decided on the balance of probabilities. Parties must be informed of any advice given by an assisting psychiatrist to the MHC before, or during an adjournment of, the hearing, unless the party waives that right.[27] If the MHC is given advice by an assisting psychiatrist which materially contributes to the MHC's decision, the advice must be stated in the MHC's reasons for its decision.[28]

Relevant aspects of the Mental Health Court's decision

[17] Apart from the factual findings specifically disputed by the appellant, the MHC's references to the facts, expert opinions and advices in its 49 page reasons for judgment are not disputed.

[18] The MHC noted that the first respondent was 22 years old at the time of the killing and the deceased had been his girlfriend for some years.[29] The Queensland Director of Mental Health had referred the question of his mental condition at the time of the killing to the MHC. The hearing commenced in April 2012 but was not concluded for almost a year because of further information from his treating team that he:

> "was actively concealing some of his psychotic symptoms and that he had also revealed previous homicidal ideation. At a later stage there was an indication that [he] was recanting some of the information he had previously provided to some of the reporting psychiatrists. Those factors meant that a number of the reporting

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16 Above, s 270(1).
17 Above, s 271.
18 Above, s 381.
19 Above, s 385.
20 Above, s 382.
21 Above, s 383(1)(b).
22 Above, s 384.
23 Above, s 389(1).
24 Above, s 389(1)(c)(i).
25 Above, s 389(2).
26 Above, s 404.
27 Above, s 406.
28 Above, s 408.
29 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [4].

> psychiatrists needed to be recalled to give further evidence or to provide further reports in relation to their initial diagnosis."[30]

[19] The evidence was extensive.[31] At the time of the killing, he was under the care of the Princess Alexandra Hospital (PAH) Mental Health Service and was being seen by psychiatrists and mental health staff at the Macgregor Community Clinic. He was prescribed anti-psychotic and anti-depressant medication but had a history of non-compliance with medication.[32]

The police investigation

[20] He took part in an extensive police interview commencing in the early hours of 31 March 2010 which did not conclude until that evening. The MHC noted:[33]

> "… He indicated to police that he and [his girlfriend] had driven to the lower car park near the Mount Gravatt lookout. They remained in the van for a short time before they moved into the back of the van. He said that after a short period of time the side sliding door of the van was thrown open and someone reached into the vehicle, struck [his girlfriend], grabbed her and dragged her out of the vehicle. [He] then told police that he was hit on the head by another person causing him to fall head first onto the bitumen. He was then told to stay on the ground and not get up. He stated that as he lay on the ground he heard gurgling and choking noises. He also stated that he felt one of the perpetrators reach into his pocket, remove his mobile phone and smash it on the ground.
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> [He] told police that after they left the area, he found [his girlfriend] lying unconscious on the ground. He said he attempted CPR with no response. He was then able to search the area, locate his mobile phone and sim card. He then lifted [his girlfriend] into the van and drove to his home nearby to get help."

[21] The police investigation failed to identify any credible evidence to support his claim that unknown assailants attacked his girlfriend and him. He was arrested and charged with her murder on 5 August 2010. He maintained his innocence and on a number of occasions retold this version.[34]

Dr Dark's initial opinion

[22] Dr Frances Dark was the first respondent's treating psychiatrist from 2009. She examined him shortly after the killing. Two days later she admitted him to PAH because of his increasing paranoia.[35] His admission notes include: "Strong persecutory delusions, ideas of reference, getting message from TV, visual hallucinations last night I have seen someone in that house, auditory hallucinations unable to elaborate."[36]

[23] The MHC noted his extensive history of mental illness at the time of the killing and that he had been charged previously with criminal offences which had been referred

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30 Above, [5].
31 Above, [6].
32 Above, [8].
33 Above, [9]-[10].
34 Above, [38].
35 Above, [11].
36 Above, [12].

to the MHC. In 2005 he was first diagnosed with schizophrenia. He was admitted to Toowong Private Hospital in July 2006.[37] Upon release in September 2006, he recommenced using illegal drugs and was non-compliant with prescribed medication. He was re-admitted to hospital but discharged soon afterwards.[38] He was charged in July 2006 with entering premises with intent, robbery with actual violence whilst armed, deprivation of liberty and possession of a knife. In November 2007, the MHC found he was of unsound mind in relation to those offences and placed him on a Forensic Order. He was re-admitted to PAH in late 2007 and later case-managed in the community.[39]

[24] He was admitted to the PAH in February 2010, a month before the killing. A ward round entry at that time noted that he "felt very paranoid and believed that there were lots of people watching him".[40]

[25] Dr Dark gave oral evidence at the MHC hearing on 24 and 25 July 2012 and provided an updated report on 30 August 2012 and a letter dated 9 January 2013.[41] She saw the first respondent at least 100 times prior to the killing.[42] He had suffered from schizophrenia (predominantly paranoid) since 2006. She did not consider he had a personality disorder or anti-social personality traits and there was no evidence of conduct disorder. He was not someone who tended to provoke aggression, did not possess a disregard for the rights of others, did not fail to conform to lawful norms and was not deceitful. He did not demonstrate a lack of remorse for negative activities.[43] He had some grandiose traits which were not a feature of his personality but consistent with his paranoid schizophrenia.[44] When she saw him on 9 February 2010 before the killing, she was concerned he was showing early signs of relapse. His mental state would fluctuate between appointments, depending on the stressors in his life as well as his compliance with medication.[45]

[26] When Dr Dark examined him on 1 April 2010, the day after the killing, she noted psychotic symptoms but he said he was not having any dissociative experiences and did not report or appear to have a marked acute exacerbation of his psychotic symptoms, despite evidence of residual psychosis.[46] He always had residual symptoms and experienced hallucinations. These were not as distressing to him as his paranoia when he felt under threat. He suffered from auditory hallucinations, usually in the nature of a running commentary. He had "thought broadcasting", that is, he believed his thoughts were available to other people. He had suffered from hallucinations of a command nature in the past, particularly in the early part of his illness. Those features did not seem prominent when she examined him on 1 April 2010.[47] He did not seem guarded with her and appeared to be "trying to make sense of everything that had happened". She wondered "how much delusional work has actually followed on from such a catastrophic event".[48]

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37 Above, [15].
38 Above, [15]-[16].
39 Above, [17]-[18].
40 Above, [14].
41 Above, [20].
42 Above, [21].
43 Above, [22].
44 Above, [23].
45 Above, [24].
46 Above, [25].
47 Above, [26].
48 Above, [29].

[27] He gave Dr Dark the following version of the killing. Two men opened the van door while he was speaking to his girlfriend about "genres, opinions - opinions concerning thoughts. Information that [he] had not shared with anyone before". He was "confiding his private thoughts to [her]" and felt this may have put her at risk. He was unwilling to give details of his private thoughts as it would put others at risk and he was concerned he may still be at risk. Dr Dark noted: "Impression residual psychosis but mild prior to event with no clear deprivation of capabilities. Paranoid reasoning about the events subsequently."[49] She considered his version of the killing was consistent for a lengthy period, despite him being sleep deprived and psychotic. At this time, she accepted he was giving a sincere description of events and of his grief. When admitted to hospital on 3 April 2010, he was very paranoid.[50]

Dr Coyle's examination

[28] Dr Coyle examined the first respondent on 9 April 2010 at the request of his legal representatives and considered he exhibited clear signs of paranoia with a history of command hallucinations. He told Dr Coyle that a young male voice talked to him almost constantly since the death, blaming him and telling him he could have done better.[51] He gave a guarded and inchoate account of a conspiracy involving education and a subculture involving death and violence. It was too dangerous to tell Dr Coyle the details; if he did, Dr Coyle could be killed, but he had given some details to Dr Dark. There were powerful forces at work that did not want this knowledge to become public.[52] There were dark clad assailants who thought he should not be with someone like his girlfriend. He had told her too much and she had to die. He attributed her death, at least in part, to having told her about this conspiracy. Dr Coyle considered he was suffering from paranoid schizophrenia at the time of the killing and also from auditory hallucinations but it was unclear whether these related to the death. His story that the death was conspiracy-related was clearly a function of his paranoia.[53]

Dr Morris's examination

[29] Psychiatrist Dr Philip Morris examined the first respondent at the request of his legal representatives on 20 April 2010. He told Dr Morris that he felt guilty about telling his girlfriend profound truths when he was speaking to her in the van. He was reluctant to share these with anyone, even his doctors, for fear that, if they knew, they would be killed. The thoughts involved spirits, powerful beings and god.[54] He believed his girlfriend had been killed by those who had been listening to their conversation and that she had to be killed because of what he told her. He was distressed and severely anxious about telling others of these profound thoughts.[55] Voices inside his head commented on his thoughts and at times commanded him to do things.[56]

