IN THE SUPREME COURT OF NEW ZEALAND

I TE KŌTI MANA NUI O AOTEAROA **SC 120/2023**

BETWEEN	**DAMIN PETER COOK**
	Appellant
AND	**THE KING**
	Respondent

RESPONDENT'S SUBMISSIONS ON APPEAL

6 June 2024

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Issue

1. Mr Cook unsuccessfully ran a defence of "sexsomnia" on charges of sexual violation. Sexsomnia is a sleep disorder in which an individual performs sexual acts in their sleep. The trial Judge classified his condition as insane automatism, which required him to prove it on the balance of probabilities and would result in an acquittal on account of insanity. This appeal challenges that classification.

2. The appellant invites the Court to rule that sexsomnia should be regarded as sane automatism, which would be for the Crown to exclude beyond reasonable doubt and would result in an unqualified acquittal. He argues the words in s 23 of the Crimes Act 1961 that govern the insanity test should be narrowly interpreted so as to broaden the availability of sane automatism and the outright acquittal it offers. This argument distils to a contention the Court should distinguish between insanity and all forms of automatism, rather than between sane and insane automatism.

Summary of Argument

3. Sexsomnia has been classified as insane automatism where there is evidence that it stems from an internal predisposition and is prone to recur. Where this is the evidence, the cause is considered a "disease of the mind", meaning that the insanity defence prescribed by s 23 of the Crimes Act 1961 will apply. This involves the application of longstanding legal tests that distinguish between internal and thereby recurring causes of incapacity, and those caused by external and effectively one-off events. Automatism caused by an internal "disease of the mind" will be classified as insane; whereas an external cause will be classified as sane automatism.

4. The classification exercise reflects legitimate social interests that have been recognised and applied across the common law. The well-established distinction between sane and insane automatism should not be disturbed by this Court. Its application to sexsomnia reflects the modern medical science about the nature of the condition, which was also the evidence in Mr Cook's case. The appeal should be dismissed.

Facts

5. Mr Cook had sex with a young woman while she slept. She was a friend of his younger flatmate and was at his house for a party. She was severely intoxicated and had been put to bed in his room after passing out outside it. He went to bed later, around 2.45am. He was fully clothed and under different blankets than her.[1] She woke around 7am to find Mr Cook sexually violating her.[2] She described the sex as "quite slow. So I feel like maybe that was in the hopes that I wouldn't wake up".[3] She said the sex "hurt" and it was "forceful".[4]

6. The complainant "froze"; she was in shock.[5] When the sex finished, she waited until she thought he had fallen back to sleep and then left to find her friend.[6] She judged this by waiting until his breathing changed to the type of slower breathing she identified with sleep.[7] She later made a Police complaint and Mr Cook was interviewed as a suspect later that day.

7. Mr Cook flatly denied the allegations. He said "[the] last thing I remember is … going to sleep, and then waking up, checking my phone, she's not even in my bed".[8] Later, though, he said he was awake when she left: "she got up out of bed, I laid there, I turned, I r-, I rolled over, she walked out closed the door, I rolled back and then felt myself drifting back off."[9]

8. At trial, Mr Cook accepted he had had sex with the complainant that night. His case was that it was an unfortunate instance of his underlying condition of sexsomnia. His mother gave evidence that Mr Cook's father also experienced (undiagnosed) sexsomnia. Mr Cook's son gave evidence that once, during shared sleeping arrangements, Mr Cook had headbutted him while apparently dreaming that he was fighting an alien on his son's head. He also called two former partners, who gave evidence about his sexual habits. Both said that he was ordinarily quite aggressive sexually, but both described waking at night to

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1 CA evidence at 138.
2 CA case book at 30.
3 CA case book at 29.
4 CA case book at 32-33.
5 CA case book at 36.
6 CA case book at 36-38.
7 CA evidence at 11.
8 CA case book at 123.
9 CA case book at 124.

more "intimate", "better" and "gentle" sex.[10]

9. One partner said she would wake to him "playing with me and trying to initiate intercourse".[11] On one occasion she woke to Mr Cook having intercourse with her.[12] Both testified that Mr Cook claimed no recollection of the sex. One partner said his response to being told about it was "[l]ike I'd conjured up some crazy story which didn't feel very good. Just denial … what the fuck are you on about".[13]

10. The Crown also called one of Mr Cook's former partners. Her evidence was that he tried to have sex with her while she was asleep, or while he thought she was asleep. She said if she "did something to make him think that I was waking up, like I might stir or I might make a noise, he would stop and then … after a while pretending I was asleep again … he would continue on again".[14] It happened regularly: "I would say weekly if not seven times a week for a period of years".[15] She described his movements as "quiet, discreet, as if he was trying not to wake me, intentional and very responsive".[16] Any time she had sought to discuss it was met with denial from Mr Cook.[17]

