SUPREME COURT OF QUEENSLAND

CITATION:	*Gonot v Director of Public Prosecutions & Anor* [2017] QCA 3
PARTIES:	**ISMAEL MARIA DESIRE GONOT** (appellant) **v** **DIRECTOR OF PUBLIC PROSECUTIONS** (first respondent) **DIRECTOR OF MENTAL HEALTH** (second respondent)
FILE NO/S:	Appeal No 2620 of 2016 MHC No 163 of 2013
DIVISION:	Court of Appeal
PROCEEDING:	Appeal from the Mental Health Court
ORIGINATING COURT:	Mental Health Court at Brisbane – [2016] QMHC 1
DELIVERED ON:	3 February 2017
DELIVERED AT:	Brisbane
HEARING DATE:	2 August 2016
JUDGES:	Gotterson and Morrison and Philippides JJA Separate reasons for judgment of each member of the Court, each concurring as to the orders made
ORDER:	**Appeal dismissed.**
CATCHWORDS:	APPEAL AND NEW TRIAL – APPEAL – GENERAL PRINCIPLES – RIGHT OF APPEAL – NATURE OF RIGHT – APPEALS IN THE STRICT SENSE AND APPEALS BY WAY OF REHEARING – APPEALS IN THE STRICT SENSE – where the appellant was charged with arson and attempted murder – where the matter of the appellant's mental state was referred to the Mental Health Court – where the Mental Health Court determined that the appellant was not of unsound mind – where some medical evidence was accepted and other medical evidence was rejected – where the appellant alleged an error of fact and an error of law – whether the Mental Health Court failed to take into account all of the relevant evidence – whether the determination of the Mental Health Court was against the weight of the evidence *Criminal Code Act* 1899 (Qld), s 27 *Mental Health Act* 2000 (Qld), s 257(1), s 334, s 267(1), s 405 *Briginshaw v Briginshaw* (1938) 60 CLR 336; [1938] HCA 34, distinguished

Collins v Minister for Immigration and Ethnic Affairs (1981) 58 FLR 407; [1981] FCA 147, considered
DAR v DPP (Qld) & Anor [2008] QCA 309, applied
McDermott v Director of Mental Health; ex parte Attorney-General (Qld) (2007) 175 A Crim R 461; [2007] QCA 51, applied

COUNSEL: M J Copley QC for the appellant
M T Whitbread for the first respondent
No appearance for the second respondent

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

[1] **GOTTERSON JA:** I agree with the order proposed by Philippides JA and with the reasons given by her Honour.

[2] **MORRISON JA:** I have read the reasons of Philippides JA and agree with those reasons and the order her Honour proposes.

[3] **PHILIPPIDES JA:** This is an appeal pursuant to s 334 of the *Mental Health Act* 2000 (Qld) (the Act) against the determination of the Mental Health Court (MHC) that the appellant was not of unsound mind at the time of the alleged commission of offences of arson and attempted murder and that proceedings for those offences should proceed according to law.[1]

Grounds of appeal

[4] An appeal from the MHC is an appeal in the strict sense and may only succeed if it is shown to have fallen into an error of fact or law.[2] The amended notice of appeal raises two grounds, namely that the MHC:

1. failed to take into account all the relevant evidence in concluding that the appellant was of sound mind; and

2. erred in deciding that the appellant was not of unsound mind, in that the decision was against the weight of the evidence.

[5] The first ground was said to raise an error of law while the second was said to raise an error of fact.[3]

Facts relevant to the appeal

[6] The primary judge summarised the relevant facts as follows:[4]

> "Prior to the offending which is the subject of charges, there had been other seemingly related incidents involving [the appellant] and the

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1 *In the Matter of Ismael Maria Desire Gonot* [2016] QMHC 1 at [81].
2 *DAR v DPP (Qld) & Anor* [2008] QCA 309 at [15] and [29] per Keane JA.
3 *Collins v Minister for Immigration and Ethnic Affairs* (1981) 58 FLR 407 at 410.
4 [2016] QMHC 1 at [2]-[6].

complainants, but these are not the subject of charges. [He] was living in a rented flat and all the incidents, both the subject of charges, and not, concern another house in the same residential street and its occupants.

I first describe the behaviour which is not the subject of the charges. The complainants say that on 27 January 2012 someone entered the area under their house, opened the valve on the hot water system, and sliced the hoses between the mains water supply and the washing machine, creating a flood of water. The water which escaped flowed onto the electric power-board and created electrical problems. In another incident tyres on a bike belonging to one of the complainants were slashed; this was on 29 January 2012. Further, on 31 January 2012 [the appellant] knocked on the front door of the complainants' house. This was the day before the behaviour which is the subject of the two charges before this Court. One of the complainants opened the door in response to his knocking. She said that a man who she described but did not know (accepted to be [the appellant]) was standing outside the front door playing music on an electronic device. To her saying 'Hello', he asked, 'Do two Asian guys live here?' The complainant replied 'No' and [he] continued to stand at the door saying nothing. Eventually the complainant asked whether there was anything else she could help him with and he said, 'No that's all'. He again remained standing silently at the door. She closed the door. The conversation unsettled her. She said that [the appellant] had a 'cheeky, smug smile on his face' throughout this incident.

The Crown case is that at about 10.30 pm on 1 February 2012, when all the occupants of the complainants' house had either gone to bed, or were in their bedrooms, [the appellant] entered the house, perhaps through the front door. The noise of this disturbed one of the complainants but she was not aware that a stranger was in the house. At around 10.45 pm she left her bedroom to go to the toilet. When she opened the bedroom door she could smell a strange smell and hear a hissing noise. In the kitchen she found that the gas stove was on, and that all four burners had been activated, allegedly by [the appellant]. The complainant turned them off. She noticed that the windows in the kitchen had been closed, again, allegedly by [the appellant]. The complainant then noticed that there was smoke coming from the external stairs at the back of the house. She was halfway down these stairs when she saw that there was an orange glow under the house and called emergency services.

Under the house it is alleged that [the appellant] placed a home-made plastic fuel brick and two wooden blocks on a post situated under the kitchen. He set fire to that fuel. Under the house were discovered skewers wrapped in cling-film.

When police located [the appellant] he had leather gloves and a knife in his pocket. They found wooden skewers wrapped in cling-film in his laundry, one with a burn mark on the end of it. They found his car, full of possessions, including his wallet, in the street, unlocked, outside the house next door to the complainants' house, some little distance from his own home."

[7] Following the appellant's arrest on 2 February 2012, he was still in custody at the watchhouse when he was visited on 8 February by Ms Marie-Claude Nicot (the President of French Assist, a nongovernment organisation supported by the French Ministry of Foreign Affairs, which provides support to French citizens or those who had previously had some association with France).

[8] Ms Nicot said that the appellant told her that he had been interviewed by a psychologist. Her statement, which was before the MHC, included the following:[5]

> "I told him to be careful of what he was saying to anyone besides his lawyer, that anything could be used against him, and that, if he was found to be of unbalanced mind, this could ad (sic) to the suspicion and could play in favour of him being culpable – this could also lead him to be incarcerated in a mental health section, where he would be likely to receive involuntary treatment."

[9] There were a number of opportunities for independent observations of the appellant and his behaviour to be made. The first was a video recorded police interview which took place on 2 February 2012, the day following the alleged offending.

[10] The second was an assessment by Court liaison on 2 February 2012. The Court liaison officer found the appellant to be calm and cooperative. There was no incongruent affect. He seemed relaxed and detached. Court liaison had received supplementary information from the appellant's brother and, suspecting an underlying mental illness, referred him to the Prison Mental Health Service.

[11] The appellant was then seen by Prison Mental Health Service intake clinicians on 7 February 2012.[6] He seemed unconcerned about his circumstances and explained this was because he had not offended as alleged. He told the clinician that he often went out until the early hours and "went a bit wild". He told the clinician that people had commented that he had changed. Previously, he worried about financial and study pressures to the point that he had considered suicide. However, he had recently taken up Spanish lessons and salsa dancing and had booked a holiday to Spain.

[12] On 13 February 2012, the appellant was received at the Arthur Gorrie Correctional Centre.

[13] Notes made by a clinical nurse consultant, Leanne Peel, on 15 February 2012 stated that there was no overt evidence of psychosis or pervasive mood disturbance.[7] He was happy to sign a consent form to allow the Prison Mental Health Service to speak to his mother and sister.