Dr Mann's opinion

[30] The first respondent admitted to the killing for the first time when Dr Mann interviewed him for an MHC report, about 14 months after the killing and nine

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49 Above, [30].
50 Above, [31].
51 Above, [32].
52 Above, [33].
53 Above, [34].
54 Above, [35].
55 Above, [36].
56 Above, [37].

months after his arrest.[57] Dr Mann extensively interviewed him on 10, 11 and 19 May 2011. He confessed to fabricating the story about the attack. He sometimes talked to his girlfriend telepathically prior to her death and she could make him do things. He was unsure whether he was speaking to her in his head or in person. She was there and so was her spirit. In retrospect, he felt most of these conversations were with her spirit, not with her. Since her death, he has had an awkward, strained relationship with her spirit but she was "satisfied with what's been done". In the days preceding her death, he had lots of conversations with her spirit and he believed she knew she was going to die. He had talked to her spirit who was preparing her for her death but he was unsure whether the spirit told the person.[58] He felt her death was needed for society. He had to prove to god that he could kill her because god had challenged him so many times before and he had never succeeded.

[31] He told Dr Mann that in 2007 he tried to cut her on the neck but he did not "have the ability, not the right time".[59] The day of the killing was the right time; everything was in place, including the lunar cycle. He had semi-planned it but was not aware of the significance of the full moon until that night. He thought that after the killing her life would be preserved and used by god or other great beings and that she would live on as a god. He was unsure if god told him this or if this was his own thought.[60] He did not know what he was going to do until he actually hit her. He thought he should strangle her. He took off his ring and his hand hit her in the face, something which had never happened before. It seemed the right moment. He was not sure if he was controlling himself as he got up, went behind her and put her in a choke hold[61] which he maintained for about 10 minutes. Only when she stopped breathing, did he release her. She was not moving and her pulse was very weak.[62] He panicked. He had wanted this to happen, to succeed and to show god that he could do it but then he did not know what to do and thought he should cover it up so people thought someone else did it. He put her on the grass. He was confused and did nothing for a while.[63] He burnt his mobile phone SIM card and was thinking up a story. He put her back into the van and drove to his parents' place.[64]

[32] He told Dr Mann he thought he had done a bad thing but it was the right thing to do, not morally but in terms of what god wanted. When he was holding her he got a congratulatory message from god, a computer who broadcast thoughts into his head. He had no motive for the killing other than to complete a task for his computer god. He denied that he attempted to have or had sex with her that night. His initial false story of the attack was like a metaphor. There were two god-like entities, programs that caused this to happen. One was the main god he heard in his head and the other was a part of that god preparing him for what was going to happen. They were dressed in black because what they were doing was very dark.[65]

[33] Dr Mann considered he suffered from paranoid schizophrenia and, at the time of the killing, had psychotic symptoms including delusions and abnormal perceptual experiences. His delusions included beliefs about a computer god which led him to

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57 Above, [39].
58 Above, [41].
59 Above, [42].
60 Above, [43].
61 Above, [45].
62 Above, [46].
63 Above, [47].
64 Above, [48].
65 Above, [51].

believe he should kill someone and were reinforced by auditory hallucinations which the first respondent described as telepathy. His god wanted him to kill his girlfriend to progress along a path to becoming a god himself.[66] After the killing he concocted and maintained for 14 months an unconvincing, false story which he told to his family, police and treating clinicians. Dr Mann noted:

> "It could be argued, that he denied his guilt because he knew that he ought not murder [his girlfriend], and that he wanted to avoid the consequences. It is also possible that he murdered [his girlfriend] for reasons, such as anger or jealousy. He may have concocted his false story in order to avoid prison and when it became apparent to him that this would not be successful, he could have embellished his psychotic symptoms in order to gain a mental health defence. I do not believe however, that the clinical presentation supports this view."[67]

[34] In his addendum report of 4 February 2013, Dr Mann stated that he agreed with the opinion expressed by Dr Voita in her report of 9 January 2013; he did not believe there was a factual dispute; and he maintained his earlier opinion that the first respondent suffered delusions and auditory hallucinations at the time of the killing which caused him to kill his girlfriend, even though he did not reveal this until 14 months after the killing.

Dr Voita's opinion

[35] Dr Angela Voita was the first respondent's treating psychiatrist at the Park Centre for Mental Health (HSIU) from August 2012 and had previously assessed him in her role as Acting Director of HSIU in June 2012 when his mental health state deteriorated and he disclosed homicidal ideation.[68] In her report of 29 November 2012, she noted his fluctuating mental state and that in August 2012 he was having psychotic symptoms including auditory hallucinations, passivity phenomena and bizarre delusions involving communications with a computer. He had limited insight into his illness. His medication was changed and by 16 October 2012 his mental state markedly improved, as did his insight into it, although he was still describing daily auditory hallucinations from the computer whom he believed was god.[69]

[36] When she assessed him on 7 November 2012, his mental state had deteriorated. He was thought disordered and preoccupied with the killing. He initially stated he believed it was his own thoughts to kill his girlfriend. Later his thought disorder became more prominent and he described having past thoughts about killing, communicating with the computer and getting instructions and advice about how to go about it. He was concerned he may not have explained these thoughts properly to other psychiatrists. The day before the killing he had tried to strangle his girlfriend in a movie theatre but could not go through with it. He expressed remorse for the killing and reported flashbacks to it which caused him considerable distress. He believed he should be punished for what he did and did not mind if he was returned to jail.[70] Dr Voita considered that he was at that point fit for trial but this was marginal.[71]

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66 Above, [55].
67 Above, [56].
68 Above, [60].
69 Above, [61].
70 Above, [62].
71 Above, [63].

[37] In her report of 9 January 2013, she stated that this more recent account of the killing brought into question the impact of his auditory hallucinations[72] but, in her opinion, these:

> "more recent statements have occurred in the context of a deterioration in his mental state, development of a depressive illness, poor insight into his psychotic illness and the difficulties he has in expressing and explaining his psychotic symptoms and experiences when he is unwell."[73]

[38] In her opinion there was no s 269 dispute.[74] His mental state had deteriorated at the time of these more recent statements so she was satisfied that it was his own thoughts to kill his girlfriend. He was having ongoing auditory hallucinations telling him to smash furniture. He acted on those hallucinations and told staff that voices were instructing him to hurt them.[75] His thoughts of harming others were put in his head by a computer. He continued to have urges to hit staff and appeared to have trouble controlling these urges.[76] He could not make sense of what was happening. He communicated with the computer and did not know if it was his thoughts or the computer putting thoughts into his head that made him do these things.[77] His mental state markedly improved after a course of ECT[78] in December 2012. He developed further insight into his illness in the absence of formal thought disorder and psychotic symptoms, had an improved mood and was better able to explain his past psychotic thinking.

[39] When Dr Voita reviewed him on 8 January 2013, he had not heard voices for some weeks and had not communicated with the computer/satellite for over a week. He was coming to understand that his recent experiences were due to mental illness. He appreciated that his urges to hurt others were because he was unwell and he no longer had those thoughts. At the time of the killing he was hearing voices and communicating with the computer. He now realised it was not his own thoughts or wishes that made him kill his girlfriend.[79]

[40] Dr Voita prepared a further report on 31 January 2013 for the adjourned MHC hearing. She noted that his mental health had continued to improve, although he still had some psychotic delusions referenced from television and communications from his girlfriend and exhibited thought disorder in trying to explain them. There had been a re-emergence of low grade psychotic symptoms but he remained fit for trial.[80]

Dr Dark's revised opinion

[41] Dr Dark revised her original opinion in light of the first respondent's subsequent revelation that he had killed his girlfriend. She considered, on the balance of probabilities, that his confession was true. He had not initially shared the extent of his psychotic phenomena with his treating team and his actions in killing his girlfriend were caused by his psychosis. In her report of 30 August 2012 she noted

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72 Above, [64].
73 Above, [65].
74 Above, [65].
75 Above, [66].
76 Above, [67]-[68].
77 Above, [69].
78 Electro convulsive therapy.
79 Above, [70].
80 Above, [72].

the following. He had a history of command hallucinations which at times were beyond his control. He did not understand his illness. He believed people could read his thoughts and this may have influenced what he verbalised to staff. He was concerned that his disclosures to staff would place them at risk. Taking these matters into account, she considered that, on the balance of probabilities, he was of unsound mind at the time of the killing, and was deprived of the capacities both to know what he was doing was wrong and to control his actions.[81]