The sexsomnia evidence

11. Dr Fernando gave evidence about the nature of sexsomnia as part of a "vast group of sleep disorders by which patients experience undesirable events and sleep-related behaviours before, during or immediately after asleep."[18] Sexsomnia itself is recognised in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as a non-rapid eye movement sleep disorder. Typical presentation of someone with sexsomnia was sexual behaviour that was "more direct, aggressive, less inhibited, less focussed on the partner and sometimes display sexual behaviour that is atypical for the individual".[19] Most patients have a history of sleepwalking, sleep talking or sleep terrors. Triggers can include sleep deprivation, fatigue, sleep disruption;

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10 CA evidence at 172 and 190.
11 CA evidence at 173.
12 CA evidence at 174.
13 CA evidence at 177.
14 CA evidence at 83.
15 Ibid.
16 CA evidence at 86.
17 CA evidence at 85-86.
18 CA evidence at 201.
19 CA evidence at 202.

recreational drug use and psychotropic medications, and potentially alcohol.[20]

12. Dr Fernando considered the evidence of Mr Cook's family history of parasomnia was unsurprising and the hereditary link "further increases the likelihood that yes I'm dealing here with a parasomnia or a sexsomnia case".[21] While childhood parasomnias were common, in most cases they would resolve. A smaller number of patients would experience persistent sleep problems throughout their adult life. The patterns could progress in adults to sleep-related violence or confusional arousals.[22]

13. Dr Fernando acknowledged that in assessing sexsomnia in a forensic (as opposed to therapeutic) setting, it was necessary to have a collateral history because "it's very easy for someone to say, oh, I did this, I did that or I was told this, I was told that. I cannot just take their statement for it".[23]

14. Dr Fernando diagnosed Mr Cook with moderate/severe sleep apnoea, which is "an established and common trigger for abnormal sleep behaviours in patients who have [a] predisposition for sexsomnia".[24] He considered Mr Cook's family history supported a diagnosis of parasomnias and sexsomnia specifically. In opining on the possibility Mr Cook had experienced sexsomnia on the evening of the sexual violation, Dr Fernando accepted he was not an expert on malingering, but in his view the collateral information supported a diagnosis of sexsomnia. This included his willingness to attend a Police interview and lack of attempts to conceal the sexual acts, the apparent lack of evidence that he had perpetrated other offences after the incident, and lack of recollection of the episode.[25] He also considered the absence of any discussion between Mr Cook and the complainant throughout the event, or anything else that conclusively indicated he was awake, also supported the proposition Mr Cook had been experiencing an episode of sexsomnia.[26]

15. Dr Fernando was cross-examined in some depth about the criteria used to diagnose sexsomnia, and their inconclusiveness in pointing either way.

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20 Dr Fernando acknowledged the role of alcohol is controversial: CA evidence at 225.
21 CA evidence at 209.
22 CA evidence at 210.
23 CA evidence at 212-213.
24 CA evidence at 211.
25 CA evidence eat 216-217.

For example, it was put that reported amnesia can be self-serving,[27] and that on Dr Fernando's evidence little about Mr Cook's partners' accounts could conclusively say either way whether he was asleep or awake.[28] He was cross-examined that the sex took place some four hours after Mr Cook went to sleep, which was outside the typical two-hour range of time in the sleep cycle for sexsomnia to occur;[29] his response was that "there's varying opinions in the number of hours" into a person's sleep cycle when sexsomnia might occur.[30]

16. It was suggested to Dr Fernando that it would be difficult for the jury to determine whether Mr Cook had sexsomnia or not if there were a range of "different options that are all seemingly plausible".[31] Dr Fernando maintained his position that the circumstances looked at in the round supported a sexsomnia diagnosis,[32] but he acknowledged his opinion derived from his clinical (and therefore therapeutic) perspective as he was "not a forensic expert".[33]

17. The Crown called a forensic psychiatrist, Dr Peter Dean, in rebuttal. Like Dr Fernando, he drew on the DSM-5 in its classification of sexsomnia as a sleep disorder. He testified that the "incidence and prevalence of sexsomnia is very uncertain", given the lack of epidemiological data and the fact it primarily arises and is diagnosed only after someone faces a criminal charge.[34] Both experts agreed that while sleep studies could be done on patients, the brain waves indicative of a parasomnia were only very rarely observed, and therefore inconclusive either way. This makes it "very difficult to be 100% sure whether it genuinely exists in an individual because you haven't seen it."[35]

18. Dr Dean's evidence, as a forensic psychiatrist, included a greater focus on

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26 CA evidence at 221-222.
27 CA evidence at 256-257.
28 See for example his evidence on how difficult it is for lay people to tell if someone is awake, and the equivocal nature of what "awake" means in psychiatric medicine at 239.
29 CA evidence at 263-264. Dr Fernando's evidence was that sexsomnia episodes typically occur during deep non-REM sleep, in the first two hours of sleep.
30 CA evidence at 264.
31 Ibid.
32 Ibid.
33 CA evidence at 266.
34 CA evidence at 281-282.
35 CA evidence at 282.