[14] Dr Timmins noted in her report information from the Prison Mental Health Service's records that on 16 February 2012 a code blue was called after the appellant was assaulted by prisoners after reporting to prison officers that he had been bullied.[8]

[15] On 17 February 2012, the appellant was interviewed by Dr Wolfenden, a psychiatrist from the Prison Mental Health Service. Dr Wolfenden saw the appellant to determine whether the appellant had a mental illness as at that date and opined that he did not.[9]

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5 AB 1120.
6 AB 700.
7 AB 488.
8 AB 1072.
9 AB 78.01-06.

The history that the appellant provided to her caused her to suspect the possibility of bipolar affective disorder or possible prodromal psychosis.[10] Dr Wolfenden understood (from notes made by an intake clinician) that the appellant had no prior psychiatric history.[11] The appellant told her that he had never been admitted to a psychiatric hospital and had never seen a psychiatrist or visited a mental health service.[12] She did not then know of his prior admission to hospitals for psychiatric issues.[13] In fact, the appellant had been admitted to the Wagga Wagga Hospital in January 2003[14] and to the Maryborough Hospital in August 2003.[15]

[16] The appellant was again seen by Nurse Peel on 24 February 2012 and was also to be seen by Dr Wolfenden again, but successfully applied for bail and was released on 8 March 2012 before that could happen.

The reference to the MHC

[17] On 12 June 2013, the appellant's legal representatives referred his mental condition to the MHC pursuant to s 257(1)(a) of the Act.[16] As a result, the MHC was required to determine whether the appellant was of unsound mind at the time the alleged offences of arson and attempted murder were committed.[17]

[18] The expression "unsound mind" is defined in sch 2 of the Act as follows:

> "… 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."

[19] Section 27 of the *Criminal Code* (Qld) (the 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

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10 AB 72.20-21.
11 AB 67.20-35.
12 AB 68.45-47.
13 AB 76.17.
14 AB 956-1009.
15 AB 914-952.
16 AB 91.
17 See s 267(1)(a) of the Act. In that proceeding, no party bears the onus of proof of any matter and the MHC's determination is to be decided on the balance of probabilities: s 405 of the Act.

> 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."

Medical opinions

[20] The MHC received expert reports from two psychiatrists, Dr Mann (reports dated 2 April 2013 and 17 August 2014) and Dr Timmins (reports dated 26 April and 17 August 2014).

[21] The MHC also obtained a report (as a result of a court-ordered examination pursuant to s 422 of the Act) from Dr Donald Grant, who examined the appellant on 3 December 2014 and provided a report dated 6 December 2014.

Dr Mann's reports

[22] In his first report, Dr Mann offered a provisional diagnosis of schizophrenia with differential diagnoses of schizo-affective disorder, bipolar disorder or substance-induced psychosis but was not able to form any view on the issue of deprivation of capacity.

[23] The primary judge provided the following summary of Mr Mann's report:[18]

> "… [the appellant] told him a long complicated story about the situation of his car near the scene of the arson. He denied that he had offended. He said that the Crown case rested on unsubstantiated circumstantial evidence. He said that he thought the police had been overzealous. He said the police did not have his fingerprints, DNA or anything else to tie him to the scene, and that all gladwrap looks the same. He did admit that he had knocked at the door of the house the day before the arson. He said that he was looking for an Asian friend who lived in the street.
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> [The appellant] told Dr Mann that he thought he had schizophrenia. He gave him a history of a breakdown in 2003 which had led to admission in Wagga Wagga and then later in Maryborough. He thought that maybe there had been a diagnosis of bipolar disorder. He said he had been admitted to a psychiatric hospital in France in 2007 for two days. He was unaware of any diagnosis which resulted from that admission but described himself as paranoid, anxious and scared of his surroundings during it.
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> He told Dr Mann (as was the case) that in July 2012 he had been found running naked down the street and had been taken by police to the Princess Alexandra Hospital where he was placed on an ITO. He could recall the circumstances of the behaviour which led to this.[19]
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> [The appellant] told Dr Mann he thought he had been unwell at the time of the offending which is before this Court because he was extroverted, spending money and shopping at the time. He told Dr Mann he had had two dexamphetamine tablets two or three days before the alleged offending and denied any other significant drug or alcohol use.

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18 [2016] QMHC 1 at [10]-[14].

19 AB 101.

> Dr Mann found [the appellant] to be superficial and guarded during this interview. His mother attended and he notes twice in his report that she seemed very anxious. [The appellant's] mother, brother and sister all wrote letters to Dr Mann to provide collateral information, and so did a psychologist. The family letters all assert that during 2011 [he] was quiet, but by the end of that year he had become irritable; was not coming home at night; not communicating; leaving doors to the house and car unlocked, and not caring about his surroundings. They described him as being arrogant, erratic, over-spending and 'manic'."

[24] Dr Mann was provided with the video record of interview of the appellant on 2 December 2012. Dr Mann observed that, during the two hour interview, the appellant:[20]

> "…remained settled throughout and appeared polite and cooperative. His affect appeared restricted and he maintained reasonable eye contact with the interviewing officers. He did not appear to be acting in a disinhibited or elevated way. He spoke with normal prosody, he was not pressured and his answers were precise and goal directed. He reported that he had consumed two alcoholic drinks approximately two hours before, but denied feeling intoxicated. He appeared to recall his movements on the day prior to being apprehended in reasonable detail."

[25] Dr Mann opined:[21]

> "Unfortunately, I have not seen any contemporary assessment of his mental state performed by a psychiatrist at the time of the alleged offences. Assessment of the video of the police interview on the day following the alleged offences was not suggestive of him suffering from symptoms of mania and there were no overt symptoms of psychosis. It remains a distinct possibility that he remained guarded throughout the police interview and did not divulge any delusional beliefs that he held at that time."

[26] While Dr Mann thought that it may have been possible the appellant was guarding, or disguising, psychosis (involving delusional beliefs) at the time of the interview, he did not canvas it as a possibility that he was guarding or disguising mania at the time of the interview. Indeed his provisional diagnosis was of schizophrenia, not bipolar disorder; that was a differential diagnosis.

[27] Dr Mann's second report dated 17 August 2014 and written after he had two reports from Dr Timmins, provided the following opinion:[22]

> "After reviewing the additional material I maintain my opinion that [the appellant] was suffering from a mental disease at the time of the alleged offence. I previously considered a number of different diagnoses but I now believe that the most likely diagnosis is bipolar disorder.
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> I have not seen any further evidence to suggest that [he] was intoxicated at the material time. ...

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20 [2016] QMHC 1 at [16].
21 [2016] QMHC 1 at [17].
22 [2016] QMHC 1 at [19].

> On the balance of probabilities I believe that [he] was completely deprived of the capacity to know that he ought not do what he is accused of doing from a moral perspective."

[28] The presiding judge of the MHC made the following comments as to Dr Mann's evidence:[23]

> "There are several points to note here. Dr Mann is still without contemporary assessment by a psychiatrist at the time of this second report. The additional information he has are the two reports from Dr Timmins. He does not explain how his diagnosis of bipolar disorder, sufficient to deprive capacity, sits with his description of the police interview in his first report. He does not describe whether or not he thinks it would be possible to disguise mania which was of an intensity sufficient to deprive someone of a relevant capacity. Further, Dr Mann does not explain at all what facts he relies upon to say that at the time of the offending [the appellant] was deprived of a capacity. That is, even if it is accepted that [he] suffered from bipolar disorder at the time of the offending, there is no reasoning in Dr Mann's report which would enable me to understand how he came to the conclusion that that mania deprived [the appellant] of a capacity at the time of the offending. In relation to the importance of an expert revealing their reasoning process in this context, see my decision in *Kalksma*.[24] Lastly, it is also apparent that Dr Mann has not used the correct legal test as to the capacity he says is deprived – in this regard see my decision in *Smith*.[25]"

Dr Timmins' reports

[29] As outlined in the decision of the MHC, Dr Timmins had available to her the files from 2003 for the admissions to both the Maryborough and Wagga Wagga Hospitals.[26] She was told by [the appellant] that he had had a week-long admission in France in 2007. The 2003 medical files show that he was admitted to the Maryborough Hospital between 6 and 19 August 2003. He was thought to be manic and psychotic and was admitted as an involuntary patient. He had been non-compliant with the Olanzapine that had been prescribed during his admission to the Wagga Wagga Hospital four months earlier. He later settled on this medication.

