THE COURT OF APPEAL

Birmingham P.
Edwards J.
McCarthy J.

Record No: 231/2016

APPLICATION UNDER THE CRIMINAL PROCEDURE ACT 1993, SECTION 2

THE PEOPLE AT THE SUIT OF

THE DIRECTOR OF PUBLIC PROSECUTIONS

Respondent

V

YUSUF ALI ABDI

Appellant

JUDGMENT of the Court delivered on the 13th of February, 2019 by Mr. Justice Edwards

Introduction.
1. On the 14th of May 2003, the applicant was placed on trial for the offence of murder in the Central Criminal Court. The applicant was alleged to have murdered his 20-month old son. That the applicant had killed the child was not in contest, but it was contended on his behalf that the applicant had been insane at the time of the killing, within the meaning of M'Naghten Rules which still applied in Ireland at the time of the trial (albeit as modified in the Irish context post *Doyle v Wicklow Co Council* [1974] I.R.55). The insanity defence advanced by the applicant was rejected by the jury, who on the 28th of May 2003 convicted the applicant of murder by a majority verdict of 10:2. The applicant was then sentenced to life imprisonment.

2. The applicant now seeks to have his conviction set aside on the basis that he is the victim of a miscarriage of justice. In brief, the basis for this claim is as follows. Psychiatric evidence was called on behalf of the defence at the applicant's trial to the effect that the applicant was a paranoid schizophrenic. There was expert testimony in that regard from Dr. Brian McCaffrey and Dr. Aggrey Washington-Burke, Consultant Psychiatrists. In response to this the prosecution called evidence from Dr. Damien Mohan, a forensic psychiatrist based at the Central Mental Hospital, who had assessed the applicant to the effect that he was not suffering from schizophrenia. The jury were therefore faced with conflicting expert opinions. The prosecution's medical evidence was ostensibly preferred by the jury, and they rejected the defence of insanity. However, some ten years later, in 2013, yet another psychiatrist (also based at the Central Mental Hospital) independently diagnosed the applicant as suffering from paranoid schizophrenia. This latest diagnosis was not made in the context of a forensic assessment conducted for the purpose of a pending trial, but rather in the context of a clinical assessment of the appellant who had been admitted to the Central Mental Hospital by reason of exhibiting symptoms of possible mental illness while in prison. The applicant maintains that this 2013 diagnosis confirms the evidence of the psychiatrists who testified on his behalf at his trial, and further demonstrates that the defence of insanity was wrongly rejected by the jury at trial. It is contended that the 2013 diagnosis, and certain medical evidence underpinning it that has been recorded since the trial, represent newly discovered facts on which the applicant should now be entitled to rely in the hope of persuading this Court that it is possible that he may have been the victim of a miscarriage of justice.

The legal rules relating to the defence of insanity applicable at the time.
3. The applicant's trial took place in 2003, some three years before the enactment of the Criminal Law (Insanity) Act, 2006. In the introduction to this judgment we stated that the "modified" M'Naghten Rules were in operation. This was in the following circumstances. The insanity defence available under the original M'Naghten Rules catered solely for insanity based on insane delusions, such as are experienced by persons suffering from psychosis. To succeed in an insanity defence based on insane delusions, the applicant would have been required to satisfy the jury on the balance of probabilities, that at the material time he was suffering from a disease of the mind that prevented him from (a) knowing the nature and quality of his act, or (b) from knowing that the act in question was wrong. However, as already pointed out, following *Doyle v Wicklow Co Council*, another possible basis for establishing insanity – namely volitional insanity – was recognised in Irish law. Volitional insanity arose where a person, who was suffering from a disease of the mind, had killed another as a result of an "irresistible impulse". Post *Doyle v Wicklow Co Council* a modified form of the original M'Naghten Rules that sought to accommodate volitional insanity was operated in Ireland up until the coming into force of the Criminal Law (Insanity) Act 2006. Allusion to this modification is relevant because it appears that the form of insanity contended for at the trial was volitional insanity. In that regard, Dr. Aggrey Washington-Burke, who gave evidence for the defence, testified that the applicant – whom he believed to be suffering from schizophrenia – did know what he was doing (in other words, he knew the nature and quality of his actions); that he did know that what he was doing was wrong; but that he couldn't prevent himself from doing what he did (in other words, that he was subject to an irresistible impulse). This evidence will be elaborated on further later in this judgment.

Subsequent procedural history of the appellant's case
4. Following his conviction of murder on the 28th of May 2003, the appellant, having been refused leave to appeal by the trial judge (Carney J.), appealed to the Court of Criminal Appeal against that refusal and sought the leave of that court to appeal. As was the usual procedure at that time, the Court of Criminal Appeal was prepared to treat and hear the application for leave to appeal as though it were the substantive appeal. The matter was heard by the Court of Criminal Appeal on the 6th of December 2004, and that court rejected the grounds of appeal advanced. See the judgment of the court delivered by Hardiman J.: *Abdi v DPP* [2004] IECCA 47.

5. As Hardiman J. notes, the grounds of appeal were very confined. They were as follows:

> *"(1) The Central Criminal Court erred in law in permitting Dr. Mohan, a Consultant Psychiatrist, to give evidence of his opinion as to the applicant's motive in killing his son.*

(2) The learned trial judge erred in law in repeating in his charge to the Jury Dr. Mohan's opinion as to the applicant's motive in killing his son."

A third ground was not pursued.

6. In summary, the Court of Criminal Appeal, following a consideration of the disputed evidence given by Dr. Mohan, was satisfied that the trial judge had been correct to admit it. In giving judgment on behalf of the court, Hardiman J. stated, *inter alia*:

"39. We wish to emphasise, however the central role of the jury on the issue of insanity. Many cases where insanity is pleaded do not in fact give rise to a great deal of controversy but, due to the difficulties and uncertainties attending on this particular area of medical science, there will always be those that do. But whether controversial or not, it is essential that every such decision be taken by a properly informed jury in a public forum. Equally it is important that where a person does not suffer a criminal conviction on the ground of insanity, such insanity should be clearly and publicly established to the satisfaction of the general public as represented by the jury. The role of the expert witness is not to supplant the tribunal of fact, be it judge or jury, but to inform that tribunal so that it may come to its own decision. Where there is a conflict of expert evidence it is to be resolved by the jury or by the judge, if sitting without a jury, having regard to the onus of proof and the standard of proof applicable in the particular circumstances. Expert opinion should not be expressed in a form which suggests that the expert is trying to subvert the role of the finder of fact.

40. But there was no question of any such thing in Dr. Mohan's evidence. The disputed opinion he offered was indistinguishable in nature (though different in content) from the opinion which the defence had led their own doctors to express. Moreover Dr. Mohan's evidence was fully and amply supported by closely reasoned arguments and properly drawn inferences, and was presented with a minimum of technicality and such technicality as there was, was comprehensively explained.

41. The jury could have preferred the expert evidence called by the defence or that called by the prosecution and were fully entitled to prefer Dr. Mohan's expert opinion."

Legal rules applicable to the present proceedings

7. The applicant has made an application to this Court pursuant to s. 2 of the Criminal Procedure Act 1993 ("the Act of 1993"). That provision (to the extent relevant) states:

2.(1) A person—

(a) who has been convicted of an offence either—

(i) on indictment, or

(ii) after signing a plea of guilty and being sent forward for sentence under section 13 (2) (b) of the Criminal Procedure Act, 1967, and

who, after appeal to the Court including an application for leave to appeal, and any subsequent re-trial, stands convicted of an offence to which this paragraph applies, and

(b) who alleges that a new or newly-discovered fact shows that there has been a miscarriage of justice in relation to the conviction …,

may, if no further proceedings are pending in relation to the appeal, apply to the Court for an order quashing the conviction or reviewing the sentence.

(2) An application under subsection (1) shall be treated for all purposes as an appeal to the Court against the conviction or sentence.

(3) In subsection (1) (b) the reference to a new fact is to a fact known to the convicted person at the time of the trial or appeal proceedings the significance of which was appreciated by him, where he alleges that there is a reasonable explanation for his failure to adduce evidence of that fact.

(4) The reference in subsection (1) (b) to a newly-discovered fact is to a fact discovered by or coming to the notice of the convicted person after the relevant appeal proceedings have been finally determined or a fact the significance of which was not appreciated by the convicted person or his advisers during the trial or appeal proceedings.

(5) Where—

(a) after an application by a convicted person under subsection (1) and any subsequent re-trial the person stands convicted of an offence, and

(b) the person alleges that a fact discovered by him or coming to his notice after the hearing of the application and any subsequent re-trial or a fact the significance of which was not appreciated by him or his advisers during the hearing of the application and any subsequent re-trial shows that there has been a miscarriage of justice in relation to the conviction, or that the sentence was excessive,

he may apply to the Court for an order quashing the conviction or reviewing the sentence and his application shall be treated as if it were an application under that subsection."

8. In the last quarter of a century the provision in question has received a good deal of judicial consideration. The cases have

focussed primarily on two issues. The first, and highly relevant issue in the context of the present case, concerns the requirement that the new evidence, which it is claimed has emerged and is suggestive of a possible miscarriage of justice, must take the form of a "*new fact*" or a "*newly discovered fact*". Clearly the definitions within subsections 3 and 4, respectively, of s. 2 of the Act of 1993, are helpful insofar as they assist with understanding what is meant by "*new*" and "*newly discovered*" respectively. However, they do not assist with determining what is or is not "a fact". However, assistance in that respect is provided by the judgments in several cases that have come before the appellate courts, the leading authority being that of *People (Director of Public Prosecutions) v Kelly* [2008] 3 I.R. 697. We will return to this momentarily.

9. Before doing so, however, it should be stated that the second issue on which there is now a significant body of jurisprudence concerns the objective evaluation of a new or newly discovered fact (assuming the existence of one or other can be established) with a view to determining whether the fact at issue, if known about and/or properly appreciated, could have been used by the defence to raise a significant doubt in the minds of the jury with respect to a significant element of the prosecution case. In other words, to what extent is there a real risk that there might have been a miscarriage of justice? Could the new or newly discovered evidence have so influenced the jury, if they had known about it, to the extent of possibly giving rise to a different verdict? The leading authorities on this are *The People (Director of Public Prosecutions) v Meleady & Grogan* [1995] 2 IR 517; *The People (Director of Public Prosecutions v Meleady (No. 3)* [2001] 4 IR 16; *The People (Director of Public Prosecutions) v Shortt (No. 2)* [2002] 2 I.R. 696; *The People (Director of Public Prosecutions) v Kelly* (previously cited) *and The People (Director of Public Prosecutions) v Conmey* [2010] IECCA 105.

10. Returning to the jurisprudence on the first issue, in *The People (Director of Public Prosecutions) v Kelly*, the Court of Criminal Appeal considered the natural and ordinary meaning of the word "*fact*" (at 708, para [34]) and adopted with approval the definitions of it contained in the Concise Oxford English Dictionary as being "*a thing that is indisputably the case*"; and "*the truth about events as opposed to interpretation*". The Court noted that "*opinion*" on the other hand was defined as "*a view or judgment not necessarily based on fact or knowledge*".

11. The *Kelly* case, which also involved an application under s. 2 of the Act of 1993, involved a contention that the following constituted newly discovered facts: newly commissioned expert reports questioning the pathology evidence given at the original trial; an expert report on the origin of a fire; and a report disputing the voluntary nature of the inculpatory statement made by the applicant to gardaí before his trial based on a CUSUM (cumulative sum) analysis (a technique not available at the time of trial). In addition, it was sought to rely on a booklet of photographs taken during the post-mortem examination of the victim that had not been disclosed to defence at the time of trial, and a further expert report that addressed these photographs.

12. The Court of Criminal Appeal accepted that the undisclosed photographs – and expert evidence in relation to the interpretation of those photographs – were capable of being newly discovered facts, and went on to engage with that evidence in conjunction with the evidence adduced at the original trial before ultimately concluding that further cross examination of Dr. Harbison (the State Pathologist who had given evidence for the prosecution at the trial) by reference to the absent photographs would not have thrown any real doubt on his diagnosis of cause of death. However, with respect to the other matters advanced as being newly discovered facts, the court rejected that the contention that they were "facts", as opposed to opinions, whatever about them being newly discovered.