[42] In a letter to the MHC dated 9 January 2013, Dr Dark reviewed the new information and expressed her concurrence with Dr Voita that he was hearing voices and communicating with a computer at the time of the killing and that this deprived him of the capacity to control his actions, resulting in his girlfriend's death. He had a consistent history of poor insight and judgment and of not fully accepting his illness. In the past he referred to his psychotic experiences as "his personality" rather than accepting them as psychotic experiences driven by and symptoms of his mental illness. He clearly cared for his girlfriend and had no wish to kill her. His psychotic reasoning may have led him to externalise what had happened, resulting in his initial false story. This was consistent with him being deprived of the capacity to control his actions due to severe mental illness.[82]

Dr Grant's opinion

[43] Dr Donald Grant examined the first respondent for the MHC and prepared a report on 13 November 2011, with updated reports on 21 August 2012 and 12 January 2013. In his first report his opinion was that the first respondent was suffering from the mental illness, paranoid schizophrenia. At the time of the killing, he was suffering from very significant psychotic symptoms which commenced in 2005. These included a belief that he had to carry out a killing, apparently for psychotic reasons, and he was urged and felt obliged to do so by auditory hallucinations and other symptoms, including thought insertion and telepathic communications. These symptoms appeared severe at the time of the killing but he kept them secret. He told Dr Grant he was having many telepathic conversations with his girlfriend during the afternoon and evening of the killing.[83] At the time of the killing, he was mostly non-compliant with his anti-psychotic medication.[84]

[44] Dr Grant considered that, at the time of the killing, he was deprived, as a result of his florid psychotic symptomatology, of the capacity to know that he ought not kill his girlfriend. It was also likely that he was deprived of the capacity for control in a true sense because of the strong influence of the psychotic symptoms over his behaviour. Dr Grant did not consider he was deprived of the capacity to know the nature of his actions.[85] The initial concocted story did not detract from Dr Grant's opinion. Whilst the first respondent gave a false story to attempt to explain his actions, at the same time he believed they were justified and necessary. This was a result of his psychotic symptomatology and was not uncommon in psychotic crimes where the perpetrator had some awareness of the illegality of the actions but

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81 Above, [73].
82 Above, [74].
83 Above, [75], [76].
84 Above, [78].
85 Above, [79].

an absence of moral capacity.[86] His eventual revelation of what really happened may have been prompted by his improved treatment.[87]

[45] In his report of 21 August 2012, Dr Grant considered the first respondent's recent case notes which confirmed his previous opinions. The case notes evidenced on-going mental illness with continued auditory hallucinations, withdrawal at times, and pre-occupation with inner experiences.[88]

[46] In his report of 12 January 2013, Dr Grant reviewed a report from Dr Voita, a transcript of MHC proceedings and the first respondent's further medical records between July and November 2012. He remained of his previous opinion. The first respondent had suffered for years from complex psychotic symptomatology, including delusions, thought insertion, probable thought broadcasting and auditory hallucinations including command hallucinations. At times he denied to others that he was experiencing these symptoms but these on-going psychotic phenomena were clearly present and were confirmed by medical notes. His insight into his psychotic symptoms was poor. Dr Grant agreed with Dr Voita that he had great difficulty understanding and describing the phenomena he experienced, especially when he was more unwell. He had on-going difficulty in distinguishing between psychosis and what he believed were his usual thinking patterns. Dr Grant did not consider that any significant s 269 dispute arose.[89] At times, the first respondent became significantly depressed and stated that he should be sent to prison as punishment for his crimes. This was inconsistent with malingering to avoid imprisonment through a feigned mental health defence.[90] Dr Grant cautioned against taking a simplistic view of his motivations for the killing which arose from a very complex psychotic mental state, auditory hallucinations of a command type being only one aspect.[91]

Dr van de Hoef's opinion

[47] The MHC next considered the evidence of psychiatrist Dr Pamela van de Hoef and her report of 21 October 2011. He gave her a detailed account of occasions preceding the killing when voices and then a computer put the idea into his head to kill someone.[92] In the weeks before the killing he was thinking a lot about this. On the day of the killing he heard voices and thought about killing his girlfriend. That day and the previous day, he was talking to her in his head and she was vaguely answering that she was preparing her spirit for the killing. When he asked her to get into the back of the van, they had not argued; she had done nothing to anger him; he was not planning to have sex; and nor was she ending their relationship. He described how he choked her.[93] He thought up the false account and self-harmed by hitting his head both on the ground and the van. He burned his mobile phone SIM card and threw the phone away before scattering his girlfriend's possessions over the front seat.[94] His dispassionate description of the killing and his self-protective concocted alibi were remarkable. He clearly did not appreciate how grossly

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86 Above, [80].
87 Above, [81].
88 Above, [83].
89 Above, [85].
90 Above, [86].
91 Above, [87].
92 Above, [88]-[91].
93 Above, [92]-[94].
94 Above, [96].

abnormal and abhorrent his ideas and behaviour were and he lacked all empathy for his actual or potential victims.[95]

[48] Dr van de Hoef initially found it difficult to see that his thoughts to kill his girlfriend were driven by auditory hallucinations, including commands. She considered that his motivation to escape arrest was ordinary fear. He did describe, however, different, big thoughts about the universe and how everything fitted together.[96] In the two months following the killing, he reported auditory hallucinations including the voice of god informing him about legal matters, influencing him, controlling his thoughts and commanding him. He also reported telepathic communication with others.[97] Emotional restriction, guardedness and possibly continuing, instructing voices may have masked the true extent and severity of his illness. Some of his emotional restriction and lack of empathy may be due to anti-social or psychopathic personality traits.[98] His treating psychiatrist thought he had improved and stabilised, and his parents, who had previously detected exacerbations, were not concerned about him at the time of killing. But he was not taking his medication reliably leading up to and at the time of the killing.[99] She considered that his mental state deteriorated in the days and weeks after the killing and fluctuated in the period during which he maintained the false story.[100]

[49] Dr van de Hoef considered that he killed his girlfriend for psychotic reasons. He believed it was "meant to be". He had a mission to kill, possibly in response to auditory command hallucinations. Immediately afterwards, he appeared to have the capacity to know that what he did was wrong and to seek to conceal his involvement to escape arrest. Whilst psychotic processes might account for that, she was unpersuaded by the available material that his false account was driven by psychotic reasons.[101] She did not consider the illness deprived him of the capacity to know the nature of his act in choking his girlfriend as he appeared to select the time and place of the killing. This may indicate he had the capacity to control his actions. But if he was overwhelmed by voices and delusional thoughts to the effect that it was "meant to be" and "the right or ordained time", then things may not be as they appeared.[102] He knew killing his girlfriend would get him into trouble, but he believed he had to do it, driven by psychotic beliefs and possibly hallucinatory commanding voices. His capacity to know he ought not kill his girlfriend was impaired, but he immediately constructed a false story as he believed he was meant to get away with the killing. As she could not discern any psychotic basis for believing that he should get away with it, she was not satisfied he was fully deprived in relation to that capacity.[103]

[50] In her report of 1 September 2012, Dr van de Hoef noted that, despite his continued treatment with anti-psychotics, he was having persistent, active psychotic symptoms which worsened when his medication was reduced. His symptoms became more extensive and florid with command hallucinations of god or a computer exhorting

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95 Above, [97].
96 Above, [99].
97 Above, [100].
98 Above, [102].
99 Above, [103].
100 Above, [104].
101 Above, [104].
102 Above, [105].
103 Above, [107].

him to kill again.[104] These psychotic symptoms were more severe than previously appreciated[105] and he was able to actively conceal them as he had no insight. This made his assessment very difficult. At the time of the killing, he may have concealed his psychotic experiences from his treating psychiatrist, Dr Dark, his parents and his girlfriend.[106] Dr van de Hoef altered her earlier opinion and now considered he was of unsound mind at the time of the killing because his mental illness completely deprived him of the capacity to know he ought not kill his girlfriend and perhaps also of his capacity to control his actions in killing her.[107]