[30] Dr Timmins also had the material from the Prison Mental Health Service after the appellant's arrest, which included information about an assault on 16 February 2012. The prison records show that he was assaulted by other prisoners because he was talking to officers, apparently reporting that he was being bullied. There was, in addition, a Prison Mental Health Service clinical nurse consultant, who interviewed the appellant on 15 February 2012, and a long assessment from Dr Wolfenden on 17 February 2012.

[31] The appellant was admitted to the Princess Alexandra Hospital from 12 July 2012 until his discharge on 21 August 2012, where he was clearly very unwell. During that admission, a drug screen performed on 15 July 2012 was negative but the

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23 [2016] QMHC 1 at [20].
24 [2015] QMHC 2.
25 [2015] QMHC 8.
26 [2016] QMHC 1 at [22].

appellant said that he might have "passively" smoked marijuana prior to his admission and admitted to having used ADHD medications (ie. amphetamine) to assist his concentration when studying. He made statements such as, "I will never take drugs again".

[32] The account given to Dr Timmins was outlined by the MHC as follows:[27]

> When talking to Dr Timmins about the offending, the appellant admitted that he knocked on the door of the complainant's house the day before the arson. This was, he told her, to enquire if his Asian friends lived there. He said he had met two Asian friends at the beginning of 2011 in a Christian group. He knew they lived in his street but not where. He went there to ask.
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> The appellant told Dr Timmins that, at the time of the offending, he had started going out to pubs and clubs. It was the end of the university year. He thought he was going three or four times a week. He said that at the time he was spending a lot of money and was very impulsive.
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> [The appellant] told Dr Timmins that after he was released on bail on 8 March 2012, he went back to Hervey Bay to live with his mother for a few weeks. He described himself as listless and not feeling safe at that time. He said he had a feeling of suffocation where he had to walk out in the fresh air. He said he was anxious. He said all this passed and he moved back to Coorparoo. Despite having missed the first few weeks of university, he resumed his studies. He said he was stressed during that time but was "doing quite well ... keeping it altogether". He said that in July 2012 he had a Court appearance and in the week before that he did not eat; felt he was going through a spiritual crisis, and felt "the early symptoms of a psychosis coming on". He said that on 12 July 2012 he was psychotic and that he ran down the street naked, yelling religious slogans.
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> As to the circumstances of the offending, he said he had taken one or two ADHD tablets the week before the alleged offences and that he had handed-in one tablet to the police. That latter information appears to be incorrect. The police found one tablet in his car which he denied belonged to him. [The appellant] said that he had knives in his possession because he was moving out. He said that he wrapped skewers in cling-film in order to transport them in the context where he was moving out of his rented flat. He said that in the days prior to the offending he had burnt some papers under his own house and that he lit the skewers under the house but did not have a good explanation for why he did that. He said the papers he burnt were banking papers which he did not want to put in the rubbish bin. He said he parked his car up the road rather than outside his own house because he thought if he could convince the landlord he was no longer living in his rented accommodation he might get some discount on the rent. He told Dr Timmins that he had "no recollection" of any facts relevant to the arson charge.
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> Dr Timmins had collateral information from [the appellant's] brother. He thought that in 2011 [the appellant] was 'depressed, stressed out

[27] [2016] QMHC 1 at [26]-[30].

> and unsure of himself'. He said that towards the end of the year, leading up to Christmas, he began to relax and enjoy life more. He said there was a change in his behaviour at that point. He said he would go out until early morning; would not sleep or eat regularly and, despite his family expressing concerns to him, he was dismissive, saying he wanted to enjoy life. He said that he had brought real estate brochures home, saying that he wanted to buy a house, which was quite unrealistic. He said that he tried to borrow money from his sister and that he bought indulgent things, such as face cream and clothes. He said he was argumentative on Christmas Day.

[33] Dr Timmins formed the view that the appellant was suffering from bipolar affective disorder at the time of the offending. As to the capacity to know what he was doing was wrong, Dr Timmins said:[28]

> "[He] has an almost complete inability to explain any of his behaviours or thoughts even when directly questioned at the material time. He seemed unaware of other people's perceptions of his behaviour either such as his brother's comments around Christmas time. Thus on the balance of probabilities [the appellant] was probably completely deprived of the capacity to know what he was doing for all of the alleged offences."

[34] The MHC made the following observations:[29]

> "The first thing to note about this conclusion is that, as will be seen below, [the appellant] was lying to Dr Timmins when he said he could not remember his behaviour at the material time. The second thing is that there is no convincing logic or reasoning to support the conclusion as to deprivation. Thirdly, that the conclusion is not tied to the known facts. While it may be that [he] was suffering from some illness at the time of the offending, he was certainly able to do things, such as organise to move out of a flat, drive a car and, on the Crown case, undertake some pretty sophisticated and surreptitious offending."

[35] The MHC remarked that, as to the capacity to know that he ought not do the act, Dr Timmins stated:[30]

> "[The appellant] is unable to explain his actions or what occurred across much of the time from early December 2011 to when he was admitted in July 2012. In addition when his behaviour is questioned he does not believe that what he was doing was wrong seemingly to be able to come up with a plausible explanation until he is questioned more in depth about his behaviour. [sic] He seems to have persecutory beliefs in relation to the neighbours and their motives and his safety. I don't believe [the appellant] was unable to reason with a moderate degree of sense and composure at the time of the offences. [sic] Thus on the balance of probabilities [he] was completely deprived of the capacity to know he ought not do the act for all the offences."

[36] The presiding judge of the MHC made the following further comments:[31]

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28 [2016] QMHC 1 at [31].
29 [2016] QMHC 1 at [32].
30 [2016] QMHC 1 at [33].
31 [2016] QMHC 1 at [34]-[36].

> "Again, Dr Timmins is proceeding on the basis that she believes the falsehoods [the appellant] has told her, and again, so far as one can tell, she seems to put store on his (false as it turns out) amnesia in reaching her conclusion. Secondly, this reasoning is almost incoherent. It is certainly not sound, logical reasoning based on the known facts at or around the time of the offending, or indeed after the offending. The persecutory beliefs are not recorded in her report.
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> It will be seen that, although Dr Timmins had Dr Wolfenden's notes (below), she does not in any way attempt to reconcile the most contemporary psychiatric assessment of [the appellant] with her conclusions. Nor does she in any way attempt to reconcile [his] performance at the police interview the day after the alleged offending with her conclusions.
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> I reject the opinions Dr Timmins gives in her first report and her second report adds nothing more to the matter."

[37] The MHC also referred to questions asked of Dr Timmins by the assisting psychiatrists at the hearing on 29 September 2014, which the Court considered revealed more difficulties with Dr Timmins' views. The MHC noted that it was clear "that Dr Timmins' belief that [the appellant] was being truthful with her very much influenced her opinion".[32] In that regard, the following evidence given by Dr Timmins was referred to:[33]

> "Was he so elevated as to have psychotic symptoms as well?---This – that is quite difficult to sort of clearly 100 per cent say yes or no. I definitely think he was manic and I do believe that he was very fearful of his life at the time. Unfortunately, he doesn't have a very clear recollection of what was going on so you can only glean little pieces of information from other sources of information and from what I could gather, it's – he was very fearful of his safety around that time and probably related that back to his – the neighbours. He was also very sort of elevated at that particular time of his life and I do wonder if the two acted together such that he couldn't remember what he was doing and couldn't understand the reasoning behind what he was doing either.
>
> And now I take it, Doctor, that, clinically, it's not unusual for people who are suffering from an acute psychotic episode not to lay down memories during the time of that acute psychosis? ---That's correct."[34]
>
> "Yes. Dr Timmins, how did you deal with the issue of what appears to be a significant dispute of the facts here?---I think the dispute of the facts is related to his mental illness.
>
> Can you please explain that to her Honour more?---I think because he has very poor recollection around what he did during that period. that it relates to his mental illness rather than any other reason.
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> No. So, wouldn't you expect to have some more evidence actually linking an abnormal mental state to that particular house?---I have no

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32 [2016] QMHC 1 at [37].
33 [2016] QMHC 1 at [37].
34 AB 3.