13. As to the jurisprudence on the second issue, in *The People (Director of Public Prosecutions) v Meleady & Grogan*, Keane J. (as he then was), giving judgment for the Court of Criminal Appeal stated:

> *"There is nothing in the wording of s. 2 or s. 3 to suggest that the applicant under s. 2, in addition to alleging that a newly-discovered fact shows that there has been a miscarriage of justice, must satisfy the Court that such a miscarriage has actually occurred before it proceeds to exercise the powers to quash the conviction or to quash and order a re-trial.*
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> *Nor is there any reason for such a requirement: the mischief which this legislation was designed to remedy was not simply the non-disclosure to the court of trial of facts which, if available, would have conclusively demonstrated the innocence of the accused. It was also to provide redress, hitherto not available, in cases where facts came to light for the first time after the appeal to this Court which showed that there might have been a miscarriage of justice. The power to order a re-trial in cases under s. 2 would be inappropriate if relief under that section was only intended to be available to those who could satisfy this Court that a miscarriage of justice had actually occurred. It seems clear to this Court that it was also intended to afford relief to those who could point to materials which, if they had been available at the trial, might — not necessarily would — have raised a reasonable doubt in the mind of the jury."*

14. Both the *Meleady & Grogan* and the *Meleady (No. 3)* cases were followed and applied by the Court of Criminal Appeal in *The People (Director of Public Prosecutions) v Shortt (No. 2)*, in which the court was concerned with whether the newly discovered facts in that case (including evidence suggesting that the principal prosecution witness had perjured himself at trial, and evidence of the suppression of material documents) were tantamount to providing a miscarriage of justice. It was not confined to the question of actual innocence but extended to the administration of the justice system itself. The court was not making a finding that the applicant was innocent of actual involvement in the events. Innocence of that kind would not have been proved as a result of an acquittal by a jury. A certificate could have been granted even if there was involvement by the applicant. Giving judgment for the court, Hardiman J. said, (at 710-711):

> *"…the mere existence of a newly discovered fact in relation to a trial is, both in law and logic, incapable in itself of leading to a successful result. The newly discovered fact may be irrelevant or of only slight relevance, it may leave untouched a compelling body of incriminating evidence. It is not sufficient for an applicant simply to plead that there is a newly discovered fact. He must go on to plead that it shows there has been a miscarriage of justice. …*
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> *There is no basis in law for suggesting that the applicant is confined to newly discovered facts known to him at the commencement of the s. 2 proceedings, before discovery or disclosure. In a case where the whole basis of his complaint is that material matters were concealed from him, it would be entirely unjust to confine him to a pleading filed at a time when evidence of undoubted relevance was wholly outside his knowledge."*

15. More recently, in the case of *The People (Director of Public Prosecutions) v Conmey*, (a case involving material statements taken from key witnesses that were not disclosed, and the existence of which only became known to the defence many years later) Hardiman J., giving judgment on behalf of the Court of Criminal Appeal, sought to emphasise that:

> *"… the task of the Court on an application such as this is not to attempt the fruitless task of achieving certainty about a*

hypothetical change in the evidence in a trial that took place more than thirty years ago. It is instead to resolve the question whether this is a case '… where facts came to light for the first time after the appeal which showed that there might have been a miscarriage of justice' The People (D.P.P.) v. Meleady and Grogan [1995] 2 IR 517 at pp. 540-41). The Court is of opinion that it is such a case."

The evidence at the trial

(i) Chronology of events leading up to the 18th of April 2001 as established in evidence

16. The applicant is a national of Somalia and arrived in the State on the 10th of June 1997. At trial, the applicant gave evidence of his time in Somalia and the difficulties his family encountered during the war in 1990 in his hometown in Kismaayo. He also gave evidence that he saw faces and heard sounds and voices, mostly of the people who had persecuted him. In 1998, he met and entered into a relationship with an Irish National, a Ms. Amanda Bailey. In or around October 2000, he was granted refugee status. On the 24th of May 1999, the applicant and Ms. Bailey married and, at this stage, Ms. Bailey was pregnant with the couple's son. In August 1999, the applicant's wife gave birth to their son. The applicant and his family moved to Clane, Co. Kildare in or about February 2000. Under cross-examination at trial, Ms. Bailey testified that during the early stage of their relationship, the applicant was a sociable person with quite a few friends in Ireland. She also gave evidence that the applicant was *"quite calm, chilled out"* and a *"very sensitive"* person. Ms. Bailey also described the applicant's initial relationship with his son in glowing terms, stating that *"he was a really good father, he never raised his voice to him. You know I lost my temper with him, well, not my temper but he would frustrate me but Joe [the applicant] never lost his patience with him, never, he loved him"*.

17. The evidence of Ms. Bailey was to the effect that the applicant's behaviour changed somewhat following an "altercation" between him and some members of An Garda Síochána on the 13th of November 1999. The applicant was apparently convicted of assaulting the gardaí in July 2000, for which he was sentenced to 100 hours' community service and placed under the care of the Probation Service. Ms. Bailey's evidence was that the applicant's behaviour changed after this incident, in that he *"began to think the Gardaí were following him [but] his paranoia was only with reference to the Gardaí at that point…I mean there was reason to be paranoid in the beginning but then it became totally not founded, I mean he thought every Garda was following him"*.

18. Ms. Bailey's evidence was that the applicant's mental state worsened throughout the course of 2000. In November 2000, the applicant travelled to the UK before going to Uganda in Africa, and ultimately onto Kenya, for the purpose of finding his younger sister whom he felt *"that he was responsible for"*. Upon returning from Kenya, Ms. Bailey gave evidence that the applicant *"had lost a lot of weight. He was even thinner than he had been and he seemed sick, tired, he didn't look well at all."* In respect of his mental state, Ms. Bailey described the trip to Africa as a *"huge changing point"*, stating that the paranoia was exacerbated in the sense that it became directed towards Ms. Bailey. The applicant, Ms. Bailey testified, accused her of trying to get him deported, of *"ringing the mosque and saying bad things about him, about calling his friends and saying bad things about him…He accused me of poisoning his food and having a plan against him."*

19. This straining of the relationship culminated in Ms. Bailey leaving the house on the 21st of February 2001. Ms Bailey was going to a friend's birthday and wanted to take her son with her, but the applicant didn't want her to. Subsequent to further accusations broadly in line with the ones outlined above, Ms. Bailey said to the applicant *"you're sick"*. The applicant then hit Ms. Bailey over the head with a telephone. After this, Ms. Bailey called her parents, before visiting her local GP, Dr. Claire O' Flynn, who was called by the prosecution at trial. She agreed under cross-examination that, based on the description and surrounding circumstances described to her by Ms. Bailey of the above incident, it was likely that the applicant had developed paranoid depression or schizophrenia.

20. Ms. Bailey moved back in with the applicant but his behaviour continued to be *"strange"*. She gave evidence of him rarely leaving the house unless it was absolutely necessary, that he would have the curtains pulled 24 hours a day, believing that his phone and fire alarm were bugged, and, more generally that *"everyone was against him"*.

21. In respect of the incidents leading up to the morning of her son's death, Ms. Bailey gave evidence that she brought their son to Clane to meet with the applicant on the 17th of April 2001. The evidence was that the applicant had taken his son for a walk at around 3pm in the afternoon, during which the applicant claimed to have had some form of altercation with a local woman. Later on that evening, the applicant left the apartment in order to get cash out of an ATM, during which he asserted to Ms. Bailey that he had been racially abused by a child en route home. Ms Bailey stayed in the applicant's house on the night of the 17th of April. She slept with her son in the bedroom, whilst the applicant slept in the living room. The evidence was that at approximately 4:20 am on the morning of the 18th of April 2001, at the family home in Clane, the applicant brought his son from the bedroom into the living room, and ultimately caused fatal injuries to his son.

22. He was arrested by Gardaí later that morning and charged with murder on the same day.

(ii) The applicant's own evidence at trial

23. As previously stated it was accepted by the defence at trial that the applicant had caused the death of his son. However, the defence of insanity was raised and this was the only issue at the trial. The applicant gave evidence in his own defence. This Court has not been provided with a full transcript of the trial, but the applicant's testimony is, it is accepted by the respondent, succinctly and accurately summarized in the grounding affidavit of his solicitor, James MacGuill, sworn on the 16th of June 2017. Mr MacGuill states:

> *'12. The applicant gave evidence about his experience of persecution during the civil war in Somalia and in a refugee camp. He said that after making his way to Ireland lie had difficulty sleeping because he had memories of what happened in Somalia. He saw faces and heard sounds and voices, mostly of the people who had persecuted him. They spoke in his native language, Bajuni. After coming to Ireland he felt very low and very tired; he felt "as [though] the world was not moving'. In 1997 he attended Dr. Whitty and was referred to the Mater Hospital. They found nothing physical wrong with him and referred him to the psychiatric services in the hospital. They did not tell him what was wrong with him but he was given medication, which he took. Nevertheless, he still felt low. He cried and sometimes felt like he no longer wanted to live. He told the psychiatrist at the Mater in 1998 that he heard noises inside his head, by which he meant that he heard voices "from the people back home". He did not explain any further to the psychiatrist about the voices (see Day 4. pp. 14-34).*
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> *13. The applicant said that in 1999 he was arrested by Gardaí for no reason and was wrongfully convicted of assaulting a Garda. He completed 100 hours of community service at the Mosque in Clonskeagh. After that incident he was scared of Gardaí. He felt like they were following him. He felt that they were tapping his telephone and that they were going to kill him. Then he started to believe that other people were also following him and were outside his house with video*

cameras, so he kept the curtains closed. He also started to mistrust his wife Ms. Bailey and believed she was going to poison him or have him deported. He thought the news on the television and in newspapers was about him. He believed a camera had been installed in his smoke alarm, to spy on him. He thought messages on billboards were intended for him. He heard voices in English and Bajuni, talking about him. Twice or three times he smclled "dog shit" very strongly, even though there was no dog. In November 2000 he travelled to England and then to Uganda and on to Kenya to search for his sister. Upon his return to Ireland in December 2000 he felt he had contracted malaria and Dr. Whitty prescribed an anti-malarial drug, Larium, which he took for five weeks. He was still taking the drug in February 2001 when he struck Ms. Bailey with a telephone. He had never struck her before then (see Day 4. pp. 35-59).

14. On the day before his son died the applicant felt something was wrong with him. He was taking anti-depressants. A woman who mistook him for a trespasser threatened to call the Gardaí, which left him fearful and upset. Some children made racist comments, which also upset him. At the time he was sleeping in the living room with the internal doors locked, because he was scared people would come into the bedrooms. His wife and son had come for a visit. They went to sleep in one of the bedrooms. The applicant got up in the early hours with the intention of praying, as was his habit. Then, he heard a voice in Bajuni commanding him to take Nathan from the bedroom. He felt like "a zombie or possessed"-, like he was in a different land; like his brain had been taken out. He picked Nathan up and went into the living room. The voice in Bajuni said "hit him. hit him" so he hit the child against the wall twice or three times. He did so by swinging the child by the legs. The child's head struck off the wall. Then, the applicant's senses came back and he decided to pray, leaving the child on the floor. He prayed that the child would wake up. He then put the child on the sofa and called an ambulance (Day 4. pp. 61-71).

15 The applicant said that after Nathan died he told the ambulance attendants and the Gardaí that Nathan had fallen because he did not trust them and did not know what to say to them. He told psychiatrists at Cloverhill Prison that he had been hearing voices. He attempted suicide while in Cloverhill and was transferred to the Central Mental Hospital (hereafter "CMH"). At first he did not trust the psychiatrists there either but eventually he told them he was hearing voices (Day 4, pp. 70-74).

16. Under cross-examination, the applicant said that when he attended Dr. Whitty and psychiatrists at the Mater Hospital he had not been hearing voices much and was having more of a problem with flashbacks (Day 5. pp. 10-12). He explained that he did not realise he was sick until he had been in the CMH for some months (Day 5, p. 16). He said he might have told ambulance attendants that Nathan had fallen to avoid them asking him questions, though he did not remember (Day 5, p. 20). He subsequently told Gardaí that Nathan had fallen because he was scared of them and did not trust them and feared they were going to poison him or otherwise hurt, harm or kill him (Day 5. pp. 22-24). He did not tell psychiatrists in Cloverhill Prison or at the CMH the truth about what happened when Nathan died because he did not trust anyone at that time and he thought the doctors were collaborating with the Gardai to kill him. Equally he did not at first trust Dr. McCaffrey, who was engaged by his solicitors, though he came to trust him (Day 5. pp. 25-27).'

(iii) The medical evidence adduced at trial

24. At trial, extensive evidence was adduced by both sides regarding the mental state and psychiatric history of the applicant. The jury heard from Dr. Mark Whitty, a GP who was called by the prosecution, that he had treated the applicant between 1997 and 2000 for various physical complaints; namely stomach pains and back pain. He gave evidence that, after referring the applicant to the Infectious Diseases Department at the Mater Hospital, he received a letter from a Dr. Hittan Tacker dated the 20th of January 1998, which stated that these physical complaints may be related to *"depression associated with his move from Somalia and distress at what he had seen in Africa"*. The applicant was subsequently referred to the Consultant Psychiatrist Unit at the Mater Hospital. A number of letters sent to Dr. Whitty from this unit were adduced in evidence which stated that the applicant had been diagnosed with Post-Traumatic Stress Disorder ("PTSD") and had been prescribed anti-depressants as a result. A letter from Dr. Sandra Clare at the Infectious Diseases Department stated that the applicant had recurring flashbacks in respect of events he experienced in Africa. He was prescribed with anti-depressants in a quantity suitable for use as a sleeping tablet. Dr. Whitty had also prescribed the applicant with anti-malarial medication, Larium, in December 2000 for a period of five weeks. Dr. Whitty agreed that Larium may cause psychosis when administered to a patient with a psychiatric disorder.