other factors at play for Mr Cook, such as his own alcohol consumption[36] and ingestion of tramadol[37] (both of which can have a disinhibiting effect and also cause amnesia).[38] He also opined that the evidence of Mr Cook's former partners did not necessarily support a narrative of previous sexsomnia behaviours, which placed further doubt on the possibility the alleged offending was a result of sexsomnia. Dr Dean took the view that regardless of whether Mr Cook had previously experienced sexsomnia episodes, Mr Cook's alcohol intoxication on the night of the offending excluded sexsomnia.[39] He referred to the DSM-5 and International Classification of Sleep Disorders (ICSD-3) which stated that "disorders of arousal [i.e. sleep disorders] should not be diagnosed in the presence of alcohol intoxication", given the absence of a compelling relationship between alcohol and parasomnias, the fact that intoxication could also account for amnesia of the event, and the difficulty in distinguishing between drunken behaviour and sleepwalking.[40]

Classification ruling

19. Mr Cook's sexsomnia defence was classified by the trial judge as one of insane automatism. Judge Garland held that "on the basis of the proposed evidence, the present case was indistinguishable from *Cameron [v R].* There was no evidence of an external cause."[41]

20. The jury by its verdict rejected the defence and convicted Mr Cook.

Court of Appeal decision

21. On appeal, Mr Cook challenged the Court of Appeal's recent decision of *Cameron v R,*[42] which summarised and applied the principles applicable to insane automatism to the defence of sexsomnia that arose in that case. Mr Cook argued *Cameron* was wrongly decided and should be revisited. The Court dealt with the submission succinctly, finding that none of the exceptions which would entitle it to depart from settled precedent properly applied.

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36 Mr Cook's account of his drinking was that he had around 12 bourbons between 7pm-3am.
37 Mr Cook's evidence was that he had taken five tramadol tablets that evening, although this was disputed, and other evidence suggested he had taken two.
38 CA evidence at 286-288.
39 CA evidence 289-290.
40 CA evidence at 284.
41 CA case book 176, Minute of Judge A D Garland at [2], citing *Cameron v R* [2021] NZCA 80 (***Cameron***).

Submissions

22. The appellant argues that because he lacked conscious volition when he performed sexual acts in his sleep, his case was one of sane automatism. He argues s 23 of the Crimes Act does not or should not extend to "total" incapacity; it should be limited by a strict reading of its words, which apply to someone conscious but "incapable […] of understanding the nature and quality of the act". He also argues a first-principles interpretation of "disease of the mind" in s 23 should be interpreted as a "serious mental illness", which would not extend to a sleep disorder such as sexsomnia.

23. This argument effectively draws a distinction between all forms of automatism as "conduct of which the doer is not conscious",[43] versus conscious but essentially delusional conduct; and also raises the threshold for a qualifying "disease of the mind" to a "serious mental illness". The appellant argues the existing legal tests—which distinguish between internal and external causes and take account of a risk of recurrence—are unscientific and unprincipled. The appellant contends his interpretation gives greater effect to his right to present an alternative defence (one of sane automatism). His challenge to the existing distinction between sane and insane automatism is driven by the consequences: the former results in an unqualified acquittal and falls to the Crown to disprove; the latter requires the defendant to prove on the balance of probabilities and results in a disposition under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (**CPMIPA**). Disposition options range from immediate release through to detention as a special patient.

24. For the reasons that follow, the respondent submits the existing legal tests properly reflect longstanding social interests in differentiating between defendants whose lack of criminal capacity was brought about by an external and one-off event that could happen to anyone, and those whose internal predisposition took them outside of society's expectations about rationality and choice. They should not be disturbed.

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42 *Cameron v R* [2021] NZCA 80, [2021] 3 NZLR 152.
43 *R v Cottle* [1958] N.Z.L.R 999 at 1007.

Insane automatism

25. The common law has long recognised a distinction between unconscious behaviour caused by a "disease of the mind" and that which is not. In *Bratty v Attorney-General for Northern Ireland*, Lord Denning observed an act committed in a state of "automatism or clouded consciousness due to a recurrent disease of the mind" is "no doubt involuntary, but it does not give rise to an unqualified acquittal, for that would mean he would be let at large to do it again".[44] The same was recognised since *R v Cottle* 1958 in New Zealand[45] and by the Supreme Court of Canada[46] and the High Court of Australia.[47]

26. The distinction between sane and insane automatism therefore lies in its cause, and what this means in terms of ongoing risk. The "cause" turns on whether a condition is a "disease of the mind", which is the terminology used in s 23 of the Crimes Act.