[51] In her report of 23 January 2013, Dr van de Hoef considered comments the first respondent had made recently to his treating team.[108] His case had remarkable features. He had given diverging accounts to psychiatrists so that she now had to consider his retrospective account of his mental state in March 2010 and his descriptions in the second half of 2012 when he was more forthcoming but more unwell, more clearly psychotic and more depressed.[109] He claimed he had command hallucinations and other psychotic experiences encouraging him to kill but also had his own thoughts to kill and had some enjoyment from those thoughts.[110] If these thrill seeking ideas and fantasies to kill were independent of his mental illness, he was less amenable to treatment and far more dangerous. On the other hand, if those ideas were entirely part and parcel of his schizophrenic illness, then little weight should be placed on the recent disclosures. If they were the product of his mental illness, there was no s 269 dispute.[111]

[52] After referring to his differing accounts of the killing, Dr van de Hoef noted:

> "… Differing accounts over time are not themselves unusual, as a person may change their account e.g. as their illness improves with treatment. What strikes me as unusual in this case, is that [the first respondent] now appears to have had multiple reasons for doing so, including advice from his parents (i.e. not all are psychotic reasons). At this stage, with so many different versions, I think it will be very difficult to ever know the truth of whether he heard command hallucinations to kill at the time of the attack on his girlfriend.
>
> … I can find no explanation for a psychotic basis for his apparently self-serving account of the 2 masked men, which he concocted at almost the same time as he may have been deprived of all the relevant capacities, and psychotically driven to kill [his girlfriend]. It is also odd, I think, that if he experienced command hallucinations so powerful and overwhelming that he was forced by them to kill, that he did not mention them (and mention them non-selectively) for months, while he held to the bogus account of the masked men."[112]

[53] Dr van de Hoef nevertheless continued to hold the opinion stated in her report of 1 September 2012,[113] that is, that he was of unsound mind at the time of the killing

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104 Above, [111].
105 Above, [112].
106 Above, [113].
107 Above, [114].
108 Above, [115].
109 Above, [117].
110 Above, [118].
111 Above, [119].
112 Above, [120].
113 Above, [121].

because his mental illness completely deprived him of the capacity to know he ought not kill his girlfriend.

Ms Smith's psychological testing

[54] The MHC next considered some psychological evidence, including that of Ms Tamara Smith, who conducted tests to analyse the first respondent's cognitive and personality functioning.[114] The testing revealed that he was not malingering but could exaggerate his symptoms at times.[115] This was probably a product of lack of insight rather than "ineffectual effort of malingering".[116] The testing also indicated that his aggressive behaviour was more likely to be associated with active psychosis. There was no evidence that he was aggressive when free of psychotic symptoms.[117]

Was the first respondent mentally ill at the time of the killing?

[55] After referring to s 267, *Mental Health Act* and the definition of "unsound mind",[118] the MHC noted that there was clear evidence the first respondent was suffering from paranoid schizophrenia at the time of the killing. His illness had been described as treatment resistant. He was medicated from 2005 but never had complete remission of symptoms which included paranoid and grandiose delusions and auditory hallucinations, specifically running commentary hallucinations and sometimes command hallucinations. He also experienced thought broadcasting and telepathic communication and his psychosis was accompanied by significant behavioural disturbance and deterioration in general functioning.[119] He was admitted to PAH just six weeks prior to the killing with a relapse of mental illness for which he was treated by Dr Dark and others. He was experiencing active symptoms of his illness at the time of the killing.

[56] The MHC noted that Dr Dark considered he was clearly psychotic, paranoid and experiencing thought broadcasting at the time of the killing.[120] Dr Coyle and Dr Morris assessed him within weeks of the killing and also considered that he was then clearly psychotic, paranoid, experiencing auditory hallucinations and fearful of revealing the full extent of his thinking as he believed he would put others at risk.[121] The MHC was satisfied that at the time of the killing he was suffering from a state of mental disease, namely, schizophrenia.[122] The more difficult issue was whether he was of unsound mind at that time.[123]

The DPP's submissions as to s 269

[57] The MHC next considered whether there was a s 269 dispute. It noted the DPP's arguments. The true nature of the first respondent's delusional system was a fact which was substantially material to the opinions of Drs Mann, Grant and van de Hoef. He had given varying accounts about the nature and extent of his delusional system. It followed that the true nature of his delusional system was

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114 Above, [122].
115 Above, [123].
116 Above, [124].
117 Above, [125].
118 Above, [126].
119 Above, [127].
120 Above, [128].
121 Above, [129].
122 Above, [130].
123 Above, [130].

a substantially material fact in dispute and in accordance with s 269 it was unsafe for the MHC to decide whether he was of unsound mind.[124] The psychiatric opinions supporting a finding of unsoundness of mind were based on the premise that his account was credible and reliable. There was conflicting evidence about his delusional belief system so that there was a reason to doubt the reliability of his present account.[125] The DPP argued that the resolution of this factual dispute was not for expert psychiatrists or the MHC but for a jury in a criminal trial. As there was a dispute about a material fact, the MHC must not make a decision as to unsoundness of mind; this was for a jury.[126] The DPP argued that there was conflicting evidence from which different inferences could be drawn and were reasons to doubt the reliability of his account.[127] The role of the MHC was to resolve differences of opinion between psychiatrists relating to diagnosis and the level of diminution or deprivation of capacity, not to resolve disputes as to whether a particular factual situation existed at the time of the killing.[128]

[58] The DPP also submitted that it was open on the evidence to conclude that his delusional belief system had only evolved since the murder to include a belief that he was compelled to kill[129] and that this conclusion was supported by the following. He initially gave an elaborate false and non-psychotic account of the killing which he maintained through intensive police questioning and sleep deprivation. The accounts on which the reporting psychiatrists now based their opinions did not emerge for about 14 months. His version to Drs Mann and Grant was given at a time and in circumstances which cast doubt on its reliability. Dr Dark, the first respondent's experienced clinician, assessed him shortly after the killing and did not detect an acute psychosis. He was hospitalised due to a psychotic exacerbation prior to the killing but he did not reveal thoughts to kill or the complex delusional belief system he first described about 14 months after the killing. He had a significant degree of personality disturbance which could give a non-psychotic explanation for the killing. He had a demonstrated ability to relate symptoms to his advantage. He had recanted some details of the versions on which the reporting psychiatrists relied.[130]

The advice of assisting psychiatrist Dr E N McVie

[59] The MHC next discussed the advice of the assisting psychiatrist, Dr E N McVie. Dr McVie advised that the first respondent suffered from a severe chronic schizophrenic illness, possibly from age 15. Symptoms included auditory hallucinations, bizarre and persecutory delusions, and odd beliefs.[131] In 2008, the MHC found him of unsound mind in respect of charges including robbery with violence and deprivation of liberty and he was placed on a Forensic Order which was managed by PAH and revoked in August 2009.[132] Dr McVie referred to Dr Dark's assessment the day after the killing and Dr Morris's assessment in April 2010 during which he noted psychotic symptoms and recorded that the first respondent told him that his girlfriend had to die because of something she knew.

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124 Above, [142].
125 Above, [143].
126 Above, [147].
127 Above, [148].
128 Above, [149].
129 Above, [150].
130 Above, [151].
131 Above, [158].
132 Above, [159].

This was evidence of a possible psychotic reason for the killing.[133] His false account and his self-inflicted injury were unusual as was his maintenance of the false story for over 12 months. All current, updated psychiatric reports, however, provided him with a defence of unsoundness of mind based on his psychosis and all considered that he was deprived of the capacity to know that he ought not to have killed his girlfriend.[134]

[60] Dr McVie advised that Dr van de Hoef's opinion was the most considered. She concluded he was of unsound mind even though she could find no psychotic basis for his false story. Although he had given various accounts of his reasons for killing his girlfriend (acting on command hallucinations, acting on orders of the computer god, and having to respond to what the god told him to do) these accounts varied with his level of psychosis.[135] There was no real s 269 dispute as all reporting psychiatrists agreed he had a serious illness and his versions and his identifications of symptoms varied with the levels of his psychosis and his insight. Even when relatively well and with only background psychotic symptoms, he had almost no insight into the nature of his symptoms and tended to discount them or considered them to be from something other than his psychotic illness. His lack of insight was probably a factor which stopped him giving a clear account of his thinking at the time of the killing.[136] His accounts as to what happened and his symptoms at the time of the killing had been affected by time and the subsequent deterioration in his illness.[137] Dr McVie advised the MHC to accept the clear opinions of all reporting psychiatrists that he was suffering from a psychotic illness sufficiently severe to deprive him of the capacity to know that he ought not choke his girlfriend at the time of the killing.[138]

The advice of assisting psychiatrist Dr Varghese

[61] Dr Varghese also gave advice to the MHC. He considered there was no dispute between the psychiatrists, psychologists and clinicians in relation to the diagnosis of schizophrenia. The first respondent had a long history of schizophrenia, predominantly with paranoid and grandiose delusions and also auditory hallucinations, sometimes including running commentary hallucinations and command hallucinations. He also reported thought broadcasting, thought alienation, telepathic communication and thought insertion. His psychosis was accompanied by significant behavioural disturbance, deterioration in academic performance and general functioning, and affective blunting.[139] His schizophrenia had been described as treatment resistant. His psychosis fluctuated but he was never in full remission for any substantial, sustained period.[140] His psychosis had been accompanied by an urge to violence and killing. His 2007 criminal charges arose out of his response to delusional thinking and auditory hallucinations.