25. In seeking to prove on the balance of probabilities that at the time of the incident the applicant was suffering from a psychosis, the defence relied on testimony from a number of experts; namely from Dr. Aggrey Washington-Burke, Consultant Psychiatrist; Professor Michael Ryan, who at the time of the trial held the Chair of Pharmacology at UCD; Dr. Séan Lynch, a General Practitioner, and Dr. Brian McCaffrey, Consultant Psychiatrist.

26. Once again, this Court has been presented with an uncontroversial summary of the medical evidence that was given by these witnesses, and again it is convenient to quote verbatim from that summary as contained in the aforementioned affidavit of Mr MacGuill. He states:

'17. Dr. Aggrey Washington-Burke, a London-based Consultant Psychiatrist, said he did not think this offence was carried out by a normal man. A normal person could not have carried out the offence without a very considerable degree of malice or personality disturbance or psychopathic tendency (see Day 5, p. 33). He said that the disease of schizophrenia is much more common among migrants, and it can be precipitated and triggered by stressful events such as migration (Day 5. p. 37). He had reason to believe that during the early months of 2001 the applicant's condition was deteriorating and his health was "on the slide". During the period when Nathan was killed the applicant "wasn't a normal man. he was suffering from an abnormality of the mind at that time". The hearing of voices was "indicative of mental illness" in the circumstances (Day 5. p. 43). Dr. Burke thought the applicant probably did know what he was doing, and he knew it was wrong, but Dr. Burke felt the applicant could not have prevented himself as he was incapable of disobeying the command given to him by the voices he had heard (Day 5. pp. 44 and 47). Dr. Burke further noted that the applicant had become irritable after his anti-psychotic medication was withdrawn at the CMH. which was due to a return of psychotic symptoms (Day 5. pp. 44-45). He concluded that the applicant was suffering from chronic schizophrenia (Day 5, pp. 46-47). He said, "it is the bizarre quality of the act and that it comes out of the blue which lends itself to the idea that it is something related to the condition called schizophrenia". He said schizophrenia can be associated with depression, suicide and murder and it has an unpredictable quality (see Day 5, p. 47). He did not agree that one would usually expect a mentally ill person who had done something extraordinary to talk about it. and he gave examples to the contrary from his own experience (see Day 5, p. 56). With regard to Larium, he said a side-effect is that it causes an increase in psychological or paranoid-type problems, and one would not discount the possibility that it was an important factor in the applicant's case (Day 5, p. 39-40).

18. Professor Michael Ryan, Professor of Pharmacology at University College Dublin, said a warning issued in 2002 that Larium should not be prescribed for patients with active depression, psychosis or schizophrenia or other major psychiatric disorders. It could cause psychiatric symptoms in a number of patients, ranging from anxiety, paranoia and depression to hallucinations and psychotic behaviour. The drug can remain in the system for months after a person stops taking it, depending on how much the person has taken (see Day 5, pp. 63-73). There is quite a high incidence of reported side effects; indeed, the drug is "notorious" for its reported side effects. The literature suggests that 1 in 140 people will have a psychiatric side effect (Day 5, pp. 79-80). After ten weeks had passed since a person stopped taking Larium, there would be a small residual amount in the blood, but the literature suggests that psychiatric disturbances do not correlate with blood levels (Day 5. pp. 82-83). Prof. Ryan further said that the medication given to the applicant in the CMH included an anti-schizophrenia and anti-psychotic drug (Day 5, p. 74).

19. Dr. Sean Lynch, a general practitioner based in Clane, said the applicant attended his surgery with physical complaints, stress and anxiety on a number of occasions in 2001, before his son's death. Dr. Lynch felt he was depressed with anxiety symptoms and prescribed him anti-depressants. He did not do this lightly. He felt the applicant was quite low at that time; quite depressed. When the applicant next attended he seemed better - his appetite had improved and he was sleeping better. He had no symptoms of psychosis and did not discuss hearing voices (see Day 5. pp. 85-94).

20. Dr. Brian McCaffrey, Consultant Psychiatrist, had a series of interviews with the applicant, commencing in March 2002. The applicant reported that he was hearing voices, taunting him (Day 5, p. 110). This, according to Dr. McCaffrey, was a classic schizophrenic phenomenon. The applicant also reported smelling ""dog shit" three times in the absence of a dog, which Dr. McCaffrey put down to olfactory hallucinations. This was not common and had three possible causes: epilepsy, severe depression and schizophrenia. The applicant did not have epilepsy and Dr. McCaffrey had never seen olfactory hallucinations in a person of the applicant's age group with severe depression, leaving only schizophrenia. The applicant's belief that he was being pursued by the Gardai was the earliest indication of paranoia, and it then expanded to his wife and beyond. The belief that he had been poisoned added to the diagnosis. His experiences in Somalia made him much more vulnerable to the pressure which brings on a psychosis. His belief that the phones were tapped and a camera was installed; his locking of doors and thinking the television and magazines were talking about him - this was psychotic behaviour. The fact that he remained flat with little reaction or emotional interaction was a further characteristic of schizophrenia. Ultimately, he fit perfectly within the criteria set out in both of the international classifications systems for diagnosing mental illness (see Day 5, pp. 106; 113-118; 122-123).

21. Dr. McCaffrey said he was aware of people trying to dupe him but he always double checked and he knew that when the applicant described the voices he heard and the smell he experienced, that "[t]his was real belief on his part. He could not have got it from anybody else" (Day 6. p. 11).

22. Dr. McCaffrey further said it was common for persons with schizophrenia not to talk about their symptoms and to keep them to themselves. Only if the right questions were asked would the person talk, and the most difficult of all is the paranoid individual. Unlike psychiatrists, general practitioners were not trained in psychiatric practice or interviewing techniques to find evidence of psychotic behaviour (Day 5, pp. 114-114 and Day 6. p. 10). Dr. McCaffrey said the applicant was very guarded with him and remained so for a long time. However, he eventually told Dr. McCaffrey about what had happened on the night that Nathan was killed. This was in January 2003.

23. It was Dr. McCaffrey's opinion that the applicant was in a disassociated state at the time of the offence. So much force was used that the offence could only have been done by somebody who was grossly psychotic (Day 5, p. 111). He was "suffering with a serious disease of the mind caused by schizophrenia which brought about this awful act and he was so mentally ill at the time that no reasoning could make him stop". Like Dr. Burke, Dr. McCaffrey felt the applicant would not have been able to refrain from doing what the voices said to him, by reasons of the disease of the mind {Day 5, pp. 112-113). He added that a psychosis can come and go, and a person could be psychotic in the middle of the night but apparently normal to the observer in the afternoon (Day 5. p. 118).

24. Dr. McCaffrey was unsure of the significance of the Larium but said it could not be dismissed. He said there had been recent reports of murders and suicides committed by persons taking Larium, and that the neuropsychiatric side effects can occur weeks to months after the person has stopped taking it (Day 5, pp. 120-122).

25 Dr. McCaffrey further said that the treatment the applicant received in the CMH was specific for the treatment of schizophrenia (Day 6, p. 12). The applicant was taking a lower dose of anti-schizophrenic / anti-psychotic medicine than Dr. McCaffrey would have prescribed, and he was also taking an anti-depressant in a high dose. As time went on he improved; the volume and frequency of the voices had decreased and he was becoming more relaxed. When he was temporarily taken off the anti-psychotic medication he relapsed and became agitated. He was put back on the drug after a number of days and improved alter two days. This suggested that the medication was appropriate for his illness (Day 5. pp.95-123).'

27. The prosecution called Dr. Damien Mohan, a Consultant Forensic Psychiatrist at the Central Mental Hospital, to give expert evidence in rebuttal. He conceded that the applicant had presented at the Mater Hospital in the years prior to his son's death with some symptoms of Post-Traumatic-Stress Disorder. However, he testified that *"there is no objective evidence which is verifiable or observable or professional evidence which confirms the presence of an underlying psychotic mental illness."*

28. Again, it is appropriate to quote verbatim from the uncontroversial summary of the evidence of this witness provided by Mr MacGuill. He states:

'26. Dr. Damien Mohan, Consultant Forensic Psychiatrist at the CMH, was called by the prosecution to give rebuttal evidence (see Day 6, pp. 16-50 and Day 7. pp. 4-71). He highlighted the applicant's interactions with medical professionals before the death of his son. He noted that the applicant had presented at the Mater Hospital in the years prior to his son's death with some features of Post-Traumatic Stress Disorder but they found no evidence of a depressive illness or of a psychosis. He also pointed to the applicant's behaviour immediately after the killing; he said there was nothing in the interviews conducted by Gardaí after the killing to suggest that the applicant was actively psychotic or suffering from hallucinations at the time of those interviews. There was no evidence of distraction or suspiciousness or guardedness. Rather, the applicant gave a clear, coherent account of the child falling twice. Equally, there was no evidence of psychotic behaviour upon admission to Cloverhill Prison on remand. Concern was expressed that he was at risk of suicide but this was not surprising as he had lost his son. In July 2001 he told staff he had taken

an overdose of tablets but tests showed he had not taken excessive medication. He also banged his head against a wall in the prison without harming himself (Day 6. pp. 16-29).

27. Dr. Mohan also pointed to various things which the applicant had said to him and to others which seemed to Dr. Mohan to be inconsistent. For instance, when speaking to psychiatrists in Cloverhill Prison and at the CMH. he tried to explain his actions in terms of them being part of his history of sleepwalking. He also told them he did not remember much about the incident but that the child probably fell. In May 2001, he denied hearing voices. In October 2001, he claimed to be hearing voices in his head and described paranoid ideation. After biting a prison officer on the hand he was transferred to the CMH for observation. He told the admitting doctor that at the time of the killing he may have been sleepwalking. He also complained that his mood was up and down and said he had been hearing voices. He continued to say that he did not remember killing his son. A psychological assessment concluded that he might have been exaggerating various aspects of his psychiatric symptoms. In February 2002 he claimed his blood was contaminated. In March 2002 he said he heard friendly voices in English. This continued in May and June 2002. In October 2002 he described toxins in his body. That month, Dr. Harry Kennedy at the CMH reported that, although the applicant was receiving anti-psychotic and anti-depressant medication, there was no obvious improvement in his symptoms. Dr. Mohan said he would have expected a response to the treatment if the applicant were psychotic (Day 6. pp. 30-37). Ultimately in May 2003 a case conference was held by the treating team at the CMH and the conclusion reached was that the applicant was not suffering from a schizophrenic illness and should be returned to prison. That evening, the applicant made "feeble" threats on his own life. He remained at the CMH because it was necessary for him to remain on high observation until the end of his trial, in light of the suicide threat (Day 6. pp. 38-40).

28. It was Dr. Mohan's own impression that the applicant was an unreliable historian as he believed there were inconsistencies in the history given to him and to others (Day 6. pp. 39-42). He said there was no objective evidence which confirmed that the applicant had an underlying psychotic mental illness before his son was killed, though he did suffer from a form of PTSD and depression. Dr. Mohan felt his depression was likely to be secondary to his cultural isolation and was exacerbated by the deterioration of his relationship with Ms. Bailey. Before he killed his son he became agitated, according to Dr. Mohan, because a situation arose regarding the religious upbringing of his child which prevented him from having custody of the child. His ability to play football on the afternoon of the killing indicated that he was not then psychotic and the fact that he locked the door to the room before killing his son indicated planning. He attempted to conceal his actions after the killing, which indicates that he knew he had done wrong. Ultimately, Dr. Mohan was of the opinion that, at the time of the killing, the applicant had the capacity to know the difference between right and wrong. The degree or extent of his mental illness was not such that it would impair his capacity to form intent. He felt his conclusion was bolstered by the fact that the treatment given to him subsequent to the killing had not made any difference. He was of the opinion that the applicant knew the nature and quality of his act, and he was aware that what he was doing was wrong. There was no evidence that his actions were the result of an irresistible impulse (Day 6. pp. 43-46).

29. Dr. Mohan further said that the anti-psychotic drugs prescribed for the applicant at the CMH were used for their sedative qualities in people who are highly aroused or agitated. The drugs were to help sedate him and to reduce the risk of suicide or self-harm. Other drugs which were used for that purpose in the past were shown to increase the risk of suicide in prisons, and they were sold from one prisoner to another, so anti-psychotic drugs are now used {Day 6, p. 47).

30. In addition, Dr. Mohan said that when the applicant was taken off the anti-psychotic medication in November 2002 for a trial period, there was an instant deterioration, followed by an improvement once the drugs were reinstated. Dr. Mohan would have expected that symptoms would relapse over a week or two, not immediately, and after the drugs were reintroduced it would take some time for the effect to be realised. This suggested to him that the applicant had conscious control over his alleged symptoms and this called into question his self-report of those symptoms (Day 6, p. 48).