27. As observed by Devlin J in *Hill v Baxter*:[48]

> The distinction is not an arbitrary one. If disease is not the cause, if there is some temporary loss of consciousness arising accidentally, it is reasonable to hope that it will not be repeated and it is safe to let an acquitted man go entirely free. But if disease is present, the same thing may happen again.

28. The nature of the insanity defence also illustrates this point. This was described by the Canadian Supreme Court as recognition "that the individual in question does not accord with one of the basic assumptions of our criminal law model: that the accused is a rational autonomous being who is capable of appreciating the nature and quality of an act and knowing right from wrong."[49] Or as put by McLachlin J in a minority judgment, "the defence of insanity rests on the fundamental moral view that insane persons are not responsible for their actions and are not therefore fit subjects for

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44 *Bratty v Attorney-General for Northern Ireland* [1963] AC 386 at 410. See also *R v Sullivan* [1984] AC 156 at 173: "The audience to whom the phrase in the M'Naghten Rules was addressed consisted of peers of the realm in the 1840's when a certain orotundity of diction had not yet fallen out of fashion. Addressed to an audience of jurors in the 1980's it might more aptly be expressed as 'He did not know what he was doing.'"

45 *R v Cottle* [1958] N.Z.L.R 999 at 1009.

46 *Rabey v R* [1980] 2 SCR 513 at 523 and 524.

47 *R v Falconer* (1990) 171 CLR 30 at 70-71.

48 *Hill v Baxter* [1958] 1 QB 277 at 285-286.

49 *R v Chaulk* [1990] 3 SCR 1303 at 1320-1321.

punishment."[50]

29. This rationale applies to both insane automatism and conscious but essentially delusional acts.[51] The majority in *Chaulk* considered the defence makes "a more basic claim which goes beyond *mens rea* or *actus reus* in the particular case – [a defendant] is claiming that he does not fit within normal assumptions of our criminal law model because he does not have the capacity for criminal intent".[52] In this way the Court placed the insanity defence on a "continuum" that began with an irrebuttable presumption against capacity for criminal intent for young children, followed by a rebuttable presumption against capacity for older children, and culminated in the presumption of sanity for those of age.[53]

30. By the same token, and in recognition of the risk posed by an individual whose mental disposition exempted them from responsibility for an otherwise criminal act, the "purpose of the legislation relating to the defence of insanity, ever since its origin in 1800, has been to protect society against recurrence of the dangerous conduct".[54]

31. By contrast, conditions that fall within "sane" automatism are ones that could effectively happen to anyone, and do not turn on an individual's personal makeup or their internal predispositions. The underlying rationale for the two defences are therefore conceptually distinct. Or as observed by Gauldron J:[55]

> In general terms, a recurring state which involves some abnormality will indicate a mind that is diseased or infirm, but the fundamental distinction is necessarily between those mental states which, although resulting in abnormal behaviour, are or may be experienced by normal persons (as, for example and relevant to the issue of involuntariness, a state of mind resulting from a blow to the head) and those which are never experienced or encountered in normal persons.

Disease of the mind

32. This conceptual distinction also informs the courts' approach to the meaning of "disease of the mind", which is a legal term that takes account both of the

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50 *R v Chaulk* [1990] 3 SCR 1303 at 1397, citing Law Reform Commission of Canada, Working Paper 29, *Criminal Law: The General Part – Liability and Defences* (1982), at p 42.
51 *R v Chaulk* [1990] 3 SCR 1303 at 1321.
52 *R v Chaulk* [1990] 3 SCR 1303 at 1323.
53 *R v Chaulk* [1990] 3 SCR 1303 at 1319-1320.
54 *R v Sullivan* [1984] 1 AC 156 at 172.
55 *R v Falconer* (1990) 171 CLR 30 at 85.

nature of a condition and what that means in terms of ongoing risk.

33. Accordingly, the term has been given a wide definition. In *R v Cottle*, Gresson P described "disease of the mind" as "a term which defies precise definition and which can comprehend mental derangement in the widest sense".[56] It may be caused by "some condition of the brain itself and so have its origin within the brain, or whether due to some effect upon the brain of something outside the brain".[57] This is different from "[t]he adverse effect upon the mind of some happening, e.g. a blow, hypnotism, absorption of a narcotic, or extreme intoxication all producing an effect more or less transitory", which "cannot be fairly regarded as amounting to or as producing 'disease of the mind'." [58]

34. "Disease of the mind" is not a medical term; and does not easily translate into medical parlance. As La Forest J observed in *R v Parks*:[59]

> In part because of the imprecision of medical science in this area, the legal community reserves for itself the final determination of what constitutes a "disease of the mind". This is accomplished by adding the "legal or policy component" to the inquiry.