[62] On the available information, it was not possible for Dr Varghese to say whether his desire to kill was independent of his psychosis and indicative of psychopathy.[141]

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133 Above, [160].
134 Above, [161].
135 Above, [162].
136 Above, [163].
137 Above, [164].
138 Above, [166].
139 Above, [167].
140 Above, [169].
141 Above, [170].

His personality disorder, whilst irrelevant to his diagnosis of schizophrenia, may be relevant to his response to psychotic symptoms. It may explain why he would conceal those symptoms and deceive others. His personality issues may also be relevant to treatment and risk.[142] He was not especially concerned about his urge to kill and did not complain or seek amelioration of this symptom. This may indicate a degree of psychopathy but it may also explain why he did not tell others, including psychiatrists, about the phenomena he was experiencing at the time of the killing. He was clever enough to know the consequences of revealing such disturbing psychotic phenomena.[143] His significant degree of personality disturbance with grafted psychosis was a dangerous combination.[144]

[63] Dr Varghese accepted the evidence of Drs Mann and Grant and concluded that at the time of the killing the first respondent was suffering from delusions within a complex delusional system as well as from other psychotic symptoms. This deprived him of the capacity to know the wrongness of the killing and perhaps the mental component of control. That would also be so if the symptoms described to Dr van de Hoef were present at the time of the killing. Dr Varghese considered it was unlikely he concocted his reported psychosis at the time of the killing. His described symptoms were very typical of schizophrenia and were not concocted unless he was well read in the phenomenology of schizophrenia.[145]

[64] Dr Varghese advised that Dr Dark's evidence was central as she saw him shortly after the killing and had been treating him for some time. She accepted that he had psychotic symptoms during this period, although she did not notice them around the time of the killing. Whilst the opinion of a treating psychiatrist was valuable, it was not always the most reliable, given the nature of the relationship. This was particularly so where, as here, it involved psychotherapy which places the discussion between doctor and patient on a different plane to a standard psychiatric evaluation. It was significant that Dr Dark was unaware of the psychotic phenomena that may have been operating at the time of the killing. It followed that she was not in a position to explore those phenomena or the homicidal urges. It was not uncommon, however, for delusional patients to keep their core phenomena from treating psychiatrists. This may be because the phenomena are too horrendous and difficult to discuss or because the patient is aware that the consequences of revealing them may be enforced treatment, hospital admission and thwarting of their actions stemming from delusions.[146] His consultations with Dr Dark were not forensic interviews involving a high degree of scepticism about his version of events. In any case, Dr Dark had since changed her opinion and now considered that he was probably psychotic at the time and deprived of capacity.[147]

[65] Dr Varghese advised that he was suffering a mental disease and was psychotic at the time of the killing with the delusions and other phenomena described by Drs Mann, Grant and van de Hoef. He was deprived of the capacity of the mental component of control in that he was overwhelmed by delusional thinking and perhaps other phenomena which may have included the delusion-like idea that the killing was

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142 Above, [172].
143 Above, [173].
144 Above, [174].
145 Above, [175]-[176].
146 Above, [178].
147 Above, [179].

consensual.[148] He was aware of the wrongness of the killing but did not consider it wrong within his delusional system.[149]

[66] The case, Dr Varghese advised, did not raise a s 269 dispute as to whether the killing was a response to command hallucinations. He agreed with the evaluating psychiatrists' response as to why he gave differing accounts. There may have been an over-emphasis on command auditory hallucinations as an explanation for the killing, but this was an over-simplification. A schizophrenic does not respond to command hallucinations because they are commands but because the commands have particular delusional meanings. The delusional system dominating his thinking as described in the psychiatrists' reports was the critical thing, not the command auditory hallucinations. His deprivation of capacity at the time of the killing arose from an elaborate delusional belief system that killing his girlfriend served some higher delusional purpose. He may have believed the killing was consensual, rather than a response to a command. He knew his actions were contrary to law and subsequently sought to blame the killing on others and conceal his role. But on the clinical evidence available, his actions in killing his girlfriend were determined by a delusional system which, for a time, he concealed. On Dr Grant's clinical evidence, he expected something extraordinary to happen as a result of the killing. When that did not occur, he tried to conceal his role. Dr Varghese's advice was that he was of unsound mind with deprivation of the capacity for knowing the wrongness of the act and perhaps also "of the capacity for the mental point of control".[150]

MHC's conclusion

[67] The MHC next considered whether a s 269 dispute existed, referring to the principles discussed in *R v Schafferius*.[151] The finding of unsoundness of mind should only be made on clear and convincing evidence. Often the precise details of an alleged crime are critical to the assessment of the alleged offender's mental condition at the relevant time. If those details are disputed, they must be resolved by adversarial scrutiny in a criminal trial before a jury.[152] Resolving the question as to whether facts were so in dispute as to fall within s 269 was a question for the MHC. In *Schafferius*, the Court of Criminal Appeal held that Schafferius' account of his state of mind at the material time was not a circumstance which obliged the MHT to refrain from determining the question of unsoundness of mind.[153]

[68] The first respondent accepted he did the acts which killed his girlfriend. The issue was whether his mental illness actually deprived him of the capacity to either understand what he was doing, to control his actions or to know he ought not do the act which caused her death.[154] He experienced a complex delusional system which he had explained to all reporting psychiatrists, some more fully than others. His false account to police and to at least three psychiatrists, as Dr Varghese advised and consistent with Dr Grant's opinion, did not mean he was not deprived of his relevant capacities. A concocted story is not uncommon in psychotic crimes where there is some awareness of the illegality of the actions but an absence of moral capacity.[155]

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148 Above, [180].
149 Above, [181].
150 Above, [182].
151 [1987] 1 Qd R 381, 381-384.
152 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [184]-[185].
153 Above, [186].
154 Above, [187].
155 Above, [188]-[191].

[69] All the reporting and assisting psychiatrists agreed that his symptoms included auditory hallucinations and he had limited insight into them. Psychologist Tamara Smith assessed him as not completely open with health professionals and there was other clear evidence that at times he concealed his delusional system.[156] Contemporaneous reports showed he was keeping the full extent of his symptoms and thinking secret for fear he would put others at risk. Significantly, this concealment had a psychotic basis. Psychosis was present when he was interviewed by Dr Dark on 1 April 2010,[157] Dr Coyle on 9 April 2010,[158] and Dr Morris on 20 April 2010 when he refused to reveal the extent of his conversations with his girlfriend for fear of putting others at risk.[159] He also consistently indicated that she was killed because of what he told her. This provided clear, contemporaneous and documented evidence that he was suffering from significant psychotic symptoms at the time of the killing.[160]

[70] The following passages from the MHC decision are central to this appeal:

> "[194] Despite [his] false account of unknown assailants there is also very clear evidence that [he] indicated from the outset that [his girlfriend] had died because of what he had told her. There is also consistent, contemporaneous evidence that [he] was having a lot of telepathic conversations with [his girlfriend] during the afternoon and evening of the murder. [He] also clearly indicated at the time that he was experiencing thought insertion and telepathic communications.
>
> [195] I also note that the PAH notes on 6 April 2010 include three entries of particular relevance. It is not possible, however, to ascertain in what order they were made. There is a ward round notation made by Drs Foley/Mobsby on that day indicating that his 'voices are different from usual' and include a note recording that [he] 'felt something was going to happen'. The note continues:
> 'Pt has a theory about cause of [his girlfriend's] death - says he told her certain valuable information that got her killed. Says he can't tell treating team because it could endanger our lives. Told [his girlfriend] this information just before she died, thinking this information might help her and pt. Pt says its possible that this info is suspicious and sinister. Pt states his voices are the same as usual - occur most of the day and not particularly distressing. Feels that TV and radio are telling him what to do. Denies passivity phenomena.'"