31. Under cross-examination Dr. Mohan said that the fact that the applicant had been prescribed Larium in the months before the killing had to be taken into consideration in the overall evaluation of the case, and was something one would be concerned about. Like Dr. McCaffrey, he said it was not clear how much significance to attach to it. He said it might or might not have caused the applicant to behave as he did (Day 7. pp. 30-34). He acknowledged that the applicant was suffering from a moderate form of depression prior to the killing and that he sought treatment from his GP. He also acknowledged that the evidence regarding the applicant's behaviour prior to the killing (as outlined by Ms. Bailey, Ms. O'Connor and the applicant) was strange. However, he was uncomfortable with this evidence because it did not come from independent sources such as medical professionals (Day 7, pp. 37-45). When shown notes prepared by other members of staff at the CMH which suggested a tentative diagnosis of schizophrenia and/or psychosis and/or PTSD and/or severe depression, he said those diagnoses were prepared by doctors training in psychiatry who had not completed their examinations {Day 7. pp. 53-55).'

29. The jury ultimately rejected the insanity defence proffered by the applicant and convicted him of murder contrary to s.4 of the Criminal Justice Act 1964.

(iv) Developments since the applicant's conviction

30. In June 2003, the applicant was transferred from the Central Mental Hospital to begin his life sentence in prison, with a diagnosis of depression without sustained evidence of psychosis. Exhibited to the aforementioned affidavit of James MacGuill is a report from Dr. Aggrey Washington-Burke dated the 5th of April 2017 (Dr. Washington-Burke's Report), to which we will return. Further, in an affidavit sworn by a Ms. Aimée McCluskey of MacGuill Solicitors, on the 8th of October 2018, there is exhibited a report from a Dr. Alex Quinn, Consultant Forensic Psychiatrist, dated the 11th of May 2018 (Dr. Quinn's Report). Ms. McCluskey avers *that "Dr. Quinn was engaged by the Director of Public Prosecutions to produce a report for the purpose of these proceedings."* Both reports document the applicant's situation since being remanded in custody on the 27th of May 2003.

Dr. Washington-Burke's Report

31. In his report Dr. Washington-Burke explains that *"I am instructed by Garret Sheehan and Company Solicitors to carry out a review of material related to the criminal hearing and conviction of Yusuf Ali Abdi and his experience in detention since then"*, and that in that context *"[i]t will be important to identify relevant changes in the defendant's management during the 12 years since his son's death."*

32. He describes the material that he reviewed which included the transcript of the trial and *"detailed follow up material"* included in

and forming part of the applicant's mental health records, namely:

> • Copies of hospital discharge case summaries (03/06/2005- 08/09/2005; 25/05/2007- 12/09/2007; 20/05/2013- 10/10/2013).
>
> • Letters from staff at Central Mental Hospital (CMH), Dundrum addressed to Dr. Rasool, GP, Midlands prison, Dublin, from Dr. Sharma, Registrar in Forensic Psychiatry to Dr. Paul O'Connell Consultant Forensic Psychiatrist (04/11/2015) and from Dr. Paul O'Connell Consultant Forensic Psychiatrist (13/01/2016).
>
> • Psychology Report for Case Conference prepared by Dr. John S. Ferguson, Senior Clinical Forensic Psychologist (23/08/05).
>
> • Case Conference notes at CMH (31/07/2007).
>
> • First page of a letter from Mefloquine Action Ireland to Dr. Brophy, Medical Officer, Arbour Hill Prison, Dublin (03/10/2003).
>
> • Psychiatric report prepared by Dr. Sally Linehan, Consultant Forensic Psychiatrist, CMH, in the matter of an Assault Causing Harm Contrary to Section 3 of the Non-Fatal Offences Against the Person Act 1997 (28/02/2011).
>
> • Irish Prison Service entries (14/01/2009;27/02/2009; 14/09/2009; 07/10/2009; 17/10/2009; 05/02/2010; 13/01/2012;18/01/2012; 30/01/2012;26/02/2013).

33. Dr. Washington-Burke summarises the factual position with respect to how the applicant has fared from a psychiatric care point of view, in the period between the applicant's conviction and the date of his report, as follows:

> *"June, 2003 - Yusuf Ali Abdi was discharged from hospital in to commence his life sentence in prison.*
>
> *On discharge from hospital the diagnosis was depression with no sustained evidence of psychosis.*
>
> *September, 2005 - Yusuf Ali Abdi was discharged from his second admission to CMH after three months as an in-patient. He complained of hearing voices, and believed that he was being poisoned as people disliked him. He alleged that foreign born nursing staff were making racist comments about him.*
>
> *At this admission Dr. John Ferguson, Senior Clinical Forensic Psychologist, noted that the defendant is believed to be malingering certain aspects of his current psychiatric presentation. Dr. Ferguson felt that there was more clinical evidence of PTSD than any psychotic psychiatric disorder.*
>
> *September, 2007 - Yusuf Ali Abdi discharged from his third admission to CMH after almost four months. This admission followed his assault of a prison officer. He complained of low mood, hearing voices commanding him to hurt others. He believed that he had cancer and expressed paranoid ideas. He engaged in self-harm behaviour and was observed to be banging his head against the wall.*
>
> *About the diagnosis at that admission the Consultant Psychiatrist, Dr. Linehan, noted that 'whilst it is possible that Mr Ali's symptoms are indicators of an underlying psychotic illness, it is my opinion that his subjective complaints are not supported by objective observations that would be consistent with a psychotic illness.'*
>
> *October, 2013 Yusuf Ali Abdi was discharged from his fourth admission to CMH after almost five months. He presented with long-standing delusions involving prison officers and visiting psychiatric staff. He believed that he had been raped by prison officers and described thought interference from supernatural forces. He admitted to auditory hallucinations of an intermittent nature which were of a derogatory nature and in the second person.*
>
> *Throughout this admission, he described an extensive persecutory belief system which appeared to be delusional in nature.*
>
> *When a decision was taken to stop his medication, it was felt that his mental state deteriorated; when his medication was re-commenced, his mental state seemed to improve.*
>
> *The final diagnoses at this admission were: - Paranoid schizophrenia and antisocial personality disorder.*
>
> *Up until this admission to hospital in 2013 a diagnosis of schizophrenia had not been given by any psychiatrist providing in-patient care for Yusuf Ali Abdi.*
>
> *Since his first admission to hospital in 2001Yusuf Ali Abdi has received anti-psychotic medication consistently.*
>
> *Yusuf Ali Abdi has received anti-psychotic medication both orally and by injection and at times by both methods simultaneously since paranoid schizophrenia was diagnosed in 2013. Since then he has received increased doses of anti-psychotic medication with good effect.*
>
> *Since his discharge from hospital in October 2013 Yusuf Ali Abdi has continued to be diagnosed as suffering from schizophrenia; it is acknowledged that he also suffers from depression and PTSD.*
>
> *Yusuf Ali Abdi has not been involved in violent attacks against staff in prison or in hospital since October, 2013.*
>
> *During his psychiatric condition, Yusuf Ali Abdi has expressed suicidal ideas and has displayed suicidal behaviour; in October, 2015 he took an overdose of tablets."*

34. Dr. Washington-Burke then goes on to offer commentary which amounts, in effect, to proffering an up to date medical opinion concerning the applicant's likely state of mind at the time of the killing in the light of the updated medical history. Dr. Washington-Burke states:

"Comment

It is my understanding that Yusuf Ali Abdi was sentenced to life following a majority jury verdict in 2003. Almost 10 years have passed by since then.

It should be noted that in the period following Nathan's death up until the time of the criminal hearing Yusuf Ali Abdi spent more time in hospital than in prison.

During the almost 14 -year period following sentencing for life, Yusuf Ali Abdi has been admitted to mental hospital on three occasions; there was good evidence of a deterioration in his mental health on each occasion. The total period in hospital during this 14- year period may be about one year.

It seems reasonable to attempt to reach some understanding of the events which could be having some influence on the life experience of Yusuf Ali Abdi and may have contributed to his role in the homicide of his son Nathan.

Yusuf Ali Abdi arrived in Dublin the first time 20 years ago in 1997; he remained single up until May 1999 when he married Ms..

The history suggests that his mental health deteriorated at some time towards the end of 2000 and deteriorated further in January 2001 following his return from a trip to Africa to seek information about family members and his commencement on Lariam tablets for malaria.

It is agreed that with the deterioration in his mental health Yusuf Ali Abdi showed evidence of a change in personality with increasing thoughts of being followed, complaints of hearing voices and unpredictable aggressive behaviour which for him was out of character. Eventually Yusuf Ali Abdi killed his son Nathan during a period when he was out of contact with reality.

At the criminal hearing the role of the anti-malarial tablet Lariam in leading to this change of character and unpredictability in Yusuf Ali Abdi's behaviour was considered. It was felt that in view of the known side-effects of Lariam it would be impossible to rule out the possible role of this substance as a factor leading to the deterioration in the mental health of Yusuf Ali Abdi.

It is undoubtedly true that several additional factors may also have played a role in the deterioration of Yusuf Ali Abdi's mental health and these were considered in the criminal hearing.

At the end of the criminal trial it was accepted that Yusuf Ali Abdi was not suffering from mental illness at the material time of carrying out the act resulting in the death of his son Nathan in the early hours of 17th April, 2001.

It was argued that Yusuf Ali Abdi was an unreliable witness. Material presented by staff working with him suggesting that he tended to exaggerate symptoms and at times he seemed to malinger as well.

Psychiatrists working with him were not convinced by the severity of his symptoms and doubted if he was suffering from a psychotic illness.

There was no disagreement on the question of his experience of PTSD symptoms; it was fully accepted that he was an asylum seeker with a history consistent with this status.

It is also true that there was no disagreement regarding the coexistence of depressive symptoms in Yusuf Ali Abdi's psychiatric presentation.

Yusuf Ali Abdi was found to be guilty of the murder of his son Nathan and sentenced to life.

During the 10- year period following the criminal hearing the fact is that Yusuf Ali Abdi continued to display evidence of severe mental illness despite receiving antidepressants for his depression and antipsychotic medication which initially might have been for non-specific reasons or as an adjunct to his antidepressant medication.

During this initial 10- year period it is highly unlikely that any side effect, of the antimalarial Lariam, could be considered relevant in Yusuf Ali Abdi's psychiatric presentation.

It would be important to consider two possible explanations for what would seem to be clear evidence that Yusuf Ali Abdi, has been suffering from schizophrenia since 2013 when the diagnosis was made of paranoid schizophrenia at the end of an almost 5-month period of inpatient treatment.

The first possible explanation is that since antipsychotic medication was consistently given to Yusuf Ali Abdi throughout his period of detention following Nathan's homicide this medication may have masked symptoms of schizophrenia which would have been more evident in the absence of that medication.

The second possible explanation may be the basis for raising the issue of a miscarriage of justice.

The reality is that at the criminal hearing evidence was provided by two experienced psychiatrists both of whom reached the conclusion, independently, that Yusuf Ali Abdi was suffering from schizophrenia at the material time of his actions resulting in Nathan's death.

The fact is that Dr. McCaffrey interviewed Yusuf Ali Abdi on six occasions over a nine-month period and obtained collateral evidence to support his view.

Dr. Burke also used collateral evidence but did not have the opportunity of studying the longitudinal course of the condition presented by Yusuf Ali Abdi; his interviews were carried out over two consecutive days.

The material suggests that in the circumstances that the finding at the criminal hearing was consistent with the views of Dr. McCaffrey and Dr. Burke the psychiatric management of Yusuf Ali Abdi would have been the responsibility of the

psychiatric system rather than the penal system.

It is unfortunate to note that during the 10-year period following conviction in 2003 and up on to being diagnosed to be suffering from paranoid schizophrenia in 2013 Yusuf Ali Abdi was frequently psychotic in his behaviour and a danger to himself and others.

One question that should be advanced may be whether Yusuf Ali Abdi has been exposed to a poor quality of life by not being afforded appropriate treatment for schizophrenia despite recommendations for this course of action, by the defence, at the criminal hearing.

Taken together the material which has been reviewed does suggest that the outcome of the criminal hearing in 2003 represents a miscarriage of justice.

It will be important for this state to consider whether it is acceptable to continue to provide psychiatric treatment for Yusuf Ali Abdi in prison facilities. If the state takes this view it should consider whether prison and hospital staff should continue to be exposed to unpredictable irrational aggressive episodes resulting from Yusuf Ali Abdi's condition.

The alternative course of action would be that the state should consider the merits of accepting the defence evidence on the question of the appropriate diagnosis in this case. It would be important to consider the difficulty faced by the jury in a situation like this. It is unfortunate that members of a jury were being asked to give a verdict on material which continues to be a source of controversy in the psychiatric profession.

The fact is that members of a jury could not be expected to take a long-term view on the consequences of failing to reach an appropriate diagnosis in a situation which resulted in the sudden death of a child following unpredictable irrational behaviour by his father and might have been associated with severe injury or death of one or another person involved in caring for that individual thereafter".

35. In the course of his commentary, Dr. Washington-Burke strays at times into matters that are beyond the scope of his expertise (assuming, just for moment, that legitimately expert opinions of his, as opposed to the facts that he records and on which his opinions are based, are capable of being considered at all by this court – a matter we will return to later in this judgment); and, moreover, that he purports to address the ultimate issue of a possible miscarriage of justice, which is a matter for us. However, this Court is an appellate court comprised of professional judges who are well capable of discerning the wheat from the chaff, and of taking account of only that to which we are entitled to have regard while disregarding irrelevant and inappropriate commentary. We are not a jury.