35. But while "disease of the mind" is a legal question,[60] it is informed by medical science. For this reason, "the concept of 'disease of the mind' is capable of evolving with increased medical knowledge with respect to mental disorder or disturbance".[61]

36. "Disease of the mind" therefore relies on expert evidence both to speak to the defendant's mental state but also to inform the underlying social objectives that form part of the legal question, namely whether the condition in question was brought on by an internal disposition or external events, and whether it is prone to recur. In this way, the application of this test does not have the effect of rigidly categorising a condition—as observed in *Cameron*,

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56 *R v Cottle* [1958] NZLR 999 at 1011.
57 Ibid.
58 Ibid.
59 *R v Parks* [1992] 2 SCR 871 at 900.
60 *R v Kemp* [1957] 1 QB 399 at 403-406; *R v Falconer* (1990) 171 CLR 30 at 68; *Rabey v The Queen* [1980] 2 S.C.R. 513 at 533; *R v Parks* [1992] 2 SCR 871 at 900; *R v Cottle* [1958] NZLR 999 at 1028.
61 *R v Parks* [1992] 2 SCR 871 at 882 and 899, citing *Rabey v R* (1977), 37 C.C.C. (2d) 461 (CA) at 472-473, affirmed by the Supreme Court.

each case will turn on its facts and the expert evidence before the court.[62]

37. The appellant criticises this frame of analysis as "simplistic" and "unscientific". But his proposed alternative—of distinguishing instead between a "lack of conscious volition" altogether and a "serious mental illness" that causes "conscious" incapacity—is not necessarily more scientific. Indeed, given that medicine does not easily align with the legal concept of a lack of consciousness[63]—and on one medical view, would classify *all* automatism as mental disorders[64]—it is quickly apparent that resort to medical science alone does not easily resolve the issues posed by automatism and insanity.[65]

38. The same point was made in the evidence in this case. Dr Fernando opined that "a lot of us have this perception that consciousness is, either we're conscious and fully awake or we're fully asleep. That's what most people think. In reality it's not that simple. There is actually a spectrum".[66] A legal distinction that turns on a complete lack of consciousness is therefore no more likely to be easily reconciled with medical science.

39. While the appellant argues a narrower interpretation of "disease of the mind" is available from a more literal reading of the terms of s 23, that approach is susceptible to the (justified) criticism of the language he goes on to make—that it is archaic and not reflective of modern descriptors of mental conditions. The old-fashioned nature of the language, which derives from the 19th century, necessarily stymies any attempt at a literal interpretation.

40. The appellant argues the recurring danger factor is an unnecessary "imported gloss" derived from "that 'unruly horse', public policy".[67] But the tests developed by the courts were done for expressly this purpose—to recognise when a person's incapacity for criminal responsibility represented an ongoing danger.

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62 *Cameron* at [82].

63 *R v Stone* [1999] 2 SCR 290 at 367, where the Court observed that the legal concept of "unconscious" behaviour is not well-recognised in medicine; medical science considers unconsciousness to be a "comatose-type state", and instead speaks of "different levels of consciousness".

64 *R v Stone* [1999] 2 SCR 290 at 333, 340 and 387.

65 The distinct role of medical experts and judges was expressed by North P in *R v Burr* [1969] NZLR 736 (CA) at 747: "It is no doubt tempting for psychologists, who are healers of individual patients, not Judges burden with the responsibility of administering the criminal law in the interests of the public, to maintain that persons in the position of this appellant should be held less than fully responsible for their acts."

66 CA evidence at 239.

67 Appellant's submissions at [73].

41. This is a legitimate and well-established objective of the insanity defence and the way it has been interpreted to apply. An interpretation of the sane automatism defence that departs from those objectives would therefore reflect a radical departure from the existing law and the social interests it is designed to meet, or as the *Cameron* Court put it, the policy rationale that "lies at the heart of the insanity defence".[68]

42. While the "internal/external" and "recurrent risk" tests have produced controversial results,[69] and have been the subject of criticism,[70] they also continue to be recognised as useful "analytical tools" that give effect to the underlying social and legal objectives at play.[71] The Court of Appeal in *Cameron* correctly recognised and applied these tests as the "traditional yardstick" used in cases where it is necessary for the court to determine whether a condition is a "disease of the mind".[72]

43. And, as developed below, they can be rationally applied to sexsomnia, without producing difficult or artificial results.

Sexsomnia as insane automatism

44. Sexsomnia, as a type of parasomnia, is a sleep disorder. The evidence in this case establishes it is part of a large cohort of sleep disorders which can manifest in different forms. Parasomnic behaviours themselves can range from sleepwalking, sleep talking, sleep terrors, nightmares, restless legs, sleep eating and teeth grinding to sleep sex.[73] Sexsomnia, therefore, is not necessarily an identical condition to sleepwalking, but rather one expression of the range of sleep disorders known as parasomnia.

45. As observed in *Cameron*, "sleepwalking" was frequently referred to in case law through to the mid-twentieth century as a paradigm example of sane automatism.[74] But those remarks were obiter and were not directly

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68 *Cameron* at [71].