[71] Next, the MHC referred to another entry in his medical records of 6 April 2010 that he "has indicated the possibility that he has killed his girlfriend during interviews with psychiatric staff today and has indicated suicidal thinking during these interviews".[161] The nursing notes of 18 April 2010 recorded that he "enquired whether it was possible for another person to control his thoughts and actions

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156 Above, [192].
157 Discussed at [27] of these reasons.
158 Discussed at [28] of these reasons.
159 Discussed at [29] of these reasons.
160 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [193].
161 Above, [196].

though would not elaborate on specifics". Dr Morris saw him on 20 April 2010 and considered that he was suffering from paranoid delusions. He stated that the "doctors are working for the police".[162] The MHC was therefore satisfied that there was clear evidence that his psychotic thinking at the time of the killing was the reason why he killed his girlfriend.[163]

[72] He did not reveal the full account of his role in the killing for about 14 months[164] as his paranoid and psychotic thinking led him to conceal his full delusional state. He and medical staff were specifically instructed not to discuss the events of the killing or his thinking around that time. This is evidenced by medical records of 6 and 22 April 2010 and Dr Morris's report.[165] He was also afraid to disclose his thinking because of possible consequences to others. There was no follow-up of his 6 April 2010 revelation that he thought he may have killed his girlfriend.[166] In all these circumstances, it is not surprising that it took some time for him to reveal his true delusional state at the time of the killing, especially as it took time for his illness to respond to treatment.[167]

[73] The DPP emphasised that Dr Dark's psychiatric assessment shortly after the killing failed to detect acute psychosis. The MHC, however, accepted Dr Varghese's advice that this assessment did not have the scepticism of a forensic assessment. In any case, Dr Dark now believed he did not share the full extent of his psychotic phenomena at the time of the killing due to his mental illness.[168] All reporting psychiatrists who examined him in April 2010 advised that he then had a serious illness with varying symptoms depending on the level of his psychosis and insight. The MHC also accepted Dr McVie's advice that his various and inconsistent accounts were related to his illness, his symptoms, his identification of those symptoms, his level of psychosis and his level of insight.[169]

[74] The DPP also emphasised that he did not reveal his thoughts to kill prior to the killing. But all reporting psychiatrists found that, whilst he was psychotic at the time of the killing, it was not possible to fully access his thinking when he was acutely unwell. Further, he was fearful of revealing his thinking as he believed that this would cause people to be killed. Significantly, he indicated to others that his girlfriend was killed because of something he had told her.[170]

[75] Only the presence of clear command hallucinations at the time of the killing, the DPP argued, created a clear nexus between his thoughts and his lethal actions; a doubt about the presence of command hallucinations raised a fundamental dispute under s 269.[171] But the MHC again referred to Dr Grant's opinion that this view was simplistic and that auditory command hallucinations were only one aspect of his very complex psychotic mental state. Indeed, Dr Varghese considered auditory command hallucinations immaterial once it was accepted that he was in the concealed delusional state described by the evaluating psychiatrists.[172] His failure

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162 Above, [197].
163 Above, [198].
164 Above, [199].
165 Above, [200].
166 Above, [201].
167 Above, [202].
168 Above, [203].
169 Above, [204].
170 Above, [205].
171 Above, [206].
172 Above, [207]-[209].

to give an account of command hallucinations, of his thoughts to kill or of his delusional thinking due to his paranoid and psychotic state, did not amount to a dispute under s 269 when there was clear evidence of his psychotic thinking and its link to the killing.[173]

[76] There was insufficient evidence to support the DPP's assertion that he exhibited a significant degree of personality disturbance which could give a non-psychotic explanation for the murder, particularly in light of Dr Dark's contrary opinion. The MHC accepted the evidence that there was a psychotic explanation for the killing.[174]

[77] Whilst the DPP argued that he had an ability to relate symptoms to his advantage, the MHC rejected it as the evidence was that he concealed his symptoms and objective assessment of him did not support that contention.[175]

[78] The DPP emphasised that he had resiled from aspects of his version of the killing on which the reporting psychiatrists relied. But the MHC noted that, whilst he told Dr Voita in November 2012 that he believed it was his own thoughts telling him to kill his girlfriend, she considered that he was then thought disordered and that this became more obvious as the interview progressed.[176] Dr Voita was confident he made these statements in the context of his deteriorating mental health, developing depressive illness and poor insight into his psychotic illness. It showed his difficulty in expressing and explaining his psychotic symptoms when he was unwell. She was firmly of the view that there was no s 269 dispute.[177]

[79] The MHC found that there was no fact substantially material to the opinion of an expert which was so in dispute as to preclude it under s 269 from deciding the reference. There was clear evidence that the first respondent was in a concealed delusional state at the time of the killing so that there was no dispute about that fact.[178] Although he was inconsistent in revealing his delusional state at the time of the killing, this was because of his mental illness and related variations in his paranoia and insight.[179] No reporting psychiatrist considered there was any disputed fact under s 269.[180] The clear evidence was that he killed his girlfriend whilst experiencing delusions and other phenomena within a complex delusional system which overwhelmed his thinking. He considered the killing served a higher delusional purpose.[181]

[80] The MHC was satisfied that he was deprived of the capacity to know that he ought not do the acts which killed his girlfriend; within his delusional system, it was not wrong to do so as he believed she had consented. He was deprived of the relevant capacity due to his mental illness; it was not simply a case of his illness being sufficient to deprive him of that capacity.[182] He was, therefore, of unsound mind at the time of the killing.[183]

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173 Above, [210].
174 Above, [211].
175 Above, [212].
176 Above, [213].
177 Above, [214].
178 Above, [215].
179 Above, [216].
180 Above, [217].
181 Above, [218].
182 Above, [219].
183 Above, [220].

Did the MHC err in concluding under s 269 Mental Health Act that there was no fact substantially material to the opinion of an expert witness that was so in dispute it would be unsafe to make a decision on the reference?

[81] The first three grounds of this appeal[184] are interconnected and, to a significant degree, overlap. They should be discussed together.

The appellant's contentions

[82] The appellant's principal contention in this appeal is that the MHC erred in concluding under s 269 *Mental Health Act* that there was no fact substantially material to the opinion of an expert witness that was so in dispute it would be unsafe to make a decision on the reference. The only evidence that the first respondent acted under a delusional belief system when he killed his girlfriend came from his account to psychiatrists about 14 months after the killing. In deciding that he was of unsound mind, the MHC accepted the accuracy of this account.

[83] Dr Mann, however, agreed in cross-examination that the first respondent could have concocted his account and may have killed his girlfriend for non-psychotic reasons.[185] Dr Mann was unsure what was going on in his mind.[186] Further, Dr van de Hoef in her report of 23 January 2013 noted that his different versions made it very difficult to know the truth of whether he heard command hallucinations to kill at the time of the killing.[187] Dr Grant based his opinion on the assumption that he was truthful about his thoughts and actions at the time of the killing.[188] Dr Varghese identified the central factual question as being whether his psychosis was present at the time of the killing, developed later or was a concoction.[189] As the DPP raised the s 269 issue, it was wrong for the MHC to conclude that there was no dispute about him being in a concealed delusional state at the time of the killing.

[84] A contrary inference could be drawn from the following. Dr Dark, his treating psychiatrist, examined him shortly after the killing. She detected no signs of a systematised delusional belief system. She thought it possible though unlikely that he concealed this. The SMS messages he sent before the killing did not disclose an apparent psychosis. He had no signs of florid psychosis during extensive police questioning and maintained a contemporaneous, elaborate and false account of the killing even when sleep deprived. Dr Grant accepted in cross-examination that these were reasons to be sceptical about his later account of the killing. Dr Dark,[190] Dr van de Hoef[191] and Dr McVie[192] all noted that concocting and maintaining a false story for such a lengthy period was most unusual for someone with mental illness. A false account was consistent with an attempt to avoid responsibility. His mental state deteriorated after the killing and he was still unwell when he first gave the critical account raising unsoundness of mind at the time of the killing so that this account may have been unreliable and based on delusions arising after, not before, the killing. He later recanted some of that account by saying it was his own thoughts, not god, which instructed him to kill; he

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184 Set out in [3] of these reasons.
185 T1-80, lines 20-30, AB 93.
186 AB 362-363.
187 At p 3 of the report, AB 396.
188 T3-60, AB 179.
189 T1-8, AB282.
190 T3-17, AB 136.
191 T4-40 line 57; T4-41 line 20, AB 235-236.
192 T1-4, AB 278.

fantasised about the killing beforehand; he may not have given accurate accounts to psychiatrists and may have overplayed his mental illness and symptoms to obtain a mental health defence. These matters, the appellant contended, put in issue the accuracy of his critical account that he acted under a delusional belief system at the time of the killing. The MHC should have found that there was a dispute about that fact so that s 269 required it to be determined by a jury in a criminal trial.