Dr. Quinn's report

36. At the outset it should be recorded that Dr. Quinn's report is an impressive document, and it is ostensibly the product of a very thorough review of the applicant's forensic medical history. He has considered, *inter alia*: the Book of Evidence; the complete transcript of the trial; Dr. Washington-Burke's recent report; Mr. McGuill's grounding affidavit; and the Court of Criminal Appeal's judgment, delivered by Hardiman J. on 6th December 2004, and alluded to earlier in this judgment. In addition, he lists 22 individual documents – or categories of documents – from the applicant's mental health records, all generated between 2001 and 2016, considered by him. He states his understanding of the circumstances surrounding the death of the applicant's son, and then reviews in detail the evidence given at the trial by Ms. Bailey, the applicant's wife.

37. He considers her account of the incident on the 13th of November 1999 leading to the assault conviction subsequently recorded against the applicant. He further describes Ms. Bailey's evidence concerning perceived racism experienced by herself and the applicant when she was pregnant with the applicant's child; her evidence concerning his apparent mental state in mid-2000; her evidence concerning the applicant's abrupt departure to the UK and onward travel to Uganda in November 2000 without notice to her; and then concerning how the applicant appeared to her to be, and his seemingly strange and paranoid behaviour following his return in December 2000, including, amongst other things; accusing her of trying to have him deported; of ringing the Mosque and saying bad things about him; of planning against him; and of poisoning his food with "Stain Devils" which were kept in a kitchen cupboard.

38. Dr. Quinn further reviews Ms. Bailey's evidence concerning her leaving the applicant for the first time on the 21st of February 2000, and concerning the events of that day, and her eventual return. He considers her evidence that the applicant continued to behave strangely; that he slept a lot; that he appeared to be depressed; that he sought to isolate himself away from the world, keeping the curtains closed 24 hours a day. He reviewed her evidence concerning an occasion on which she was hit with a telephone following which she had locked herself in a bedroom and called her father. Other incidents of physical and verbal aggression that had been described were also considered; and also evidence concerning a belief asserted by the applicant that his phone and the smoke alarm in their residence were "bugged". This belief led the applicant to dismantle the smoke alarm in search of a camera – he then demanded that Ms. Bailey telephone Eircom to ask them how one could determine if one's telephone was bugged, a demand with which Ms Bailey ultimately complied with under duress.

39. Dr. Quinn further considered Ms Bailey's evidence that on an occasion in early April (of 2003, it is understood) she returned home to find many of the internal doors of their apartment to be locked; and her evidence about her worries and concerns at the time, one of which was that the applicant might be suicidal; and the assurances she received from him when he eventually emerged from a locked room that although he had thought about suicide he had not gone through with it, and didn't think that he would go through with it, because it was against his religion. Her evidence was that he appeared to believe that everyone was against him and conspiring behind his back to have him deported and to do him injustice and badness.

40. He considered in very great detail Ms. Bailey's evidence concerning events on the day of the killing, including the fact that she had told the applicant that she wanted to leave, and concerning the discussion they had had relating to the custody of their son. She confirmed that although she feared that the applicant would try and take the boy from her, he had never been violent towards him, and that he had in fact always been a caring, sensitive and loving father. She described how later on that afternoon the applicant had been upset by receiving some racial abuse from a child when getting money out of an ATM; how he had been so upset on his return that he had thrown a mug at the fireplace; how he had complained of being tired of living in the village in which they were residing; how she had informed him that if he wanted to move out she would help him to find somewhere else, and how she had decided to stay the night after all. Dr. Quinn then considered her recollection of the central event in which the applicant came to kill his son. Ms. Bailey had not witnessed the killing but had been awoken in the early hours by the applicant coming into the bedroom and picking up Nathan (who was also sleeping in that room) from his bed. She followed him to the living room but was unable to enter as he had locked the door. She then went to the bathroom and whilst there heard a "thud" coming from the kitchen. She then emerged and looked through a glass panel in the locked living room door, and could see the applicant kneeling and praying through the partially

opened door leading in turn from the living room to the kitchen. She began knocking on the door but this elicited no response. She then heard the applicant on the telephone, initially believing that he was calling a taxi, before realising it was a call to somebody else. The applicant had then opened the door; upon entering the room Ms. Bailey had found Nathan lying on the living room couch and in extremis.

41. Dr. Quinn further considered the record of the applicant's interviews with gardaí in which he was asked to account for his actions. He comments

> *"Mr Abdi has given a changing account of the events of the 17th of April 2001 over the course of the investigation, the trial and the following years. He has described being unable to remember the events when first detained by police. He later described Nathan having fallen and struck his head in a way that caused the injuries. Latterly he attributed symptoms of mental health to the events, and during my assessment of him in March of 2018 he gave a description of profound symptoms of mental illness which may have been responsible for the commissioning of the events in hand."*

42. Dr. Quinn further considered the account given by the applicant to Dr. Damien Mohan on the 19th of January 2013, and then the account given by the applicant to him on the 14th of March 2018.

43. Dr. Mohan had recorded the following account:

> *'I started by asking him about events leading up to the alleged offence. He said that on the afternoon of the 16th of April Ms Bailey came out to visit him in Clane and she wanted to leave. He said he wanted to spend more time with Nathan. She agreed to stay. Mr Ali said that he was playing football that afternoon with his son Nathan. He said that they then had dinner and Ms Bailey then went to bed. He said he himself was "not feeling well". He said that he was "feeling low by myself". He then went to bed. He said around 4.00am he woke up and wanted to pray. He said when he woke up Ms Bailey's door was open and Nathan was with her. He said "all of a sudden I just hear a voice like-somebody told me to take him, take him ". He said he then went into the room and "took him ". He then said he "brought the child to the living room and closed the door behind him ". The reason for closing the door behind him was that he was "afraid Amanda was going to take Nathan". He said "when he was holding Nathan he felt he was in the middle of somewhere, I don't know where I was, I heard another voice commanding hit him hit him ".*
>
> *He said he was not aware he was giving these commands. He said he felt like "somebody that was possessed". He said he then "started hitting him on the wall". Mr Ali said he then "came back to normal". He said he then "began to panic" as he did not know how badly Nathan was injured. He said he then phoned the ambulance which brought Nathan to hospital.'*

44. The applicant stated to Dr. Quinn on the 14th of March 2018:

> *'llooking back now I think I was sick...I didn't know at the time...I thought police were after me and wanted to kill me... if I saw police while walking I would think they were trying to harm me.*
>
> *I had been hearing voices for a number of weeks. I was noticing them more...before I wouldn't pay attention... they were inside my head, some of the voices were people back home and some of the voices had an Irish accent. The voices from back home said things like "we know what you are"... "we're coming to get you ".'*

45. In his report Dr. Quinn relates how Mr Abdi also described voices running him down and telling him to kill himself. He described unusual experiences coming from the television *"people on TV would say things to me...they would make comments like "we're coming to get you once we've finished this*. At the time Mr Abdi describes that *"I was in a completely different world...I thought this was all completely normal... I could smell dog faeces...or a smell that was like my father"*.

46. Dr. Quinn remarks that:

> *'During my assessment of Mr Abdi he described the finding of his father's body after he had been set on fire. At times he was not able to differentiate whether the smell was that of faeces or of the decomposing body of his father. He described that Ms. and Nathan had left but that they had come to visit him for the day. He described being very confused at the time like he was "in a different land completely". He remembered eating something and going outside to play football with a group of boys and Nathan. The boys were teenagers and Yusif at the time was a young man. Nathan watched as opposed to taking part. He describes then coming in and that he had a cup of tea but for some reason flung the teacup at the fireplace. He didn't remember what was said and didn't particularly remember an argument. He thought that it was "just me" and that he was "acting out of nowhere". He describes almost waking up and noticing the broken cup. He collected the pieces and put them in the bin. He is aware that he slept separately to Ms. and Nathan in the living room.*
>
> *He described no good recollection of the night time. He found it difficult to remember "the whole thing now" that he believes he was hearing a voice from the TV. The voices were saying things such as "we're going to get you...we know who you are". Mr Ali describes trying to block it all out, that he was frightened and anxious in his emotions.*
>
> *In the morning he remembers lying down and hearing voices telling him to "wake up, you've got to wake up ". He got up and wanted to go to the toilet which was through a corridor. He went to the toilet and on the way back was hearing a voice. He looked into the room where Nathan was sleeping next to his mother Amanda, and the voice was telling him to go into the room and saying "take him take him ".*
>
> *He gave the following account of his following actions;*
>
> > *'I went and took him...I didn't know what I was doing...it was like I was being pushed...like someone else was controlling me...I went to the living room...I could hear this voice telling me kill him kill him...all of a sudden I throw him down...and I threw him down once, twice and before I knew it he was cold and afterwards 1 started panicking...voices telling me to pray, that I'd killed him...and I started to pray...pray that he would come to me...it was like I was a zombie on remote control".*
> >
> > *He talked about the locked door and Mr Abdi gave the following account;*

" When I was coming into the living room I was thinking that someone else was following me...so I locked the door... the person following me was wanting to attack me and when I threw him down he banged his head against the surface, like a table, twice three times...he hit his head on the surface twice or more than that perhaps ".

He gave the account that one voice started to tell him that;

"he was dead he was dead he was dead" on repeat.

When he stopped assaulting him he felt like he was in a "different land completely He panicked and prayed and when finished praying tried to wake him up and revive him. He couldn't find his pulse and couldn't explain or understand that he'd killed him. He realised he was dead and phoned the ambulance.

On further questioning as to why he perhaps perpetrated the act, he went on to add;

"I thought he was evil... I don't know, it felt like I was being controlled... I was looking at him like...I was looking at him and it was like I wasn't looking at my son...I was looking at a devil...when I'm holding him he is not my son...he is a different shape entirely...he is a devil...his face is different, like a devil... everything I was thinking made sense. I can't make sense of it now...people who were threatening me...I believed they were devils....called Jin...they come to you to do something bad to you...they can get inside you and take possession of you... I thought that Jin had come and turned into him... I thought he was going to kill me...I believed he was the devil"

47. In the next sections of his report Dr. Quinn considered in detail the applicant's ethnic, social and cultural background; his drug and alcohol history; his past psychiatric history as summarised by Dr. Mohan in his report of 2003; the evidence given at trial by Ms. Bailey's own GP, Dr. Claire O' Flynn, concerning a visit to the applicant's home in February 2001, following up on her concerns arising from Ms. Bailey's reports as to the applicant's mental well-being, which had caused her to suspect that the applicant had developed *"some kind of paranoid depression or schizophrenia"*. He also considered in detail the applicant's psychiatric presentation while in prison; first of all while he was on remand during which time he was assessed on several occasions by Professor Harry Kennedy at both the surgery in Cloverhill Prison and the Central Mental Hospital following an admission there on the 5th of November 2001; and then secondly as a sentenced prisoner following the applicant's conviction of murder in May 2003, when he was admitted to the Central Mental Hospital on three further occasions.

48. As stated the applicant was first admitted to the Central Mental Hospital on the 5th of November 2001, and discharged on the 27th of May 2003, at which time he was remanded into custody. This first admission is described as being for depression. Dr. Quinn notes that the applicant was discharged on 6mgs of Risperidone, a treatment dose for schizophrenia. However, he notes that during this admission, there were marked concerns over the applicant's reliability and that he may have been malingering his symptoms.

49. Dr. Quinn reports that the applicant was re-admitted to the Central Mental Hospital on the 3rd of June 2005. He was admitted on the basis that *"he was expressing suicidal ideations to other inmates and was placed in the pad for a week and a half prior to admission for his own safety. He was refusing to eat any solid food for several days and was drinking sparingly."* On this admission, the applicant was described to as having *"problem features of Post-Traumatic Stress Disorder, schizoid and depressive dependent, negativistic personality patterns and some exaggeration or fabrication of symptoms"*.

50. Upon being returned to Cloverhill Prison on the 8th of September 2005, Dr. Quinn notes that the applicant was prescribed with 10mgs of Olanzapine – which he describes as *"a potent anti-psychotic agent and this is at a treatment dose for psychosis. This would have been an effective dose for both psychotic depression and schizophrenia"*

51. On the 25th of May 2007, the applicant was again admitted to the Central Mental Hospital on the basis that there had been a *"relapse of a depressive illness with possibly psychotic symptoms."* The notes recorded that *"Yusif alleged that the prison officer who he assaulted made racist comments about him and this caused Yusif to hear voices telling him to harm this officer. Yusif was convinced that people were plotting against him and trying to poison him. Of note Yusif described the voices as inside his head."* Dr. Quinn observes that the applicant's behaviour during this admission to the Central Mental Hospital was described as *"disturbed"* to the extent that he required seclusion from other patients, as he had attacked a cleaner during this time. Upon being returned to prison on the 12th of September 2007, he was prescribed with a different anti-depressant, namely Venlafaxine, and Olanzapine once again. However, at one point during this admission he had been prescribed Risperidone at 5mgs twice daily, leading Dr. Quinn to comment:

"This is a high dose of this antipsychotic medication, the maximum recommended daily dose being 12.5mg in Scotland, where I practice."