69 The most famous of which is the distinction between hyper- and hypoglycaemia, which has respectively been found to be insane and sane automatism. Some of these results should be read against the fact the consequences of an insanity verdict were both severe and non-discretionary; see for example *R v Quick* [1973] Q.B. 910, [1973] 3 All ER 347.

70 See for example Jones T.H. "Insanity, Automatism and the Burden of Proof on the Accused" (1995) 111 L.Q.R 475 at 498.

71 *R v Parks* [1992] 2 SCR 871 at 902; *R v Stone* [1999] 2 SCR 290 at 390.

72 *Cameron* at [71].

73 CA evidence at 201.

74 *Cameron* at [72] and [73], and the cases cited therein.

concerned with sleepwalking. The New South Wales Court of Appeal in *R v DB*[75] cited a number of criminal trials, of a similar vintage, in which a plea of sleepwalking had resulted in an outright acquittal.[76] It cannot readily be gleaned that those cases relied on more than the prevailing view that was expressed in *R v Tolson*:[77]

> …can any one doubt that a man who, though might be perfectly sane, committed what would otherwise be a crime in a state of somnambulism, would be entitled to be acquitted? And why is this? Simply because he would not know what he was doing.

46. Indeed, many of the cases cited in *DB* appear to involve violent acts in pursuit of a dream, often either by members of the armed forces and/or in the post-war period. In short, there is little to be drawn from these cases in application to sexsomnia and the expert evidence of its nature in present terms.

47. In 1992, the Canadian Supreme Court determined a man who drove 23kms and fatally stabbed his mother-in-law and seriously injured his father-in-law had acted in a state of somnambulism and, on the evidence before it, sane automatism.[78] As that Court observed:[79]

> Although sleep-walkers have always received an absolute acquittal for what they do, no social inconvenience has hitherto resulted. There seems to be no recorded instance of a sleep-walker doing injury a further time after being acquitted.

48. The evidence in that case was that sleepwalking was viewed in psychiatry as neither a mental illness nor a disease, and that a person who is sleeping could not think, reflect or perform voluntary acts.[80] A family history of sleep "difficulties" had been identified but experts testified there was "no reported cases in the literature" of recurring violent parasomnic behaviour, meaning recurrence was "absolutely improbable".[81] The expert opinion on treatment in *Parks* was that no more than "sleep hygiene", such as regular bedtimes, and avoiding stress and fatigue, would be effective.[82]

49. The Court considered the "dichotomy between internal and external causes

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75 *R v DB* [2022] NSWCCA 87.
76 *R v DB* [2022] NSWCCA 87 at [11]-[43]. The cases range from the 19th century through to the 1970s.
77 *R v Tolson* (1998) 23 QBD 168 at 187.
78 *R v Parks* [1992] 2 SCR 871.
79 *R v Parks* [1992] 2 SCR 871 at 883.
80 *R v Parks* [1992] 2 SCR 871 at 886.
81 *R v Parks* [1992] 2 SCR 871 at 887-888.

becomes blurred" in the context of sleepwalking, and adopted an obiter remark from *Rabey* that "somnambulism is an example of a condition that is not well suited to analysis under the internal cause theory", because "certain factors can either legitimately be characterized as either internal or external sources of behaviour".[83] These remarks must be read in light of the evidence before the Court, however, which emphasised Mr Parks' unique convergence of stressors[84] that precipitated what the experts described as effectively a one-off event, almost certain not to recur.

50. The Canadian Supreme Court were aware of a similar case in England, *R v Burgess*,[85] which involved sleep-related violence and in which the expert evidence had supported a ruling of insane automatism. The Court observed the evidence was that the behaviour was liable to recur, and involved a pathological condition because it was an abnormal brain function. The evidence in *Burgess* was also that sleepwalking was highly treatable and so "sending them to hospital after a violent act to have their sleepwalking sorted out, makes good sense".[86] The *Parks* Court acknowledged the evidence in *Burgess* supported this different result, and that the outcome in *Parks* was "not to say that sleepwalking could never be a disease of the mind, in another case on different evidence."[87]

51. In *Burgess*, the English Court of Appeal applied the "internal/external" test with reference to *Rabey, Sullivan* and *Bratty*, to circumstances it described as follows:[88]

> The appellant plainly suffered from a defect of reason from some sort of failure (for lack of a better term) of the mind causing him to act as he did without conscious motivation. His mind was to some extent controlling his actions which were purposive rather than the result simply of muscular spasm, but without his being consciously aware of what he was doing. Can it be said that that "failure" was a *disease* of the mind rather than a defence or failure of the mind not due to disease? That is what the distinction, by no means always

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82 *R v Parks* [1992] 2 SCR 871 at 888-889.
83 *R v Parks* [1992] 2 SCR 871 at 902-903.
84 These are outlined at 879.
85 *R v Burgess* [1991] QB 92 (CA), [1991] 2 All E.R. 769.
86 *R v Parks* [1992] 2 SCR 871 at 891, citing *Burgess* at 775-776.
87 *R v Parks* [1992] 2 SCR 871 at 891. See also 909, where La Forest J agreed and affirmed the comment of Dickson J in *Rabey*: "What is disease of the mind in the medical science of today may not be so tomorrow. The court will establish the meaning of disease of the mind on the basis of scientific evidence as it unfolds from day to day. The court will find as a matter of fact in each case whether a disease of the mind, so defined, is present."
88 *R v Burgess* [1991] QB 92 (CA) at 98.