> further evidence and I'm – and that – and that's one of the things that I've struggled with with this case is – is that there's this – when he talks about the case I really don't think that he's trying to tell – tell me a story that I – I, you know, and be dishonest to, you know, in his – in his answers. I think he honestly can't really remember around that time."[35]

[38] The MHC remarked that, "[i]t might also be observed from the last of these passages that Dr Timmins had no evidence of persecutory beliefs towards the neighbours – this further invalidates her conclusion extracted … above, which relies on the existence of unspecified persecutory beliefs".[36] Further, the MHC considered that Dr Timmins' view that the appellant "was so manic at 1 February 2012 that he was deprived of a relevant capacity does not fit with the natural history of mania in that he was seemingly not manic at various times between February and July 2012".[37] In that regard, the MHC referred to the following relevant parts of Dr Timmins' evidence:[38]

> "Can I just ask you to explain the difference between the state of [the appellant's] mental health at the time here in January as compared to when he had a later psychotic episode in July. What was the difference – because he was acting very differently at those times?---I think you need to see it as a sort of a timeframe of unwellness where he started to become very unwell before Christmas in 2011 and gradually become more and more and more unwell and then by the time July 2012 came along, he was floridly psychotic and extremely unwell and just unable to control his behaviour in any way and, subsequently, you know, found in a state of nakedness and praying to, you know, Allah and other religious deities."[39]

> "How do you explain by the assessments by court liaison and the detailed assessment over 90 minutes by Dr Wolfenden in Arthur Gorrie? ---I think both of those clinicians suspected that there was something quite suspicious about [the appellant] and I think those assessments are – are reflective of his ability to be able to control himself, you know, and appear - - -
>
> How does someone control their mood?---Well, he – on the – on the first – I mean, you can't actually control your mood but he has – and he had evidence that was quite suspicious [indistinct] incongruent [indistinct] he was [unconcerned] that he was actually in prison. These sorts of things that people are very suspicious of a mental illness but there was not enough evidence to be able to place him under the Mental Health Act in order to get him properly assessed. When you look at his behaviour in custody – and he was subject to an assault. He was very inappropriate with the other, you know, prisoners not understanding that he couldn't go and talk – well, he can go and talk to the officers but it was frowned upon and would place him in harms way from the other prisoners.

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35 AB 13.
36 [2016] QMHC 1 at [38].
37 [2016] QMHC 1 at [39].
38 [2016] QMHC 1 at [39].
39 AB 7.

And what of that is consistent with mania?---Well, I think it indicates that he really had very poor judgment and limited understanding of the seriousness of where he was and what was actually happening to him.

But there's no elevated mood. There's no pressured speech. There's no flight of ideas and they're the basic elements that you want before you make a diagnosis of mania?---Well, not on those assessments. No.

And you'd have to agree that those things should be consistent over time for a diagnosis of mania? ---Well, yes. They are. But I still think that [he] has had abilities to be able to hold himself together very well if he needed to."[40]

"And there was no evidence of elevated mood on the court liaison assessment or on Dr Wolfenden's assessment two weeks later?---Not two weeks later.

And there was no evidence of flight of ideas or pressured speech two weeks later?---No.

What's the natural history of mania?---It progressively gets worse over time, if left untreated that is."[41]

"Well, if we look at the facts of the alleged offence, someone entered the house – someone quietly enough that no one heard them. Someone turns on the gas rings and that someone didn't leave fingerprints or DNA as far as I'm aware. That someone closes the windows and the doors. That someone then goes downstairs and, again, without anyone hearing it and lights a fire down there, even if perhaps not expertly at least lights a fire. Is this – people with mania – do they normally behave that way – quietly, with a lot of self-control over their behaviour, wearing – perhaps wearing gloves, being careful not to leave behind other evidence. Is that consistent with someone with a severe mania?---Well, you wouldn't normally consider so. I agree with you. However, I think [the appellant] – in his case, I think it is consistent with his behaviour.

So you're suggesting, Dr Timmins, that mania is a subtle illness?---No. I'm not at all suggesting that. I'm suggesting in his case [the appellant] can – is able to control and contain himself such that he can act in – in a – in what looks like a normal way.

Is that usual in mania? Normally, most people - - -?--"'No.

- - - mania - - -?---No, it's not.

- - - you can almost see it across a football field, can't you?---Yes, I agree with you. And by July you could see that. However, I still think he was really unwell in February around the time of the offences.

…

Okay. Thank you. Now, if we – you agreed with Dr McVie, he was seen by court liaison on the 7th of February. He was seen again by staff

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40 AB 8.

41 AB 10.

> of Prison Mental Health on the 15th of February and he was interviewed at some length by Dr Wolfenden on the 17th of February. During none of those interviews was there any evidence, objectively, of mania, was there?---A few people were very suspicious of his mental state and I think there was - - -
>
> No. That's not the question I asked you – whether they were suspicious. I'm asking what evidence was there objectively of mania?---If you're talking about pressured speech or elevated moods, a flight of ideas, then, no, there was none of that.
>
> There wasn't even any irritability, was there, really?---There was no incongruence of affect."[42]

[39] The MHC reached the following conclusion:[43]

> "In all the circumstances I am not prepared to act on Dr Timmins' view of the case. Nor am I prepared to act on Dr Mann's view of the case because, as is hopefully apparent from the discussion of his reports above, he seemed to accept Dr Timmins' reports as correct, and changed his own view on the basis of them, without any independent reasoning in circumstances where I am convinced Dr Timmins' views were not themselves sound."

[40] It was in those circumstances, and with that state of the evidence, that an additional report was sought from Dr Grant by the MHC.

Dr Subramaniam's reports

[41] The MHC was provided with two reports dated 19 May and 17 November 2015 from Dr Subramanian, a psychiatrist who has a particular interest in affective disorders to whom the appellant was referred because of the diagnosis of bipolar disorder by Dr Mann and Dr Timmins.

[42] The MHC noted that Dr Subramanian raised a concern as to the correctness of the bipolar affective disorder diagnosis and also opined that, even if the diagnosis of bipolar disorder was a correct diagnosis, the objective facts surrounding the offending and the appellant's behaviour after the offending did not sit easily with his having been manic at the time of the offending, let alone so manic that he was deprived of a relevant capacity.[44]

Dr Grant's report and evidence

[43] The appellant admitted the offending and some of the anterior behaviour to Dr Grant. The appellant's recollection was described as "rather patchy". The MHC observed that the appellant told Dr Grant much more about the 2007 episode in France than he had told anyone else who examined him:[45]

> "He said that he had been admitted to a psychiatric ward in France, but then a doctor who believed in scientology came and took him out of

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42 AB 11-12.
43 [2016] QMHC 1 at [40].
44 [2016] QMHC 1 at [45].
45 [2016] QMHC 1 at [49].

> the ward and cared for him at home. There are odd, unsigned documents put forward in relation to this. Their provenance involves [the appellant's] mother who, herself, adhered to the views of scientology propaganda, at least at some stage. I have not seen [his] mother, nor seen her cross-examined. The material put before this Court from, and about, her leads, I must say, to a story which becomes more peculiar, she having had quite a psychiatric history herself, according to a GP (who is probably not qualified to say, or is repeating hearsay from those who are), including having been diagnosed with Munchausen syndrome by proxy. None of this history convinces me that the statements made by [the appellant], or his family, as to what happened in France in 2007 is reliable."

[44] In his report of 6 December 2014, Dr Grant opined that the appellant was of unsound mind at the relevant time, stating:[46]

> "In my opinion, at the time of the alleged offences [the appellant] was suffering from a manic phase of bipolar affective disorder, with that illness building up over the previous two weeks or more. At the time of the offences there is no evidence that he was actually psychotic but he did appear to be elevated in his mood, prone to developing irrational ideas and anger, insightless and irrational in his behaviour. Having taken all the evidence into consideration, I am of the opinion that at the time of the alleged offences [he] would have been sufficiently manic to have been unable to think about his actions with a reasonable degree of sense and composure and that his illness was depriving him of the capacity to know that he ought not do his actions. His control over his behaviour would also have been significantly impaired but perhaps not deprived. He would have been aware of his actual actions in terms of understanding what he was doing, but in my opinion would have been deprived of the capacity to know that his actions were wrong at that time."