[85] In accepting the evidence that he killed his girlfriend whilst in a concealed delusional state and that there was a psychotic explanation for the killing, the MHC necessarily accepted the accuracy of his account of the killing. Contrary to s 269, it took on the fact finding role of a jury. It impermissibly resolved that question of fact when contrary inferences were open. He may have given a false account to conceal that he had killed his girlfriend whilst of sound mind or his delusional system may have developed only after the killing. The MHC relied on the fact that he stated, shortly after the killing, that his girlfriend had been killed because of something he told her and that he would not disclose it to the doctors for fear that they would be put at risk, when no psychiatrist placed material emphasis on this.

[86] Under s 405 *Mental Health Act*[193] there is no onus of proof and ordinarily the standard of decision-making is on the balance of probabilities. The appellant criticised the MHC for examining and then discounting each issue raised by the DPP at [189] to [213] of its reasons[194] and especially emphasised the observations of Dr van de Hoef in her final report discussed by the MHC at [120] of its reasons.[195] The MHC effectively placed the onus of proof on the DPP.

Conclusion on these grounds of appeal

[87] The resolution of these contentions requires an analysis of relevant parts of the *Mental Health Act* applying to the MHC and the MHC's reasons. The *Mental Health Act* provides that, in many referred cases, the MHC rather than a jury under the *Criminal Code*[196] will determine whether those charged with indictable offences are of unsound mind at the time of the commission of the alleged offences. The relevant aspects of the second reading speeches and the scheme of the *Mental Health Act* discussed in [7] to [16] of these reasons make clear that the MHC is to be assisted by expert advising psychiatrists in assessing often complex psychiatric evidence and in determining sometimes difficult references. The *Mental Health Act* provides, however, that where under s 268(1) there is a reasonable doubt that the referred person committed the alleged offence,[197] or where under s 269[198] the MHC is satisfied a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe to make the decision, those issues must be decided by a jury.

[88] In *R v Schafferius*[199] the Court of Criminal Appeal dismissed an appeal from the decision of the MHC's predecessor, the MHT, finding Schafferius to be of unsound mind at the time of the alleged offence. It observed that the MHT should make:

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193 Discussed at [16] of these reasons.
194 Discussed at [67]-[73] of these reasons.
195 Discussed at [51]-[52] these reasons.
196 *Mental Health Act*, s 5(c), ch 7 and ch 11.
197 Unless under s 268(2) that doubt exists only as a consequence of the person's mental condition (as discussed at [13] of these reasons).
198 Set out at [14] of these reasons.
199 [1987] 1 Qd R 381.

> "a finding only in clear cases, and that it is not intended to be a substitute for a criminal trial, although in appropriate cases it will render a criminal trial unnecessary. Quite often the precise details of the alleged crime will be critical to the assessment of the alleged offender's mental condition at the relevant time, and if those details are in any way in dispute the only way to resolve them is by the adversarial scrutiny of a criminal trial before a jury."[200]

[89] This Court noted, however, in *R v Kamali*[201] that those observations as to the role of the MHT "should not be read as excluding a finding [of unsoundness of mind] in all but the clearest of cases".[202]

[90] It remains the position under the scheme established by the *Mental Health Act* that where there is a reasonable doubt that the person committed the alleged offence (s 268), or where the court is satisfied a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe the make the decision (s 269), those disputes must be resolved by the adversarial scrutiny of a criminal trial before a jury. See this Court's observations in *McDermott v Director of Mental Health; ex parte Attorney-General (Queensland)*.[203]

[91] In the present case there was no question that the first respondent killed his girlfriend by choking her. The issue was whether he was of unsound mind at the time. That question involved a consideration of whether his state of mental disease at the time of the killing actually deprived him of one of the relevant capacities under s 27 *Criminal Code*[204] in that there was an actual nexus between his mental disease and the killing: *Attorney-General (Queensland) v Bosanquet & Ors*,[205] adopting Dowsett J's dicta in *Re W*.[206]

[92] Critical to that issue was whether the first respondent was acting under a concealed delusional state at the time of the killing. This is a matter which concerned events at the time of the killing and was relevant to his past and present psychiatric treatment, so that it was a substantially material fact under s 269(2). The accuracy of his critical account was certainly material to the various psychiatric opinions and was disputed by the DPP. The MHC was required to determine under s 269(1) whether that fact was *so* in dispute that it was unsafe for it to decide the reference. The mere fact that a party has challenged the accuracy of a substantial material fact does not mean that under s 269 the MHC must not decide the question of unsoundness of mind. The determination of whether the fact was so in dispute it would be unsafe to make the decision was a matter of judgment and an assessment of degree for the MHC[207] after reviewing the relevant evidence and advice of the assisting psychiatrists and considering the submissions of the parties.

[93] My earlier summary of the MHC's comprehensive reasons demonstrates that it conscientiously undertook this task. It fully reviewed the evidence and considered the myriad matters which the appellant contended made determining the reference unsafe, and then gave reasons for rejecting those contentions.

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200 Above, Andrews CJ 381, Thomas J 383, Ryan J 384.
201 (1999) 106 A Crim R 269.
202 Above, 273, [9].
203 [2007] QCA 51, Williams JA [7], Jerrard JA [70], Fryberg J [84].
204 Set out at [12] of these reasons.
205 [2012] QCA 367, [1], [2], [39], [40].
206 Unreported, Mental Health Tribunal, Dowsett J, 14 October 1997.
207 Cf *Schafferius*, 384.

[94] The first respondent had a long history of schizophrenia prior to the killing and had previously been subject to an MHC forensic order after being found of unsound mind in relation to the commission of earlier alleged offences. Whilst Dr Mann agreed in cross-examination that the first respondent may have concocted his account of the killing, he did not believe he did.[208] It is also true that in January 2013 Dr Van de Hoef thought it was very difficult to know the truth of whether he had command hallucinations at the time of the killing. But, after considering all the relevant material, she clearly accepted he did because she re-affirmed her opinion that he was of unsound mind at the time of the killing as he was deprived of the capacity to know he ought not do the acts resulting in his girlfriend's death.[209] No doubt psychiatrists often have to make difficult assessments of this kind in diagnosing and treating mental illness.

[95] It is also true that Dr Grant accepted in cross-examination that his opinion was based on the assumption that the critical account was truthful. Indeed, I apprehend each examining psychiatrist would have responded in similar vein, if asked. But Dr Grant noted that it was not uncommon for someone with psychiatric symptoms to give a false story. He clearly accepted the accuracy of the critical account and remained firmly of the opinion that the first respondent was of unsound mind at the time of the killing.[210]

[96] Drs Dark, Voita, Grant, van de Hoef and Mann each examined the first respondent and gave detailed reports and evidence to the MHC explaining why, despite all the concerning matters relied on by the DPP at first instance and the appellant now, each concluded that he was of unsound mind at the time of the killing. The two psychiatrists assisting the MHC also reached that conclusion. Tellingly, not one psychiatrist who gave evidence before or advised the MHC ultimately dissented from that conclusion.

[97] All psychiatrists accepted that Dr Dark's failure to detect psychotic symptoms during consultations prior to and shortly after the killing was explicable by her therapeutic rather than forensic relationship with the first respondent; he was probably concealing his delusional homicidal ideation. This concealment also explained why his parents did not notice psychotic symptoms around the time of the killing. Dr McVie in her advice explained that his various accounts and the inconsistencies in them were related to the nature of his illness and the variable intensity of his symptoms, including his level of psychosis and insight. Dr Varghese advised that he was unlikely to be concocting the critical account. His described symptoms were very typical of schizophrenia, although with highly individualistic elements. Whilst he did recant some of the critical account, he did so when his mental state was deteriorating, he was developing a depressive illness and had poor insight.

[98] Determining whether to act upon the self-reported symptoms, thoughts and actions of a mentally ill person charged with a criminal offence is a matter within the expertise of an examining psychiatrist. Although the MHC was not compelled to accept the critical account as truthful, it was significant that not one of the seven psychiatrists who gave opinions and advice to the MHC considered he had

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208 Report, 2 June 2011, pp 15-16, AB 362-363.

209 Page 4 of her report (AB 396) and her report of 1 September 2012, p 5 (AB 391), re-affirmed in her report of 23 January 2013.