> easy to draw, upon which this case depends, as others have depended in the past.

52. The Court excluded "external factors" such as concussion: "Whatever the cause may have been, it was an 'internal' cause."[89] It "accept[ed] of course that sleep is a normal condition, but the evidence in the instant case indicates that sleep walking, and particular violence in sleep, is not normal."[90] The Court acknowledged the apparent incongruity of labelling the condition as "insanity" but emphasised the technical nature of the term, which lay in Parliament's power to change if it wished.[91] But:[92]

> It seems to us that on this evidence the judge was right to conclude that this was an abnormality or disorder, albeit transitory, due to an internal factor, whether functional or organic, which had manifested itself in violence. It was a disorder or abnormality which might recur, though the possibility of it recurring in the form of serious violence was unlikely. Therefore since this was a legal problem to be decided on legal principles, it seems to us that on those principles the answer was as the judge found it to be. It does however go further than that. Dr d'Orban, as already described, stated it as his view that the condition would be regarded as pathological. Pathology is the science of diseases. It seems therefore that in this respect at least there is some similarity between the law and medicine.

53. Since *Parks*, the Ontario Court of Appeal recognised sexsomnia specifically as insane automatism in *R v Luedecke.* Mr Luedecke had sex with a young woman who had fallen asleep near him at a party. She screamed and pushed him away. Based on the evidence in that case, the Crown did not dispute that it was an episode of sexsomnia: the complainant described Mr Luedecke as looking "dazed", "completely incoherent", "like just when you've just woken them up out of a sound sleep".[93] Mr Luedecke had a history of sexsomnia and sleep lab testing showed "hallmark" signs of parasomnia during his sleep.[94] He also had a family history of parasomnias, which condition was known to be hereditary. The issue on appeal was classification; the trial Judge having determined it to be sane automatism. The Ontario Court of Appeal allowed the Crown's appeal and ruled it was insane automatism.

54. The expert evidence in Mr Luedecke's was circumspect about sexsomnia as a

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89 Ibid.
90 *R v Burgess* [1991] QB 92 (CA) at 100.
91 *R v Burgess* [1991] QB 92 (CA) at 102.
92 *R v Burgess* [1991] QB 92 (CA) at 101-102.
93 *R v Luedecke* 2008 ONCA 716, 236 CCC (3D) 317 at [18].
94 *R v Luedecke* 2008 ONCA 716, 236 CCC (3D) 317 at [34].

mental disease or disorder, given it arose out of a "normal process", namely sleep.[95] The expert noted that medication could reduce likelihood of recurrence, as could good sleep practices, and that as a result of Mr Luedecke's awareness of his condition he would "surely" take steps to avoid sleeping near strangers again.[96] That said, he acknowledged that a failure to take these steps would increase risk of recurrence.

55. *Luedecke* must be read in light of *R v Stone*, in which the Canadian Supreme Court reformulated the approach to automatism in Canada by applying the standard of balance of probabilities to sane, as well as insane automatism;[97] and setting a presumption in favour of *insane* automatism, to be rebutted by the evidence.[98] The Ontario Court of Appeal considered risk of recurrence of an internal feature to be a dominant concern in classifying Mr Luedecke's condition. The Court was satisfied that the medical opinion "that parasomnia did not constitute a mental disorder was largely irrelevant to the determination of whether, for policy reasons, the condition should be classified legally as a disease of the mind."[99] The Court identified Mr Luedecke's established history of sexsomnia and the strong likelihood of recurrence of the events that triggered sexsomnia were factors that warranting an insane automatism classification.

56. The only appellate case in Australia to consider the classification of sexsomnia is *R v DB*.[100] The case has limited application in New Zealand because of the different test adopted in New South Wales law (there, the equivalent test has been amended and the issue concerned whether the defendant had a "disturbance of volition" as provided in New South Wales law, as opposed to an "absence" of volition).