[45] In addition to providing a report, Dr Grant gave evidence on 28 May 2015. The contentious parts of his evidence concerned whether or not it was possible for the appellant to have been so manic as to be deprived of a relevant capacity on 1 February 2012 but to have been able to disguise that mania when seen by police and the Prison Mental Health Service and during the two months he was a prisoner and the four months he lived in the community between March and July 2012. The relevant parts of Dr Grant's evidence, referred to by the MHC, are as follows:[47]

> "So, Dr Grant, if in fact he was trying not to disclose any history of mental illness, as you've mentioned, do you think that if – in a manic state, he would have been capable of masking or covering up his symptoms when he was seen by the prison mental health service?--- Well, I think it means that he wasn't too horribly manic at that point, and for whatever reason, it might have settled to some extent – it certainly got worse later. If he was – I mean, you would have expected to see some other activity and grandiosity and so on. He did get assaulted in prison, and it was not clear why that was, but he suggested

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46 AB 1223.

47 [2016] QMHC 1 at [51].

> – I read something that suggested that he was assaulted because he was too friendly with the prison officers. And so there were some behavioural issues in custody which could indicate that he was disinhibited and inappropriate in his behaviour, and that's why he got assaulted. So I'm not sure if he wasn't showing symptoms, but certainly at interview, he appears to have been able to contain any manic overactivity, but he continued to show this blandness and unconcern and lack of insight into the serious situation he was facing, so I think Dr Wolfenden was suspicious about what was wrong with him, and if she'd had the benefit of all of the collateral history, then her conclusions might well have been a bit different or a bit more different."[48]
>
> …
>
> "Well, that seems reasonable, doesn't it?---Well, look, I can't comment. Dr Wolfenden has her observations and she's come to whatever conclusions she came to. I've come to my conclusions on the basis of all the information I had from him about his mental status at the time, his relatives and his mother and his sister – so his brother and his mother – and I think, you know, I've come to the conclusion that I have. Dr Wolfenden may come to a different conclusion on the basis of her evaluation, but I repeat again that I've seen many manic patients who have been able to hold themselves together and not appear manic for periods of hours, and a case before a court not that long ago I remember actually got admitted overnight to a hospital and discharged because they couldn't see enough evidence of any illness. And, again, in interviews, repeatedly, people can hold it together. So he certainly became, obviously, more manic later in that year, and he has a history of severe bipolar disorder. So, I mean, I've just put all that evidence together, talked to him about the mental status at the time and what was happening and what he was thinking about, and I've come to my conclusions [indistinct].
>
> …
>
> Dr Grant, but the test is not just that you've got a mental illness?---No, I know that.
>
> It's also deprivation, isn't it, of one of the three capacities?---Absolutely.
>
> Yes?---And, you know, the definitions vary, but I think that he was manic enough not to be able to think clearly and rationally about his behaviour at the time, and I think he'd lost insight into what was going on, and he reacted irrationally during the offences. That's my conclusion."[49]

[46] The following oral evidence by Dr Grant extracted in the judgment of the MHC is particularly pertinent:

> "Just – the only question is really in a way – similar to what her Honour in that what I think Dr Subu's questioning is his mental state

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48 AB 32-33.

49 AB 40-41.

at the time of the alleged as being sufficiently severe to warrant a defence of unsoundness of mind and yet he didn't then require any treatment or admission until July. And even though I think – as I said before, Dr Grant, the grammar is a little bit confusing, I think that's really what he's saying. He's raising a question about that, isn't he?---Well, he is. Yes. And that's – that is obviously a relevant and reasonable question.

But you don't agree that it would have been very – Dr Subu says it would have been very difficult for him to control his symptoms in a very stressful situation. And that's, I guess, the point which you disagree with Dr Subu, isn't it?---Well, I guess he was in a contained environment in prison. He didn't have any access to any drugs. He wasn't going out at night – all that. So it seemed to settle to some extent – to a reasonable extent in prison and to the extent where he was under the radar there in terms of whether he was ill or not. There's a lot of ill people in prison who go under the radar, but if you're manic you would probably – usually not go under the radar. But I think – I still hold the opinion [indistinct] what I felt he was like at the time of the ---

Thanks. Thanks, your Honour."[50]

"I really do have a difficulty with the idea that he did not know that he ought not do these actions when he's gone about it in such a surreptitious way, that is a way designed not to be caught, and then when asked about it, doesn't just deny it, he tells lies, and lies that are sophisticated enough in that they admit quite a lot of the truth – you know, they're quite good lies – that's the way you tell a good lie, stick to the truth as much as you can – so that it seems to me that those behaviours do indicate that he knows that he ought not do these things?---Well, I think that – as I said to Dr Reddan, people who are unwell are often very well organised in what they do. And he actually wasn't all that organised, because his car was found abandoned on the street next to this – a fence, and in this was his wallet, and the car was unlocked, and there was other things that sort of implicated him in the offence, and he'd gone and just passed out and gone to sleep in his house some distance away. It wasn't all that well organised. I don't know – I can't see any other alternative motivations for why he would behave in all these strange ways.

Well, can we leave motivation out of it. I don't know if you can. But it doesn't quite seem relevant to me to understand his motivation. I have to know whether or not he understood that he ought not do these acts. And he was surreptitious about them, and then he denied them?---But that's very common with people with mental illness. Even if they are deprived – and he did deny them for a long time, and I think – I've described some of the reasons why I think that he did. And so people with a mental illness may well deny and go on denying that they did it. I think that – my consideration was – I mean, I also was quite concerned about the whole thing, whether he was manic enough, if you like, at the time.

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50 AB 50-51.

> Yes. I think that encapsulates probably a [lay way] of saying it, but I think that encapsulates my concern?---But while – wondered whether he was manic enough. In the end, I thought that he was manic enough not to be able – if you take the sort of softest definitions of deprivation. he wasn't able to think with a moderate degree of sense and composure about what he was doing, because he was too manic, too irrationally angry, too disinhibited, and just sleep-deprived and all the rest of it that he carried out these strange actions against people he hardly knew. And this was a man who normally has a pretty normal personality structure. He's had a difficult background and so on, but when he's not unwell, he's at university, getting 6s and 5s in his subjects, and is proceeding with trying to establish his career and all the rest of it, and it's not – he's not an antisocial man who would suddenly go out and do these very strange things. He hasn't got a history of violence. So I think motivation is important to consider from a – on a psychiatric point of view, and if the motivation seems lacking and strange or psychotic or just – he said he couldn't think clearly – then that's relevant to a sense of deprivation."[51]

[47] The MHC noted Dr Grant's report directly addressed those matters:[52]

> "He said that in the police interview and in custody [the appellant] 'appeared to show no gross evidence of mental illness. However, he was very nonchalant in the police interview and subsequently in custody about the offences and their severity, appearing to lack any insight.' Dr Grant said that the assessments made of [him] in custody were not informed by information about his past history of psychosis suggesting bipolar affective disorder. He notes, and I think it may well be accepted, that Dr Wolfenden had concerns that [the appellant] may have mental illness, including mania. Dr Grant's reasoning was that, having regard to the collateral information particularly provided by his family, [he] was exhibiting increasing symptoms of mania leading up to the offence. He says he was overactive, disinhibited, over-spending, incurring many traffic fines and debts and spending money which he did not have. He was buying excessive clothing and personal goods and being overbearing and irrational with his family. He was planning to travel to Spain to go on a pilgrimage and was learning Spanish and salsa dancing. He was looking at buying real estate. All this in a context where he had no available funds. Dr Grant reasons that, while [the appellant] was falling short of displaying completely psychotic symptomatology, he was in a disturbed mental state and developing increasingly severe symptoms of a manic phase of his manic depressive psychosis. He thought that he had no insight into the irrationality of his behaviour and his offences were out of character, apparently motivated by quite irrational anger towards the occupants of the house where the offences occurred."

[48] The appellant told Dr Grant that he had lied in the past because it was very hard for him to accept he had behaved in this way and that he was ashamed of having a mental illness. The MHC observed that so far as the second part of that explanation was

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51 AB 51-52.

52 [2016] QMHC 1 at [54].

concerned, it did not sit happily with the fact that he had consistently, from the time he saw Dr Mann, described having a history of mental illness and relied upon a defence of mental illness in relation to the offending (even though he did not admit that it had occurred).