52. Dr. Quinn's review of the notes revealed that applicant was returned to the Central Mental Hospital yet again on the 20th of May 2013. By the end of this admission, the applicant's diagnosis had changed. On the 10th of October 2013, the applicant had been diagnosed with paranoid schizophrenia, along with anti-social personality disorder. Dr. Quinn further notes that the most recent correspondence concerning the applicant is from a Dr. Paul O' Connell. Dr. O' Connell, another Consultant Forensic Psychiatrist, reviewed the applicant in custody in 2016 and noted that his primary diagnosis was that of schizophrenia, notwithstanding that his psychotic symptoms were well-controlled on foot of his anti-psychotic medication – Risperidone.

53. In his concluding comments, Dr. Quinn states that he was *"fundamentally in disagreement"* with the views expressed by Dr. Mohan for the prosecution at trial, namely that the applicant did not have schizophrenia. This divergence of views seems to largely stem from the fact that Dr. Mohan *"did not interview the family and did not feel that the evidence of Amanda Bailey was sufficient to point to such a diagnosis…I am of the opinion that Amanda Bailey's evidence to the trial describes with exceptional clarity the development of psychotic symptoms in an account which has internal consistency as she describes the development of a complex set of delusional symptoms over a number of years. She tracks the changes in her husband and her attempts to access him care. She identifies his pre-psychotic personality as being kind and sensitive, and has no concerns about his ability to parent Nathan. She notes his symptoms of psychosis to the trial, his increasing social isolation and strangeness. In essence her evidence speaks clearly. I do not feel this was given sufficient weight by the prosecution expert during his assessment of Mr. Abdi."*

54. Dr. Quinn's report goes on to describe in detail the features of Paranoid Schizophrenia as an illness, and then opines:

"Holding in mind the criteria above, I believe his wife gives a clear account of psychotic symptoms in the years

approaching the index offence and at the time of the killing of their son.

In addition, whilst in prison, over a prolonged period of time, Mr Abdi has presented with symptoms consistent with the above psychotic mental illness, Schizophrenia. I am of the view there are consistent descriptions in his records of symptoms of psychosis from the beginning of his admission into custody. These were in the form of delusions, auditory hallucinations (hearing voices) and olfactory hallucinations (smelling of dog faeces). At the time he was prescribed antipsychotic drugs and his presentation was put down to a reaction to the events (the killing of his son) and more latterly to depression, post-traumatic stress disorder and personality disorder.

He has since been treated in the Central Mental Hospital and over time this view has changed and he has received a diagnosis of schizophrenia. He is now maintained on antipsychotic medication to control his symptomatology.

His time in prison after the killing of his son, and prior the beginning of a period of stability in 2013, was characterised by a turbulent presentation from Mr Abdi with episodes of aggression and violence, associated with symptoms of mental illness.

Since 2013 he has become calmer, less disordered and there have been no further episodes of significant aggression. The issues and concerns around the nature of his presentation and diagnosis seem to have settled into a consistent account that Mr Abdi is a man with the severe and enduring mental illness, namely Schizophrenia.

Examining the evidence available at the trial I believe he developed a first presentation of his psychotic mental illness in 1999, precipitated by his experiences of racism and the stress of the assault conviction with local Gardai. There is also an association with immigration and the development of psychosis. From that time his ex-wife consistently describes Mr Abdi as being a man beset with psychotic symptoms (namely delusions) with paranoid themes around being poisoned, followed, being the subject of a conspiracy to be deported and believing that his phone and stair fire alarm were bugged.

In keeping with this, prior to the offence I believe he was suffering from significant symptoms of a psychotic mental illness, namely schizophrenia.

Mr Abdi's account of his mental state prior the assault of his son is largely consistent with those of other parties. His account of his mental state at the time of the killing however, has varied over time however, and as such is perhaps a little difficult to interpret. Without reference to his account however, 1 believe there is sufficient evidence to believe that Mr Abdi was suffering from symptoms of psychosis at the time of the killing of his son. Given the profound change that his ex-wife describes in him, from a sensitive, gentle man to a paranoid, deluded and suspicious individual; I am of the clear view that he should have received a hospital disposal.

Given this, I believe the recommendations made to the trial by psychiatry in 2003 were incorrect. It is of note that Mr Abdi was prescribed antipsychotic medications shortly after his admission into custody by Professor Harry Kennedy. These were at doses effective to treat psychosis, At the time he would have been "neuroleptic naive" or unused to their effect. As such those drugs may have been potent in their effect. 1 le was being kept in a padded cell due to his presentation. He was maintained on such medications throughout his detention on remand, his admission to Central Mental Hospital and discharged back to prison on antipsychotics.

It is perhaps not difficult to consider that this may have masked his presentation and made his psychotic symptoms less clear and more difficult to assess by those trying to make sense of events thereafter.

At the time, given the evidence of the time I believe Mr Abdi should have received a hospital disposal. The passage of time and the continued nature of his psychotic presentation has removed any doubt that may have been present in 2003. His diagnosis is clear and he has shown response to medication. At the time of sentencing disposal to hospital should have been made using the then-appropriate Irish legislation.

The issue of insanity and disposal should be considered separately. One is clear (that of hospital disposal) and the other is less so. The evidence for his mental illness is clear, corroborated and consistent over time hence the reason for my views on his disposal. His own account of his mental state directly during the killing has changed and although appeal's psychologically consistent is not easily corroborated in the same way. As such, although it is clear that the events leading to the killing of Nathan were in large part driven by psychosis it is difficult to be quite so certain that they would reach the high bar set for insanity.

If the account he gave to me were to be considered truthful, however, I would be of the view that he would have met the criteria for insanity under M'Naghten's Principles now enshrined under Irish law in the 2006 Insanity Act. Although he knew the nature of the act, he describes acting under an irresistible impulse, and given that he thought that his son was possessed by some sort of Jin or devil that was trying to harm him and take his life, he would not have known that what he was doing was wrong.

Consideration of whether or whether not his current account is to be believed is perhaps a matter for a Jury.

Opinion and Recommendations

1. Mr Abdi has a diagnosis of Schizophrenia, a form of mental illness. This is characterised by hallucinations, delusions regarding being poisoned and of a conspiracy to harm him which has changed in nature over the years. In the community he believed that people were conspiring to have him deported, in prison he has complained of believing the food was poisoned and that people were raping him.

2. Treatment is available for this mental disorder in the form of anti-psychotic medication and the interventions of a multi-disciplinary forensic psychiatry team. lie is currently relatively stable but has been shown to deteriorate when not in receipt of antipsychotics.

3. If Mr Abdi were not provided with this treatment he would pose a risk to himself others. At times when his psychosis has been most profound he has killed a child (his son), attacked prison and nursing staff and his self-care has deteriorated. He has stopped eating and has made attempts on his own life.

4. Given the account Mr Abdi gave to me at the time of my interview in 2018 I believe that Mr Abdi should be found to be legally insane due to mental disorder. He has given the account that he acted believing that his son was a transformed into a devil, or Jinn and that the Jinn intended to harm him, most likely kill him. As such he would not have known the nature of what he was doing was wrong.

5. Again, in considering legal insanity he described feeling like he was being controlled, feeling as if he was being pushed; fulfilling, in my opinion the irresistible impulse test for this defence.

6. I am of the view that Mr Abdi should have received a hospital disposal due to his symptoms of mental illness. Subsequent evidence of multiple hospital admissions and a diagnosis of schizophrenia have further cemented this view."

The Present Application

55. In his Notice of Application and Statement of Grounds, dated the 5th of August 2016, the applicant applies to this Court for an order quashing the verdict of the jury of the 14th of May 2003 on the grounds that a newly discovered fact shows that there has been a miscarriage of justice in respect of the applicant's conviction. The grounds pleaded for so contending are that:

> *"The verdict of the jury indicated that they had rejected medical evidence called at the trial on my behalf and accepted the medical evidence called on behalf of the Director of Public Prosecutions.*
>
> *Since my imprisonment and up to the present date I have received further intensive medical treatment which treatment confirms the diagnosis made prior to the trial but rejected by the jury in their verdict. A reassessment of the medical evidence in the light of my established post-conviction psychiatric history will support the defence unsuccessfully advanced on my behalf at trial."*

56. The grounding affidavit of James MacGuill, Solicitor, after setting out the chronology of events as outlined above, avers that:

> *"I say and believe in light of the foregoing that Dr. Mohan's diagnosis though bona fide was erroneous and amounts to a new or newly discovered fact which shows that there has been a miscarriage of justice in relation to the applicant's conviction."*

57. Similarly, a second affidavit avers that:

> *"… the conclusions drawn in the report of Dr. Quinn accord with, support and confirm the conclusions drawn in the report of Dr. Aggrey Washington-Burke".*

The applicant's submissions

58. Counsel for the applicant submits that the *"newly-discovered facts"* are the applicant's psychiatric presentation and history in the years subsequent to his sentencing, and in particular the symptoms and signs exhibited by him during those years, which when taken into account and considered with his overall psychiatric history, has led to his diagnosis being changed from one of depression and non-psychotic paranoid state to one of paranoid schizophrenia following his fourth admission to the Central Mental Hospital in 2013. His case is that his actual condition is not new; rather it is the changed diagnosis with respect to same consequent upon the additional symptoms and signs of paranoid schizophrenia exhibited by him in the years since his sentencing – necessitating several re-admissions to the Central Mental Hospital – that is new. Putting the matter another way, he has newly discovered that his treating doctors now consider him to be suffering from paranoid schizophrenia in circumstances where they had previously not recognised him as being psychotic. It is contended that heretofore he was misdiagnosed by the psychiatrist who initially was treating him, Professor Harry Kennedy, and also by Dr. Mohan who independently assessed him on behalf of the State; and that in truth he was suffering from paranoid schizophrenia both at the time of the killing and at the time of his trial. It is not suggested that those who provided the incorrect diagnoses were negligent, dishonest, incompetent or biased; or that their diagnoses were offered other than in good faith, but merely that they were wrong and that subsequent events have established that they were wrong.

59. Counsel for the applicant submits that since his client has been correctly diagnosed, he has been prescribed with anti-psychotic medication in doses appropriate for that illness. Subsequent to this, his behaviour and attitude has become calmer and there have been no further episodes of aggression, as noted in the Report of Dr. Quinn.

60. In respect of whether the 2013 diagnosis, and the medical evidence which has emerged since the trial on which it is partly based, constitute *"new facts"*, or *"newly discovered facts"*, or a combination of both, so as to trigger s. 2 of the 1993 Act, the applicant submits that it is clear that the information now to hand could not reasonably have been known or acquired by the applicant or his legal team at the time of the trial. Accordingly, having regard to the provisions of s. 2 (3) and s. 2 (4) of the Act of 1993, we are in fact concerned with alleged newly discovered facts. The change of diagnosis came to the attention of the applicant almost a decade after his appeal proceedings were finally determined in December 2004. Moreover, it was based in part on further medical evidence not available at the time of the trial, being the further symptoms and signs of paranoid schizophrenia exhibited by the applicant in the years since his sentencing, necessitating several re-admissions to the Central Mental Hospital.

61. Although the present application is an application brought under s. 2 of the Act of 1993 in which the applicant alleges that newly discovered facts show that there has been a miscarriage of justice in his case, and it is not merely an application to adduce fresh evidence at the hearing of an appeal, these different procedures do share certain common features, and certain of the applicable principles are the same. The principles applicable to deciding on applications to adduce fresh evidence, were laid down in *The People (Director of Public Prosecutions) v. Willoughby* [2005] IECCA 4, and approved by the Supreme Court in *The People (Director of Public Prosecutions) v. O'Regan* [2007] 3 I.R. 805. They were expressly applied in the context of an application under s. 2 of the Act of 1993, in both *The People (Director of Public Prosecutions) v. Kelly* [2008] 3 IR 697 and in *The People (Director of Public Prosecutions) v. Anthony Buck* [2018] IECA 59. Moreover, in the present case both sides make reference to them in their written submissions and accept that they apply.

62. The principles in question may be stated as being:

> (i) that exceptional circumstances must be established before the court should allow fresh evidence to be called; and that onus is particularly heavy in the case of expert testimony, having regard to the availability generally of expertise

from multiple sources;

(ii) that the evidence must not have been known at the time of the trial and must have been such that it could not reasonably have been known or acquired at the time of the trial;

(iii) that it is necessary for the evidence to be credible and to be such that it might have had a material and important influence on the result of the case; and

(iv) that it is necessary that the assessment of credibility or materiality be conducted by reference to the other evidence at the trial and not in isolation.