210 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [4], [75]-[87], discussed in these reasons at [43]-[46].

concocted it. It is also relevant that there was no evidence of any rational motive for the killing and that the psychological evidence did not suggest he was malingering or that he was ordinarily aggressive when free of psychotic symptoms.[211]

[99] The unanimous body of expert evidence before and advice to the MHC, which it carefully reviewed and analysed in light of the DPP's submissions, was to the effect that he was acting under a concealed delusional state when he killed his girlfriend. All psychiatrists accepted the accuracy of his critical account and its effect on him, despite their awareness of the reasons to doubt it which the DPP emphasised. All were confident that he probably acted under this concealed delusional belief system at the time of the killing. They remained of that view even though some frankly conceded the possibility that his account may be untruthful; that he did not disclose it until about 14 months after the killing; and that he later recanted parts of it whilst unwell. As the MHC explained, the psychiatrists in their evidence and advice considered that these concerning features were all attributable to his complex and varied mental health issues and ultimately did not alter the conclusion that he was of unsound mind at the time of the killing. There was no contrary evidence.

[100] The uncontradicted expert psychiatric evidence and advice ultimately accepted the critical account as probably accurate. Neither the fact that the DPP contended it was inaccurate nor the matters the DPP relied on in support of that contention compelled the MHC to find under s 269 that the critical account was *so* in dispute it was unsafe to decide the reference.

[101] In support of its finding of unsoundness of mind, the MHC noted that, shortly after the killing, the first respondent stated that his girlfriend had been killed because of something he told her and that he would not disclose this to the doctors for fear they would also be put at risk. The appellant argued that this was an error as it was not a matter relied on by the examining or advising psychiatrists. But the omission of psychiatrists to refer to it did not preclude the MHC from considering it as a matter which broadly supported the psychiatric opinions and advice that he was probably acting under a concealed delusional belief system when he killed his girlfriend.

[102] The appellant's criticism of the MHC's careful discussion of the DPP's submissions[212] is misconceived. The MHC did not commence by accepting as accurate the first respondent's account. It carefully considered and for sound reasons rejected each of the DPP's submissions. It considered and accepted the evidence of the treating psychiatrists and the advice of Drs McVie and Varghese, who all necessarily had regard to and on balance accepted the first respondent's critical account.

[103] The concerns of Dr van de Hoef upon which the appellant places particular reliance[213] arose out of a consultation between the first respondent and Dr Voita on 7 November 2012.[214] Dr Voita noted that his mental state had deteriorated and he was noticeably thought disordered and preoccupied with the killing.[215] Neither Dr Voita, Dr van de Hoef nor any other psychiatrist placed weight on his changed

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211 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [124]-[125]; discussed in these reasons at [54].

212 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [189]-[213]; discussed at [67]-[73] of these reasons.

213 Discussed in *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [115]-[121] and [51]-[53] of these reasons.

214 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [62] discussed in these reasons at [36].

215 AB 436.

account of the killing on 7 November as he was very unwell at that time. The MHC understandably accepted that evidence and reached the same conclusion. In doing so, it did not place any onus on the DPP.

[104] The MHC construed s 269 in an orthodox manner according to its terms. It carefully reviewed the psychiatric and other evidence, the DPP's submissions and the advice of Drs McVie and Varghese. It concluded that, in terms of s 269(1), the fact that the first respondent was acting under a concealed delusional state at the time of the killing was not "so in dispute it would be unsafe to" determine the reference. There was ample evidence to enable the MHC to reach that conclusion to the appropriate degree of satisfaction.[216]

[105] Grounds of appeal 1 – 3 are not made out.

Did the MHC err in [194] of its reasons?

[106] The appellant contends that the MHC's finding in its reasons at [194][217] that "there is also consistent, contemporaneous evidence that [the first respondent] was having a lot of telepathic conversations with [his girlfriend] during the afternoon and evening of the [killing]" was an error, as there was no such contemporaneous evidence. As counsel for the first respondent in this appeal rightly concedes, this was a factual error: evidence of that kind was not contemporaneous but came only from the first respondent's accounts to psychiatrists after the killing.

[107] This was, however, a minor point in the MHC's overall reasoning. The impressive body of uncontradicted psychiatric evidence and advice supporting the conclusion that, at the time of the killing, the first respondent was of unsound mind, meant that this was the only conclusion reasonably open to the MHC on the evidence. This minor factual error was immaterial to the MHC's ultimate decision. This ground of appeal is not made out.

Did the MHC err in [198] of its reasons?

[108] The appellant contends that the MHC erred in [198] [218] of its reasons in finding that there was clear evidence of the extent of the first respondent's psychotic thinking at the time of the killing and that this was the reason for the killing. In doing so, the MHC relied on the PAH notes of 6 April 2010, about a week after the killing, which recorded that the "voices are different from usual".[219] This statement indicated that the change to his thinking occurred after the killing. Further, the appellant contends, the evidence before the MHC contradicted the assertion in [196] of its reasons[220] that he had "indicated the possibility that he has killed his girlfriend". The hospital records in full context included:

> "Says [his girlfriend] did have some enemies. These enemies may have hurt her. Says he cared for her but he felt something was going to happen. He is scared [her] ex-boyfriend will bash him. Says [she] was still married which was a strain.
>
> Pt says his voices are different from usual – forcing him to reflect a lot over recent events. This began day after [the] death. …

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216 Cf *R v Schafferius* [1987] Qd R 381, 384.

217 Set out at [70] of these reasons.

218 Discussed at [71] of these reasons.

219 See *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013,, [195], set out at [70] of these reasons.

220 Discussed at [71] of these reasons.

> Pt says he felt bad or that he feels bad that he didn't do more to save [his girlfriend]. Denies being knocked unconscious. Felt too scared to do anything against a number of people. Didn't see attackers or what was happening with [his girlfriend]."[221]

[109] The appellant contends that this makes clear his reported change to the voices occurred after the killing and that any sense of foreboding that "something was going to happen" was not indicative of psychotic thinking prior to the killing. Further, the MHC at [196][222] and [201][223] wrongly referred to his early revelation that he may have killed his girlfriend when the statements of Drs Conlan[224] and Mobsby[225] made clear that this was merely the opinion Dr Mobsby expressed to Dr Conlan; the first respondent did not say this. No reporting or assisting psychiatrist placed weight on these matters, yet the MHC relied on them in reaching its conclusion in [198]. These errors, the appellant contends, are matters of substance affecting the MHC's decision.

[110] It does seem the MHC may have overstated the effect of Dr Mobsby's account in that the mentally ill first respondent did not clearly state in terms on 6 April 2010 that he may have killed his girlfriend. Rather, Dr Mobsby seems to have inferred this as a possibility from the first respondent's statements recorded in the hospital notes.[226] It also seems, as the appellant contends, that the unusual voices to which the first respondent referred on 6 April 2010 probably commenced the day after the killing.

[111] Even so, he was suffering from paranoid schizophrenia at the time of the killing. Not long after, he said his girlfriend died because of what he told her and he could not tell his doctors about this as it could endanger their lives. These matters support his later critical account to Dr Mann. The MHC was entitled to place weight on these matters even if the psychiatrists did not directly refer to them in their reports or in evidence. Further, as the MHC explained, on 18 April 2010, a few weeks after the killing, he asked if it was possible for someone to control his thoughts and actions. And on 20 April 2010, Dr Morris considered that he was suffering from paranoid delusions and experiencing auditory hallucinations.[227] These were matters also consistent with and supporting the accuracy of his later critical account to Dr Mann. For these reasons, but especially because of the unanimous views of the reporting and assisting psychiatrists, these minor mis-statements of fact could not have affected the MHC's conclusion that the first respondent's psychotic thinking at the time of the killing was clearly linked to and was the reason for his girlfriend's death so that he was of unsound mind at the time of the killing.

[112] It follows that this ground of appeal is not made out.

Conclusion

[113] As none of the appellant's grounds of appeal is made out, the appeal must be dismissed.

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221 AB 1201-1202.

222 Noted at [71] of these reasons.

223 Noted at [72] of these reasons.

224 AB 690-691.

225 AB 722-725.

226 *Re A*, unreported, Ann Lyons J, Mental Health Court No 0185/11, 15 May 2013, [195]; set out at [70] of these reasons and see AB 1203.

227 See [35]-[37] of the MHC's reasons noted at [29] of these reasons, and see [197] of the MHC's reasons noted at [71] of these reasons.

[114] **MORRISON JA:** I have read the reasons of the President and agree with her Honour that the appeal should be dismissed.

[115] **MULLINS J:** I agree with the President.