[49] In addition, the MHC noted that the appellant had disclosed to Dr Grant that he had been influenced through his childhood by scientology propaganda, believing that psychiatry was evil, and therefore he did not wish to tell those asking him questions about his past mental illnesses. Largely for the same reasons, the MHC did not find this a very credible explanation, at least after July 2012. From the time the appellant saw Dr Mann, he described having mental illnesses. Furthermore, the MHC observed the fact that in prison the appellant cooperated with the Prison Mental Health Service even though he was not required to do so.

[50] The presiding judge of the MHC made the following remarks about Dr Grant's evidence:[53]

> "I note that on questioning from me Dr Grant thought that [the appellant] told him the truth at interview. I have not seen [the appellant] give evidence or be cross-examined. It may be that my view of him would be different if I had. I would, however, note that Dr Timmins' evidence also expressly addressed this point and she thought [that the appellant] told her the truth, see above at [37]. I know that he lied to her, at least that is so if he told Dr Grant the truth. I am sceptical about all the statements [the appellant] has made. The procedures in this Court are not such as to enable me to form a definitive view of his credit."

Dr Wolfenden

[51] On 17 February 2012, Dr Wolfenden saw the appellant for one and a half hours, making very detailed notes. In her evidence to the MHC, she said that she was deliberately trying to give the appellant "enough time to demonstrate signs of mental illness" as her experience was that normally somebody with mania or hypomania would eventually give themselves away, usually sooner rather than later in terms of how they present and what they say.

[52] Dr Wolfenden examined the appellant because of the serious charges against him and not because of his behaviour in prison. The MHC considered this relevant because it remarked that "if someone were so manic that they were deprived of the capacity to know what they ought and ought not do, and were subjected to the additional stress of being in prison, and subject to the close observation[54] which prison entails", it was unlikely that mania could be hidden for a period of two months on the prison unit and from professionals like Dr Wolfenden who were alert to the possibility of mania and looking for it.

[53] Dr Wolfenden was aware that the appellant had an incongruent (unconcerned) affect and she had family reports of recent behavioural changes, including increased spending, traffic infringements and staying out all night.

[54] The MHC made the following observations about the examination:[55]

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53 [2016] QMHC 1 at [48].

54 See the questions and answers between Dr Reddan and Dr Wolfenden at AB 10-11.

55 [2016] QMHC 1 at [62]-[65].

> "[The appellant] lied to Dr Wolfenden about his psychiatric history. He said that he had never been admitted and never taken psychotropic medication. He told her that he had had 'a nervous breakdown' which occurred in the context of his having been accused of sexual assault while he was on the Young Endeavour ship. He said that after that incident he felt his life was ruined and had been depressed for one or two months: he lost his appetite, had poor sleep and could not function. But that after the charges were dropped, he felt that his mood changed and he became elevated and on top of the world so that he felt indestructible. He said that he was out to have a good time and stayed out every night. He said that after one or two months his elevated episode finished spontaneously and he returned to normal. This is a false history. In fact what happened was that he was admitted to Wagga Wagga Psychiatric Unit in January 2003 with depressed mood; then went on the Young Endeavour; was in fact charged with sexual assault; did in fact have charges dropped in July, and then was admitted to Maryborough Psychiatric Unit with elevated mood, which he told that hospital was due to his not being able to sleep due to the stress of his impending Court case (according to the notes). So the false history is very close to the truth, but structured in a way that does not reveal the previous psychiatric admissions. That is, telling the false history looks like purposeful, directed behaviour and does not sit with someone whose mental state is so disordered by mania that they lack capacity to judge whether their actions are right or wrong."
>
> [The appellant] lied about the subject matter of the allegations which are referred to this Court. He said he knew nothing about the offences with which he is charged, yet giving other peripheral details with some particularity as to the fact that he was moving house; as to the knocking on the door inquiring for two friends from his church, et cetera. [He] told Dr Wolfenden that he was not worried about the charges he faced because he 'didn't do it.'"
>
> [The appellant] told Dr Wolfenden he was sleeping eight or nine hours a night and that his appetite was good and his energy was normal. …
>
> Dr Wolfenden noted that [the appellant] tolerated the 90 minute interview without difficulty. She said his speech was spontaneous and normal in rate, tone and volume. She said there was no formal thought disorder and no flight of ideas. She thought his affect was somewhat incongruent in that he appeared unconcerned by his current predicament, but otherwise she thought he was euthymic and reactive in affect. He denied having any perceptual disturbances and she did not notice that he was distracted or preoccupied during the course of the 90 minute interview, the way somebody who was psychotic might be. He did not demonstrate any delusional thought content and denied having any delusions or hallucinations or other signs of psychosis. She thought his insight and judgment was reasonable and he agreed to her assessing him again for diagnostic clarification."

[55] Dr Wolfenden opined that the appellant "presented as mentally well", but she was concerned that, given the history he and others had provided to her, he might have bipolar affective disorder or a prodromal psychosis. For that reason she sought the

Queensland Police Service court briefs (QP9s) from the police and requested that the appellant be observed in prison as to his mental state behaviour and sleeping patterns.[56]

[56] Dr Wolfenden told Dr McVie that she did suspect that the appellant had an underlying mental illness but that he was not acutely unwell and was not ill enough for her to recommend that he be treated, either in the custodial setting or in the hospital – that was the purpose of her assessment. He was not manic when she saw him. She said that the natural history of manic illness was that it was relapsing and remitting but that it was unusual for somebody with a significant degree of mania to have their symptoms resolve except over a long timeframe or with significant treatment. In particular, somebody who was under stress – charged with criminal offences and incarcerated – would be more likely to exhibit mania if they were prone to it.

[57] Dr Wolfenden was given some information from clinical Nurse Peel about the appellant having said that he took dexamphetamine tablets belonging to somebody else. Dr Wolfenden suspected that the appellant may have been using illicit substances and this may have accounted for his previous behaviour and also why that behaviour appeared to have settled now that he was in a controlled custodial environment, without access to drugs. The MHC considered this legitimate speculation on her part, just as Dr Grant speculated about the same thing. There was, of course, no evidence about it and, accordingly, the MHC could not find that is what accounts for the factual matters in relation to this offending and subsequently. The primary judge indicated that it might be that, on full factual examination after a committal, and perhaps a trial, it would emerge that drug use accounts better for these facts than any other psychiatric diagnosis.

[58] Dr Wolfenden planned to see [the appellant] again, but he was released on bail. When she discovered this, she wrote to him saying that he ought to follow up his mental health in the community.

[59] Following Dr Wolfenden's interview with the appellant, he was seen by Nurse Peel on 24 February 2012. She found him polite and cooperative and that he continued to seem unconcerned about the charges. He spoke to her about possibly having one tablet of dexamphetamine about the time of the offending. Her notes were that he presented as euthymic and reactive in mood, that he reported good sleep and appetite and denied any perceptual disturbances, special abilities or powers.

Advice of the assisting psychiatrists

[60] The MHC summarised the advice of Dr Reddan, one of the assisting psychiatrists, as follows:[57]

> "The advice from my assisting psychiatrists was that it is likely that [the appellant] does suffer from bipolar disorder, particularly having regard to the clearly manic behaviour in July 2012. Dr Reddan's advice was that, on the evidence, from the time of the alleged offending, right through to the week after Dr Wolfenden saw him, [he] did not demonstrate any evidence of severe psychiatric illness. She thought he may have been "on the prodrome" but she thought it was not until July there were clear signs of mania – t 1-18. She pointed out

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56 [2016] QMHC 1 at [66].
57 [2016] QMHC 1 at [72].

> that certainly Dr Wolfenden and Nurse Peel had turned their mind to exactly the point this Court is interested in, and could not find hypomania or mania. In her view then, notwithstanding the opinions of the reporting psychiatrists, the evidence did not support a finding that [he] was deprived of any relevant capacity at the time of the offending".