63. The applicant contends that each of these conditions is readily satisfied in the circumstances of his case.

64. As to whether the 2013 diagnosis may properly be characterised as a "fact"; the applicant submits, referencing *The People (Director of Public Prosecutions) v Noel Callan* (Unreported, Court of Criminal Appeal, McCracken J., 9th December 2002), that the test is whether the fact was relevant to the trial itself, and whether it would have been admissible and relevant in evidence in the trial. He submits that the 2013 diagnosis itself, and certainly the medical evidence on which it is based, fulfils those criteria. It is acknowledged that the emergence of a new expert opinion will not normally amount to a newly-discovered 'fact' within the meaning of the Act. However, it was submitted that that is not what has occurred here. It is not simply that a different opinion is now available which would support or supplement the applicant's case, or contradict the evidence of Dr. Mohan. This is not a case of a new, divergent or revised scientific opinion or a new theory of the case based on the same evidence. The 2013 diagnosis is, rather, a factual matter, and is capable of being established as such in evidence in the sense envisaged by the Act. Moreover, to the extent that it represents an opinion, that opinion is based on more extensive medical evidence than was available at the time of the formation of the opinion given at the trial. It is not simply the product of a re-evaluation of the same evidence by a new expert. It is a fresh evaluation based on a combination of the evidence that existed at the trial and additional evidence that has come to light since.

65. Further, the applicant submits that he satisfies the second element of the legislative requirement; namely he has pleaded and argues that there has been a miscarriage of justice on foot of the newly discovered facts that he seeks to rely upon. From here, it is submitted, the Court must carry out an objective assessment to determine whether the applicant's conviction is unsafe and unsatisfactory, and in that regard the applicant references: *The People (Director of Public Prosecutions) v. Gannon* [1997] 1 IR 40, *per* Blayney J. at p. 48; applied in *The People (Director of Public Prosecutions) v. Kelly* [2008] 3 I.R. 697 and in *McKevitt v. Director of Public Prosecutions* [2013] 1 IR 750,).

66. Whilst conceding that there is no universal definition for a "miscarriage of justice", the applicant invites this Court to consider the definition adopted Kenny J. in *People (AG) v. Murtagh* [1966] I.R. 361, at p. 364: *"But what is meant by miscarriage of justice? It means that a person has been improperly found guilty"*. In respect of the s. 2 test to be applied by this Court in the present case, the applicant points us to *People (Director of Public Prosecutions) v. Meleady & Grogan*, cited earlier in this judgment, where the Court of Criminal Appeal outlined various, non-exhaustive categories of *'mischief'* which the Act of 1993 was designed to remedy. The Court held that, among other matters, the Act was *"intended to afford relief to those who could point to materials which, if they had been available at the trial, might — not necessarily would — have raised a reasonable doubt in the mind of the jury."*

67. The applicant relies on the following quotation from *The People (DPP) v. Kelly* [2008] 3 I.R. 697, in which the Court of Criminal Appeal identified the test. It said: *"the test is not to inquire whether the new material rendered the conviction of the applicant unsafe and unsatisfactory having regard to the course actually taken by the defence at trial but rather to ascertain whether the defence could have used the material in such a way as to raise a doubt about a significant element in the prosecution case and the possibility that a different approach by the defence may have led to an acquittal"*. The applicant has also referred us to *The People (Director of Public Prosecutions) v. Pringle* [1995] 2 I.R. 547; *The People (Director of Public Prosecutions) v. McDonagh* [1996] 1 I.R. 305; *The People (Director of Public Prosecutions) v. Shortt (No. 2)* [2002] 2 I.R. 696; and *The People (Director of Public Prosecutions) v. Mullins and Nevin* [2010] IECCA 106, in support of this proposition.

68. Applying this test to the facts of the present case, the applicant submits that his case exceeds the threshold required. No reasonable juror, it was submitted, irrespective of age, gender, ethnicity, profession, or creed – could have been unaffected had he or she known that Dr. Mohan's colleagues at the Central Mental Hospital would go on to officially adopt the very diagnosis that had been rejected at trial. The significance of the 2013 conviction, the applicant argues, might have impacted on the course and outcome of the trial in a myriad of ways, such as the way in which the State prosecuted the case; the manner in which the defence was conducted; the trial judge's charge to the jury; as well as possibly raising a reasonable doubt in the mind of the jury with regard to the applicant's mental condition at the time of his son's death. Indeed, the applicant goes so far as to say that it would have done all of those things as a matter of probability and would have affected the result of his trial to his benefit; notwithstanding that *Meleady* does not require him to go that far.

69. Further, the applicant submits that the newly discovered facts that he seeks to rely upon cannot be characterised as of only slight relevance or as leaving *"untouched a compelling body of incriminating evidence"- The People (DPP) v. Kelly* [2008] 3 I.R. 697, at p. 720 (paragraph 90) (judgment of Kearns J.). Rather, these newly discovered facts centre around the only piece of prosecution evidence relevant to the question of whether the applicant had been insane at the time of the killing, within the meaning of modified M'Naghten Rules. Further, it was contended that as the applicant was convicted, it is clear that the jury based its decision on Dr. Mohan's evidence. Thus, it was submitted, the newly discovered facts cast considerable doubt over the reliability of his testimony, with the applicant drawing support from the report and findings of Dr. Quinn (the independent expert retained by the respondent), in particular his conclusion that *"the recommendations made to the trial by psychiatry in 2003 were incorrect".*

70. In sum, the applicant's case is that the prosecution's case against him at trial was advanced on the premise that he was not suffering from a psychosis at the time of his son's death. The 2013 diagnosis suggests that that premise was fundamentally flawed; that it was a false premise which goes to the very heart of the case against the applicant. Thus, the applicant asks this court to declare that his conviction for murder is unsafe, and to quash it. Further, given the fact that the applicant has spent over 15 years in prison on foot of the impugned conviction, the applicant submits that his Court should exercise its discretion under s. 3(1)(b) of the 1993 Act upon quashing his conviction and make no order as to a re-trial.

Respondent's submissions

71. The respondent has drawn our attention to a strong line of authorities, all of which make the distinction between fact and opinion in respect of applications under s. 2 of the 1993 Act. Moreover, the Court of Criminal Appeal had conducted an extensive review of those authorities in the course of its judgment in *The People (DPP) v. Kelly* [2008] 3 IR 697.

72. In *The People (Director of Public Prosecutions) v. Meleady & Grogan* [1995] 2 IR 517 the *"newly discovered fact"* was evidence of a fingerprint found on the inside of a front passenger door window in a car. The gentleman whose fingerprint it was gave evidence on behalf of the applicants at the trial that he had been the front seat passenger in the vehicle that night and that neither of the applicants had been in the car, which had been stolen by several youths. Kearns J. stated: *"the two matters which persuaded this Court to receive evidence were clearly factual matters and not matters of opinion"*.

73. In *The People (Director of Public Prosecutions) v. Pringle* [1995] 2 IR 547 the Court of Criminal Appeal considered as capable of amounting to *"newly discovered facts"*:

> (a) Evidence of the CUSUM technique, assuming if admitted that it would have raised a doubt in the mind of the jury;
>
> (b) Evidence that a tissue had not been forwarded to the State Forensic Laboratory for analysis so that the court of trial was deprived of the results of an analysis which might have been of assistance in establishing the innocence of the accused;
>
> (c) The non-disclosure of the circumstances surrounding the forwarding, or not forwarding, of the tissue to the State Forensic Laboratory and the non-disclosure of the conflict between two members of the gardaí as to what happened the tissue;

Having considered the *Pringle* case, Kearns J had remarked in *Kelly* that *"all matters in respect of which the court heard evidence were matters of fact and not opinion"*.

74. In *The People (Director of Public Prosecutions) v. Gannon* [1997] 1 I.R. 40, two documents had come to light, copies of which had not been furnished to the applicant's legal advisors at the time of his trial, prompting Kearns J. to remark in Kelly that *"[c]learly in this case also the newly discovered material was factual in nature"*.

75. In the *People (Director of Public Prosecutions) v McDonagh* [1996] 1 I.R. 305, the *"newly discovered fact"* evidence consisted of a signed statement brought into existence subsequent to the appeal in the Court of Criminal Appeal, in which the applicant's co-accused sought to exonerate the applicant and accept sole responsibility for a sexual assault. Per Kearns J. in Kelly – *"again plainly a factual matter only"*.

76. In *The People (Director of Public Prosecutions) v Shortt (No. 1)* [2002] 2 I.R. 686, the non-disclosure prior to trial of serious allegations raised against the principal State witness was conceded by the State as constituting a newly discovered fact within the meaning of s. 2 of the Act of 1993. However, Kearns J stated with respect to this in the Kelly case: *"Again, no issue of opinion evidence arose in this case either"*.

77. In *The People (Director of Public Prosecutions) v. Kelly*, Kearns J., having conducted this review, went on to say:

> *"41 In ruling on the present application, the court is strongly of the view that opinion evidence, subject to the qualification hereinafter expressed, should not constitute a newly discovered fact within the terms of the Act of 1993. Firstly, to so interpret opinion evidence would be to give a meaning to the word "fact" which is quite different from its ordinary and natural meaning. Secondly, it would have the effect of rendering virtually every conviction, even one upheld by this Court following an appeal, open to later challenge if a further or new expert could be found to offer an opinion which went further than a defence expert had done at trial, or which tended to contradict or undermine experts called on behalf of the prosecution at trial. It would open the door to the introduction of additional evidence in circumstances which were plainly contra-indicated by this Court in The People (Director of Public Prosecutions) v. Willoughby [2005] IECCA 4, (Unreported, Court of Criminal Appeal, 18th February, 2005). Having conducted an extensive review of both the Irish authorities and a number of English authorities in that case, this Court considered it could formulate principles appropriate to an application to introduce new or fresh evidence in the Court of Criminal Appeal as follows at pp. 21 and 22:-*
>
> > *"(a) Given that the public interest requires that a defendant bring forward his entire case at trial, exceptional circumstances must be established before the court should allow further evidence to be called. That onus is particularly heavy in the case of expert testimony, having regard to the availability generally of expertise from multiple sources.*
> >
> > *(b) The evidence must not have been known at the time of the trial and must be such that it could not reasonably have been known or acquired at the time of the trial.*
> >
> > *(c) It must be evidence which is credible and which might have a material and important influence on the result of the case.*
> >
> > *(d) The assessment of credibility or materiality must be conducted by reference to the other evidence at the trial and not in isolation."*
>
> *42 This approach to the admissibility of new evidence on appeal was expressly endorsed by the Supreme Court in The People (Director of Public Prosecutions) v. O' Regan [2007] IESC 38, [2007] 3 I.R. 805 and must now be seen as settled law in this respect.*
>
> *43 It would in my view be altogether impermissible for this Court to adopt an approach to opinion evidence which both ignores the express terminology of s. 2 of the Act of 1993 and also, by implication at least, goes totally against the thrust of the two decisions to which I have just referred.*
>
> *44 That is not to say that opinion evidence is in all circumstances inadmissible, as the court's present ruling will make clear. There may be cases where a state of scientific knowledge as of the date of trial may be invalidated or thrown into significant uncertainty by newly developed science. There may also be cases where the opinion of an expert at trial may later be shown to have been tainted by dishonesty, incompetence or bias to such a degree as to render his evidence worthless or unreliable. Once such "facts" are established, expert opinion evidence must clearly then be admissible so that such new "facts" can be properly interpreted.*

45 It is perhaps easiest to illustrate the distinction between opinion and fact by reference to the evidence which the court does propose to consider in this matter. The court is quite satisfied that the evidence contained in the third booklet of photographs, and expert evidence in relation to the interpretation of these photographs, is admissible as "newly discovered fact". These photographs were not available to the defence either at the time of trial, or the appeal. The emergence and existence of these photographs is quite obviously a factual matter and capable of being established as such in evidence in the sense envisaged by the Act of 1993.

46 Equally, the development of the CUSUM technique, which in essence is directed to ascertaining whether more than one contributor was involved in the making of a statement, is a science which, though no longer new, was not available at time of trial. The court is disposed to hear evidence about the technique, and will of course also entertain opinion evidence as to its reliability and credibility. It will also hear opinion evidence as to the interpretation of any analysis undertaken by reference to the CUSUM test.

47 The court however will decline to receive evidence on the remaining matters which, in the opinion of the court, are entirely matters of expert opinion falling short of the criteria outlined above."

78. The respondent contends that any attempt to characterise *"the 2013 diagnosis"* of schizophrenia as a newly discovered fact is misguided; it is the medical opinion of schizophrenia reached in 2013 that the applicant calls in aid of his application pursuant to s. 2 of the Act of 1993. It was submitted that *"a diagnosis taking place is clearly a fact as is an examination taking place to opine a medical condition. However, it is not the fact that a diagnosis or medical examination took place in 2013 that is called in aid of the s. 2 application but rather the opinion of schizophrenia itself, which is an opinion and clearly not a fact."*

79. Moreover, it was submitted, it is hard to see how the diagnosis temporally reached in 2013 is a *"newly discovered"* matter. It is the same diagnosis as that advanced by the applicant in his original trial and thus it is not in any way *"newly discovered"*. It may be better described as a buttressing up of an earlier diagnosis proffered at trial. In the affidavit sworn by the applicant's solicitor dated 16th June 2017, Mr. MacGuill sets out the medical evidence called at trial by the applicant in which several experts called on behalf of the applicant diagnosed – or gave evidence of suspecting – schizophrenia. The applicant is asserting that another person, namely the person who changed the diagnosis in 2013, also opines schizophrenia. There are others who agree and perhaps there are others who may disagree. As a matter of principle, s. 2 of the Act of 1993 is not for the buttressing up of facts or opinion already called in evidence. To do so would be to turn s. 2 on its head for a purpose not intended. There must be finality of the trial process and any re-opening of a matter is purely exceptional and must come within the statutory boundaries that have been set in order to do so. It was submitted that the applicant's case does not fall within those statutory boundaries.