[61] Dr Reddan said that mania was not a subtle illness which could be controlled or concealed during the time the appellant was in prison. She accepted that persons who were psychotic and had delusions might be able to hide their delusions in such circumstances, but she did not think a major mood disorder could be hidden for that time. The presiding judge of the MHC asked Dr Reddan whether Dr Subramanian was correct to postulate a diagnosis other than bipolar affective disorder, and whether or not it was possible that some sort of psychosis could have been operating on 1 February 2012, but had resolved by the time the appellant arrived at Arthur Gorrie. Dr Reddan did not think that it was likely that psychosis would spontaneously remit under the stress of being incarcerated and living in prison.[58]

[62] The advice of the other assisting psychiatrist was summarised as follows:[59]

> "Dr McVie's advice to me was that the natural history of mania is that it would not have disappeared spontaneously without some sort of treatment. She told me that mania normally takes weeks, if not months, to resolve even with appropriate medication. Therefore she did not think that the diagnosis of mania at the time offered by the reporting psychiatrists sat with the assessments done in Arthur Gorrie. Further, she did not think that some other type of acute psychotic disorder would resolve spontaneously, particularly having regard to the fact that, from the time of arrest, [the appellant] was under stress because of the arrest and also because he was in custody. Dr McVie said that some sort of acute psychotic disorder of short duration did not fit with [his] long-term history, where he had had three episodes of treatment for a psychotic illness, each of which was quite lengthy.
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> Dr McVie noted that [his] illness in July 2012 was complicated by cannabis abuse, and she also turned her mind to whether or not the offending may have been related to the use of amphetamines. She described the offending as bizarre, but also planned. She thought that it may have been motivated by some kind of persecutory ideation, which may have been precipitated by amphetamine use. Dr McVie's advice to me was that the clinical evidence did not fit with the presence of a manic illness or even acute psychotic illness at the time of the offending."

MHC's analysis of the evidence and conclusion

[63] Having given reasons for rejecting the opinions given by Dr Mann and Dr Timmins, the MHC recorded that it was not persuaded by Dr Grant's opinion, observing that he, himself, found the point which troubled the assisting psychiatrists to be a difficult one.

[64] The MHC summarised the evidence about mania previously outlined in the expert evidence in the reasons for judgment: "it is not a subtle illness.[60] Basic signs of its

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58 [2016] QMHC 1 at [73].
59 [2016] QMHC 1 at [74]-[75].
60 [2016] QMHC 1 at [39].

presence are elevated mood, pressured speech and flight of ideas.[61] Mania gets progressively worse overtime if it is left untreated.[62] Mania is more likely to be exhibited by someone who is under stress if that person is prone to manic behaviour".[63]

[65] The judge constituting the MHC stated:[64]

> "In this case, in order to qualify for a defence of unsoundness of mind at 1 February 2012 it is necessary for me to be persuaded not only that [the appellant] suffers from bipolar affective disorder, but that he was manic at 1 February 2012, and that mania, at that time, was so severe as to deprive him of the capacity to know he ought not do the act. [He] was not treated until July 2012. It therefore must be postulated that he was manic enough to be deprived of a relevant capacity on 1 February 2012, but did not show any of the basic indicia of that illness when examined by Dr Wolfenden on 17 February 2012; when examined by nurses and other mental health staff around that time, or during a two hour police interview on 2 February 2012. Nor did he show any sign of mental illness severe enough to warrant treatment during two months' incarceration in jail. From 8 March 2012 to July 2012 it must be postulated that he was able to live independently in the community whilst being subject to a mania which on 1 February 2012 was so severe that it deprived him of a relevant capacity."

[66] In relation to Dr Grant's conclusion of deprivation, the judge made the following comments:

> "I cannot reconcile Dr Grant's conclusion of deprivation on 1 February 2012 with all the objective evidence as to [the appellant's] condition. The offending itself is odd, in the sense that there appears no motive for it. Of course it may simply be that [he] has not revealed his motive. Nonetheless, the offending was planned, and organised. [He] was able to access the house concerned very quietly and purposefully turn on the gas in the kitchen and seal that room by closing the windows. He then placed fuel directly underneath the kitchen floor and lit it. This was quiet, covert and logical behaviour.
>
> In a two hour police interview the next day there were no signs of mania. [The appellant] was in a stressful prison environment for two months from the time he was arrested until the time he was granted bail. This did not provoke his mania to appear. As well as being a stressful environment, prison was an environment where [he] was closely observed. There were no observations that provoked a referral to Prison Mental Health. Nurse Peel and Dr Wolfenden, who were particularly looking for mania given the collateral history they had, could not see any signs of mania when they were looking to see if [the appellant] needed treatment. Dr Grant said that he was aware of someone hiding severe mental illness through an interview, and even on an overnight admission. I do not think the current situation compares to that: it was very stressful; provided opportunity for close

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61 [2016] QMHC 1 at [39] and [65].
62 [2016] QMHC 1 at [39] and [68].
63 [2016] QMHC 1 at [67] and [68].
64 [2016] QMHC 1 at [78].

> observation and lasted two months. Not only was [he] not displaying symptoms of mania in prison, once he was released on bail he apparently spent four months living independently in the community in circumstances where he reported to Dr Timmins he felt listless, and to Dr Timmins and Dr Subramanian that he resumed his studies, before becoming manic in July 2012.
>
> My view on the evidence before me is that [the appellant] was of sound mind at the time of the alleged offending. I allow for the possibility that he was suffering some abnormality of mind related to bi-polar affective disorder, but I cannot conclude on all the evidence that he was deprived of any relevant capacity. The charges against him ought to proceed according to law. The only evidence before me was that he is fit for trial."

Ground 1 – Failure to have regard to the evidence of Ms Nicot

The appellant's submissions

[67] The ground of appeal alleging that the MHC failed to take into account all the relevant evidence was premised on a submission that the MHC "did not consider and evaluate the significance of the evidence concerning the advice Ms Nicot gave to the appellant".

[68] Counsel for the appellant placed reliance on the following passage from the report of Dr Grant dated 6 December 2014:[65]

> "When [the appellant] was in the watchhouse [he] was visited by a support organisation that assists French people and the woman from that organisation had warned him not to mention anything about mental illness because that could make his situation worse. These influences all added to the fact that he denied involvement in the offences and denied his history of mental illness in the period after he was arrested
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> …
>
> [The appellant] has subsequently indicated (as noted above) that he was being deliberately guarded in regard to his history because of his involvement with Scientology, his own lack of insight and shame, and the advice he had been given by the French support agency in the [watchhouse]."

[69] It was submitted that it was clear from Dr Grant's report that he considered that Ms Nicot's advice could have played a significant part in motivating the appellant to conceal signs of mania from Dr Wolfenden on 17 February 2012 and that view became clearer in his oral evidence. In addition to attitudes that the appellant claimed he gained from Scientology, which might have caused him to conceal his mania, Dr Grant added:[66]

> "Also when he was in the watchhouse, he said that he was advised by a member of the French consulate not to talk to doctors either, for reasons that were not clear to me, but those, along with his lack of

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65 AB 1213 and 1217.

66 AB 32.34-38.

> insight, I think probably might explain to some extent, anyway, why he wasn't obviously manic."

[70] Later, Dr Grant said:[67]

> "It is possible for people with mania to sometimes contain their symptoms to a certain extent, especially if they are raised to never talk to a psychiatrist, never accept anything about mental illness and have been told by their consulate not to talk to doctors. So people can contain it, and I think he must have been containing it when he was interviewed."

[71] It was argued that the MHC "did not consider at all the significance of this relevant evidence from Ms Nicot in circumstances where Dr Grant regarded it as possibly an important contributing factor in the appellant masking his mania from Dr Wolfenden". It was also submitted that had the MHC considered it, the MHC "would have had to conclude that the appellant was indeed told to conceal any mental illness". Additionally, it was submitted that had the MHC taken Ms Nicot's evidence into account, it may not have rejected[68] the other influences that the appellant claimed contributed to him masking mania, because, it was said, there can be no doubt that the appellant was truthful when he told Dr Grant about what Ms Nicot had said. It was said that, had the evidence been taken into account, the scepticism of the MHC "about all the statements [the appellant] has made"[69] may have resulted in the MHC accepting that the appellant had masked his mania from Dr Wolfenden and others and accepting Dr Grant's opinion that he masked a mental illness that deprived him of a relevant capacity. A finding of unsoundness of mind, it was submitted, would then have been made.

Consideration

[72] This ground of appeal is not made out for the following reasons. Firstly, I do not perceive from Dr Grant's evidence that he placed as much significance on what Ms Nicot told the appellant in terms of being careful about what he said to anyone other than his lawyer as the appellant's counsel placed on it.