80. In respect of the miscarriage of justice element of the provision, the respondent argues it is hard to see how a diagnosis temporally reached in 2013 touches upon the state of play at the time of the killing in 2001 as, again, it is the same diagnosis which was run by the applicant in his original trial with many experts giving that view. Dr. Mohan's evidence was accepted at that time over a vast quantity of defence evidence. As the respondent puts it in her written submissions *"In a sample of experts in any chosen field, there will be experts who fall on one side and those who fall on the other side and the fact that more come forward on one side does not mean that a miscarriage of justice has occurred."* Whilst not seeking to gainsay the findings of Dr. Washington-Burke, or of Dr. Quinn, in their respective recent reports, the respondent argues that this does not change the position that the application herein does not validly engage s. 2 of the Act of 1993.

The Court's Decision

81. Counsel on both sides are to be congratulated for the excellence of their respective submissions and arguments.

82. While acknowledging, and not in any way disagreeing with, the views expressed by Kearns J. on behalf of the Court of Criminal Appeal in *The People (Director of Public Prosecutions) v. Kelly* to the effect that opinion evidence should not, in general, be regarded as being capable of constituting a newly discovered fact within the terms of s. 2 of the Act of 1993, we do note that Kearns J went on to state that:

"That is not to say that opinion evidence is in all circumstances inadmissible, as the court's present ruling will make clear. There may be cases where a state of scientific knowledge as of the date of trial may be invalidated or thrown into significant uncertainty by newly developed science. There may also be cases where the opinion of an expert at trial may later be shown to have been tainted by dishonesty, incompetence or bias to such a degree as to render his evidence worthless or unreliable. Once such 'facts' are established, expert opinion evidence must clearly then be admissible so that such new 'facts' can be properly interpreted."

83. We consider that the circumstances in which the applicant seeks to introduce evidence of the 2013 diagnosis to be exceptional, and the question is: could that exceptionality perhaps justify a departure from the general rule? Notwithstanding that the circumstances of the present case are exceptional (and we will elaborate below on why we consider it to be so), it cannot be claimed that the opinion that it is sought to introduce is based on any newly developed science. Neither can it be claimed that the original opinion of Dr. Mohan is tainted by dishonesty, incompetence or bias. While the manner in which these two possible exceptions proffered by Kearns J. were presented might, on one view of it, suggest a reluctance by the Court of Criminal Appeal to contemplate, and leave open, the possibility that yet other exceptional circumstances might equally permit an opinion being received as a newly discovered fact, we do not consider that it was the intention of the Court of Criminal Appeal to foreclose on that possibility. It seems to us to be much more likely that their intention was to emphasise that the general rule was to apply in most cases, but that a departure from it could be allowed in circumstances of sufficient exceptionality, which cases are likely to be rare.

84. Accordingly, in our view, the two instances identified of exceptional circumstances capable of justifying a departure from the general rule are not to be taken as representing comprehensively the only circumstances in which the general rule might be departed from. Although not stated to be such in express terms, we are satisfied that these were proffered merely as examples or illustrations of circumstances that would be of sufficient exceptionality as to justify a departure, but that there was no foreclosure on the possibility that yet other circumstances could be sufficiently exceptional to also justify a departure.

85. We think that there is substance in the argument made by counsel for the appellant that the 2013 diagnosis is not simply a further expert opinion which supports the applicant's case, and which seeks to contradict the evidence of Dr. Mohan given at trial. Counsel is right when he says that this is not a case of a new, divergent or revised scientific opinion, or a new theory of the case based on the same evidence that was available and considered at the trial. It is not a revised opinion based on the same evidence. Certainly, the evidence available at the time of the trial has again been taken into account, but that is just part of the evidence that underpins the changed 2013 diagnosis. The 2013 diagnosis also takes account of the applicant's extensive further psychiatric history since the trial; including his continued and worsening symptomology, his hospital admissions, and his responses to treatment provided

since the trial.

86. Counsel for the respondent has argued that there is no new diagnosis nor new opinion. He relies on the fact that the jury in 2010 had before it a diagnosis of schizophrenia, supported by several medical experts called by applicant. Admittedly, the jury also had conflicting evidence from a witness called by the prosecution. However, counsel says, the applicant's fundamental case has not changed. The evidence he adduced was to the effect that he was suffering from schizophrenia. That remains his case. Nothing has changed. He does not rely, fundamentally, on any newly discovered fact. It is still his case that he suffers from schizophrenia, that he was suffering from it at the time of the killing, and that it triggered an irresistible impulse in him that led him to kill his son. In our view, therein lies the weakness in the respondent's position.

87. It is simply not the case that the applicant does not seek to place fundamental reliance on the newly discovered facts that he identifies. To suggest otherwise is to deny reality. Time has moved on since the trial and in so far as the appellant has had ongoing mental ill-health issues there has been further opportunity to observe his presentation at length and in depth. In that time, the appellant has manifested further and additional symptomology; there has been a further opportunity to observe his responses to treatment; he has had numerous further hospital admissions to the only dedicated forensic psychiatric facility in the State (namely the Central Mental Hospital); and the doctors now treating him at that facility have changed the diagnosis that was attributed to him at an earlier point by another doctor or doctors at the same hospital. He places fundamental reliance on all of that.

88. Moreover, and what renders this case wholly exceptional, quite apart from the documented continuation of the applicant's illness culminating in a change of his diagnosis to one of paranoid schizophrenia by the doctors now treating him at the only dedicated forensic psychiatric facility in the State in the circumstances outlined earlier in this judgment, is that the recent independent review which was commissioned by the respondent, namely that by Dr Quinn, has concluded that prior to the offence the applicant was suffering from significant symptoms of a psychotic mental illness, namely schizophrenia. Clearly Dr Quinn's conclusion, following his said review, is not based on the same evidence as was the expert evidence adduced on behalf of both sides at the trial. It is only based in part on that. Critically, however, it is also based on what has happened in the years since the appellant's conviction, and the placing of the evidence adduced at the trial in the new context provided by that additional information. Accordingly, Dr Quinn's opinion would, it seems to us, also qualify as a newly discovered fact sufficient to engage s.2 of the Act of 1993, although it has not specifically been relied on for that purpose by the appellant. Be that as it may, it is contextual evidence of which we can take account in considering whether by virtue of those newly discovered facts on which the applicant is entitled to rely, and in particular the changed diagnosis, this represents an exceptional case. As we have already indicated, we are satisfied that it is.

89. A medical diagnosis is undoubtedly the opinion of the medical person that has arrived at it, but the existence of such an opinion is a fact in itself, as is any promulgation of it and reliance on it. Moreover, a diagnosis does not exist in a vacuum as the dictionary definition of the term makes clear. *"Diagnosis"* is defined in The Oxford English Dictionary (2nd ed, Vol IV) as:

> *"Determination of the nature of a diseased condition; identification of a disease by careful investigation of its symptoms and history; also the opinion (formally stated) resulting from such investigation."*

A diagnosis cannot easily be divorced from the investigation of the symptoms or history on which it is based. If, as between diagnostic exercises conducted on different occasions, either the manner or extent of investigation was not the same, or the symptoms and history were not the same, then they are different diagnoses, and that would be so even if the eventual conclusion reached was the same in both cases.

90. In our view the applicant's psychiatric symptomology, presentation and treatment since he was sentenced are undoubtedly newly discovered facts. Moreover, his current diagnosis of schizophrenia is also a newly discovered fact, because it is not based on an investigation of the same symptoms and history as underpinned the previous diagnoses, be it that of Professor Kennedy's diagnosis of depression and non-psychotic paranoid state, with which Dr. Mohan was in agreement; or that of Dr. Washington-Burke's and Dr. Caffrey's respective diagnoses of paranoid schizophrenia. Moreover, that the applicant's treating doctors now regard his earlier diagnosis made at the same hospital as having been incorrect, is itself a newly discovered fact in our judgment; and the opinion evidence of Dr. Washington-Burke and Dr. Quinn that in the light of the applicant's subsequent psychiatric history, the symptoms and signs with which he had presented before his trial were possibly incorrectly interpreted and wrongly classified as not being psychotic by his former treating doctor, Professor Kennedy, and by Dr. Mohan who independently assessed him, is a newly discovered fact.

91. In our deliberations we have posited the following hypothetical situation, to assist us in arriving at a conclusion as to whether, by reason of the existence of these newly discovered facts, it is possible that the applicant might have been the victim of a miscarriage of justice.

92. Let us suppose that for some technical reason or reasons, following the killing of Nathan on the 18th of April 2001, e.g., highly prejudicial publicity and the non-availability, or unwillingness, of certain key witnesses to testify at that point, it had not been possible to place the applicant on trial for this murder as soon as May 2003, as in fact occurred. Let us further suppose that it only became possible post 2013 to overcome the various technical hurdles that were holding up his trial for murder, but that in the meantime the applicant had been imprisoned throughout having been tried and sentenced for something unrelated, e.g., armed robbery. Let us further suppose that during the interval between 2001 and 2013 he had had, while in prison, the exact same psychiatric presentation, symptoms, hospitalisations and treatment that he has had in real life, including the change of diagnosis in 2013. Finally let us suppose that post 2013 he was finally put on trial for Nathan's murder, and ran a defence of insanity as he did in 2003 in real life, in which the same evidence as to what had factually occurred up to 2003 was put before the jury, as at his actual trial, but with the addition of supplementary evidence from the defence concerning how he had fared in terms of his mental health since 2003. It may further be supposed that the same expert witnesses were called on both sides as at the actual trial and that they sought in this hypothetical trial to adopt the same positions with respect to diagnosis as they done in 2003 in real life.

93. We have asked ourselves whether, in such a scenario, it could seriously be contended that the further defence evidence concerning how the applicant had got on from a mental health perspective in decade between 2003 and 2013 would not be relevant; that his symptomology and psychiatric presentation, hospital admissions and treatment during that period would not be relevant; and that the fact that in 2013 he had received a change in diagnosis from doctors at the Central Mental Hospital would not be relevant, in so far as the issue before the jury was concerned. In our belief it would be untenable to suggest this evidence would not be potentially relevant and potentially influential in respect of the outcome. It would not be possible, of course, to state for certain that such evidence would influence the outcome, but the possibility that it might do so could not be tenably or credibly denied.

94. Returning to the real life circumstances of this case, we are satisfied that the material being relied upon as being newly discovered facts, would, if it had been before the jury at the original trial, have had at least the potential to influence the outcome. The case might have been either prosecuted or defended materially differently. Moreover, the new evidence, if the jury had known of

it, might have significantly influenced the jury's view of the reliability of the expert evidence adduced before them, and the weight to be afforded to the different views being advanced. It is entirely possible that it could have led to a radical recalibration by the jury as to how they should view the evidence. We are in no doubt but that it could potentially have precipitated a different verdict, although clearly we cannot go so far as to say that it would necessarily have done so.

95. How the applicant would actually fare in the future in terms of his mental health was not capable of being known at the time of the trial. As it would have involved foresight of the future, it was not something capable of being discerned with reasonable diligence. At best the most that could have been offered was a forecast, that might or might not prove to be reliable. However, the newly discovered material at issue here is at this point largely historical with much of it now a matter of record. It is a matter of record that the applicant remained mentally unwell. It is a matter of record that he continued to experience paranoia and other symptoms associated with psychosis. It is a matter of record that he was hospitalised in the Central Mental hospital on multiple occasions since his trial. It is a matter of record that in 2013 the doctors treating him in the Central Mental Hospital changed his diagnosis, and diagnosed him as suffering from paranoid schizophrenia. It is a matter of record that his mental ill-health is of long standing. There has been no suggestion that he has only lately developed or acquired the psychotic condition from which he presently suffers.

96. There is a cogency to all of this additional evidence, particularly when it is viewed together with the evidence given at the actual trial, and to the respective opinions of Dr. Washington-Burke and Dr. Quinn concerning it. The material, including the expert opinions relied upon, appears to us to be credible, although it may not be incontrovertible. However, there is no requirement that it be incontrovertible. It is clearly substantial in its potential import and not in any sense trivial.

97. In the circumstances, we are satisfied on the basis of our review for the purposes of s.2 of the Act of 1993 that the applicant has established the existence of newly discovered facts and that he alleges and has pleaded that these newly discovered facts show that he was the victim of a miscarriage of justice. While we are not required to determine conclusively whether or not there has in fact been a miscarriage of justice, we harbour a significant level of concern that the newly discovered facts that are being relied upon, if they had been before the jury, might have influenced the outcome of his trial. We therefore feel justified in concluding that the applicant's trial was indeed unsatisfactory and that the verdict of murder that was recorded is unsafe. In the circumstances we consider that we must quash the conviction and direct a re-trial.