[73] Further, the real issue was whether or not it was possible for the appellant to have been so manic that there was a deprivation of a relevant capacity although symptoms of mania were unable to be detected soon after the events in question and for a prolonged period thereafter. Counsel for the appellant did not seek to dispute that there was a lack of objective evidence of mania, rather, his argument was that an explanation for the lack of objective evidence was that the appellant was masking the symptoms for a number of reasons, including what he was told by Ms Nicot.[70]

[74] Although counsel for the appellant made the point that the lack of detection of symptoms of mania during Dr Mann's examination might be understood in terms of what Ms Nicot had told the appellant, the weight of the expert evidence, to which the MHC expressly had regard, was against a person with mania being able to mask symptoms for a prolonged period. The fact is that none of the examining psychiatrists reported observing symptoms such as elevated mood, pressured speech and flights of

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67 AB 38.10-14.
68 See [2016] QMHC 1 at [49].
69 See [2016] QMHC 1 at [48].
70 TS 10-11.

ideas. Significantly, as the MHC observed, mania is not a "subtle mental illness" nor one which would be expected to improve without medication. The advice of Dr Reddan, as assisting psychiatrist was that the appellant may have been "on the prodrome with clear signs of mania only apparent in July 2012". The MHC did give proper consideration to the issue of whether the appellant may have been masking his symptoms for a number of reasons. In the final analysis, the Court was simply unable to be satisfied to the requisite degree that the appellant had masked any symptoms of mania and that there was a deprivation of capacity as a result of the appellant being in a manic phase.

Ground 2 – error in finding that there was no deprivation of capacity

The appellant's submissions

[75] Whether the appellant was of unsound mind when the alleged offences were committed required satisfaction about two matters. First, that he probably then had a mental disease. Second, that that disease probably deprived him of at least one of the capacities referred to in s 27 of the Code. The *Briginshaw*[71] principle was not relevant to satisfaction about either matter.[72]

[76] As to the first matter, it was submitted that the MHC came to no conclusion about the issue, beyond proceeding to consider the second matter on the basis that the appellant possible had a mental disease, bipolar affective disorder.[73] It was accepted that the MHC's inability to "conclude on all the evidence that he was deprived of any relevant capacity"[74] rendered it unnecessary to consider the first matter further. However, for the appellant to succeed on this ground it is first necessary to demonstrate that the evidence permitted a conclusion that he probably had a mental disease. The evidence did permit of that conclusion.

[77] Dr Grant was of the opinion that the appellant suffered from bipolar affective disorder at the time the offences occurred. The MHC referred to his opinion.[75] The MHC noted that Dr Timmins was also of that opinion[76] and that Dr Mann ultimately came to that diagnosis as well.[77] The MHC said that Dr Wolfenden thought that the appellant might have had bipolar affective disorder or a prodromal psychosis.[78] Dr Subramanian preferred a diagnosis of acute polymorphic psychiatric disorder;[79] however, that did not preclude a conclusion that the appellant suffered bipolar affective disorder given the preponderance of opinion.

[78] As to the second matter, it was submitted that the conclusion[80] that the evidence did not establish more probably than not that the appellant was deprived of a relevant capacity was wrong. In that regard, it was argued that Dr Grant's evidence should have been accepted. Dr Grant's opinion was rejected because, firstly, it could not be reconciled with the way in which the alleged offence was committed[81] and because,

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71 See *Briginshaw v Briginshaw* (1938) 60 CLR 336.
72 *McDermott v Director of Mental Health; ex parte Attorney-General (Qld)* [2007] QCA 51 at [84].
73 [2016] QMHC 1 at [81].
74 [2016] QMHC 1 at [81].
75 [2016] QMHC 1 at [50].
76 [2016] QMHC 1 at [37].
77 [2016] QMHC 1 at [19].
78 [2016] QMHC 1 at [66].
79 [2016] QMHC 1 at [44].
80 [2016] QMHC 1 at [81].
81 [2016] QMHC 1 at [79].

secondly, no signs of mania were apparent in the police interview on 2 February 2012 or when seen by Dr Wolfenden and others in prison.[82]

[79] Counsel for the appellant submitted that, as to the consideration, referred to by the MHC, that planned or organised offending was inconsistent with mania, Dr Grant's evidence was that people who were mentally ill could often be well organised in their actions. However, he did not regard the appellant's actions as well planned or well organised because he left his car, and identifying documents in that car, parked outside the next door house when he lived further away from the fire.[83] He said that a lot of mentally ill people, although deprived of the capacity to know that they ought not to do any act, were not deprived of the ability to plan and carry out complex actions.[84]

[80] Counsel for the appellant also argued that, as to the absence of evidence of mania at the time of the offending, referred to by the MHC, Dr Grant's opinion was that there was evidence of it before the offending and after it and that the appellant hid or masked his mania to a large extent from Dr Wolfenden. The evidence Dr Grant gave relevant to there being signs of mania prior to 1 February 2012 was that the appellant had a number of "classic symptoms" of mania in the period leading up to the night of the fire.[85] Those symptoms were listed by Dr Grant.[86] He also thought that the appellant may have revealed a symptom of mania around the time that Dr Wolfenden saw him in the form of disinhibited behaviour that resulted in a prison assault.[87] Dr Grant also pointed to Dr Wolfenden's observation that during her interview with the appellant he was not concerned that he was facing very serious charges.[88] Other evidence of mania after the alleged offences involved the appellant's behaviour whilst on bail, which involved him running naked along a street.[89]

[81] Dr Grant's evidence as to whether the appellant's mania had been sufficient to deprive him of a capacity was that it was.[90] He did not consider the appellant's denial of involvement to the police as inconsistent with deprivation of the capacity to know that he ought not to have done the acts.[91] Dr Grant said he had often seen people contain their mania.[92] Dr Grant's evidence was:[93]

> "It is possible for people with mania to sometimes contain their symptoms to a certain extent, especially if they are raised to never talk to a psychiatrist, never accept anything about mental illness and have been told by their consulate not to talk to doctors. So people can contain it, and I think he must have been containing it when he was interviewed. But the history from the relatives is not just suggestive in my view, it's diagnostic. They don't just say he's a bit hypomanic. He was unbearable. He was spending all their money. He was clearly

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82 [2016] QMHC 1 at [80].
83 AB 51.40.
84 AB 45.25-30.
85 AB 35.05.
86 AB 30.38; 31.15.
87 AB 33.01-07.
88 AB 32.25-30; AB 33.05-10.
89 AB 31.45-AB 32.05.
90 AB 36.05-13.
91 AB 36.10-15).
92 AB 38.44; AB 40.45-41.02.
93 AB 38.10-20.

> manic, when you talk to the mother and siblings, and they're very, very concerned about him. So I don't think it's just suggestive, Dr McVie. I think it's much more than that, so that's why I made the diagnosis."

[82] It was noted by the appellant's counsel that although she thought that mania could not be effectively concealed either during a 90 minute interview or during an extended stay in prison, Dr Wolfenden did not exclude the possibility completely.[94]

Consideration

[83] The weight of the medical evidence was that the appellant suffered from bipolar affective disorder. There was no error in failing to consider whether the appellant was suffering from a mental disease at the relevant time. The approach of the MHC was to proceed on the basis that the appellant was suffering from a state of mind related to bipolar affective disorder.

[84] It was relevant to take into account, as the MHC did, in determining whether there was mania such as to result in deprivation of capacity that the alleged offending in question involved planned and organised conduct that was carried out very quietly and purposefully. The assessment of that evidence was one that was open to the MHC.

[85] As to the MHC's emphasis in reaching the conclusion that there was no deprivation of capacity that there was an absence of relevant signs of mania, the MHC was entitled to consider the issue against "the objective evidence as to his condition". This included the lack of signs of mania during the two hour police interview, or during the long examination by Dr Wolfenden, and that no such signs emerged during the two month period of the appellant's imprisonment when he was in a stressful prison environment. Further, the MHC placed emphasis on the fact that the appellant did not display symptoms of mania until some four months after release on bail when he was living independently in the community. In reaching the conclusion that there was no relevant deprivation of capacity, the MHC also had regard, as it was entitled to, to the advice of the two assisting psychiatrists which supported the conclusion reach by the MHC.

[86] I am unable to be persuaded that the MHC's determination that the appellant was not of unsound mind at the relevant time involved appellable error.

Order

[87] I would dismiss the appeal.

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94 AB 38.30-37; AB 40.23-27.