57. What these cases show is that modern medical science about parasomnias (as opposed to the traditional conception of sleepwalking) tends to describe the condition as an "internal" one which—as in Mr Cook's case—can be prone to recur. But as *Cameron* held, "the classification of the particular defendant's

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95 *R v Luedecke* 2008 ONCA 716, 236 CCC (3D) 317 at [39].
96 *R v Luedecke* 2008 ONCA 716, 236 CCC (3D) 317 at [38] and [40].
97 *R v Stone* [1999] 2 SCR 290 at 378, 379.
98 *R v Stone* [1999] 2 SCR 290 at 388.
99 *R v Luedecke* 2008 ONCA 716, 236 CCC (3D) 317 at [103].

condition must be decided on a case-by-case basis, with the assistance of expert evidence."[101] This explains the conclusion reached in *Parks*, but also the different outcomes reached in *Burgess*, *Luedecke* and *Cameron*.

58. On the evidence in Mr Cook's case, his defence was appropriately classified as insane automatism. Mr Cook's sexsomnia—if accepted by the jury—consisted of persistent and longstanding sexual acts during his sleep, often amounting to full sexual intercourse with bed partners. His case was he had a family history of sexsomnia, which was a recognised sleep disorder, diagnosed and treated by psychiatrists with expertise in sleep medicine; and which was a condition recognised and described in DSM-5, used to classify mental disorders.

59. Moreover, there was evidence (from the Crown's witness) that she disliked and resisted the conduct despite its persistence; and two partners spoke of Mr Cook's unwillingness to accept these events occurred when confronted after the event. If accepted as evidence of sexsomnia, these features spoke to both the extent of recurrence but also Mr Cook's unwillingness to confront his condition. Both features speak to the risk of ongoing social harm resulting from his conduct, which disturbed former partners and culminated in sexual violation of a relative stranger.

60. The evidence therefore engaged classic policy considerations underpinning the classification exercise and was informed by medical evidence on the nature of the condition. It was appropriately classified as insane automatism, on the basis of the law recognised and applied in *Cameron*.

Sexsomnia and CPMIPA

61. The appellant argues there is no treatment for sexsomnia, which in turn calls into question the utility or need for a qualified acquittal, as disposition options under CPMIPA would effectively be limited to immediate release.[102] This argument is not borne out by either the evidence at Mr Cook's trial or the broader authorities.

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100 *R v DB* [2022] NSWCCA 87.
101 *Cameron* at [82].
102 CPMIPA, s 25(1)(d).

62. There was little direct evidence regarding treatment options for sexsomnia at Mr Cook's trial; this is unsurprising given it was not an issue for the jury to determine. Had Mr Cook been acquitted on account of insanity the Court's disposition inquiries under CPMIPA would have necessarily included evidence about treatment, but the jury by its verdict had rejected the sexsomnia defence. But it does not follow from this absence of evidence about treatment that the condition is in fact untreatable. To the contrary, Dr Fernando described Mr Cook, from a clinical (as opposed to forensic) perspective as a "slam dunk sexsomnia patient who needs to be treated".[103] This is consistent with both literature and case law, which indicates that medication can treat the condition, and other interventions are also available.[104]

63. It is conceivable, given the varied and often-recurrent nature of parasomnias, that a special patient order under s 24 CPMIPA *might* be appropriate in the interests of the public if a convergence of features raised the prospect of frequent violent or sexual attacks against members of the public.

64. And while inpatient orders under s 25(1)(a) of CPMIPA are only available for defendants who meet the definition of "mentally disordered" under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**MHCAT**),[105] which does not readily lend itself to the popular conception of sleepwalking, the availability of this option will always depend on the evidence before the court, and whether the underlying condition is capable of satisfying it.

65. Conversely, an argument that CPMIPA is inapplicable in parasomnia cases, based on no evidence as to treatment and only the facts of the particular case, is difficult to reconcile with the flexibility of disposition options and the variable nature of sleep disorders. If anything, the recurring nature of

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103 CA evidence at 266.

104 See for example *R v Luedecke* 2008 ONCA 716, 236 CCC (3d) 317 at [38]; see also Brian J Holoyda and others "Forensic Evaluation of Sexsomnia" (2021) 49 J Am Acad Psychiatry Law 202 at 205. In *Burgess*, the expert witness was of the view that hospital treatment may be appropriate for recurring violent parasomnias.

105 "Mental disorder" under MHCATA has its own meaning that is distinct from the concept of insanity (or fitness to stand trial, which is the other basis on which a s 25(1) CPMIPA order may be made). "Mental disorder" under MHCATA is defined as: "an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself".

sexsomnia, in which the sufferer is capable of carrying out what would otherwise be a serious criminal offence with concomitant victim impact, lends itself to scrutiny under CPMIPA.

New Zealand Bill of Rights Act 1990

66. The appellant contends the minimum standards of criminal procedure guaranteed by s 25(c) (the presumption of innocence) and 25(e) (the right to present a defence)[106] of the New Zealand Bill of Rights Act 1990 (**NZBORA**) support a narrower approach to the insanity defence. He argues narrow reading of "disease of the mind" should be adopted so as to free the defendant to advance a defence of automatism without having to rely upon and prove the insanity defence.

67. Although invoking the NZBORA in an interpretive capacity, the argument is not framed in terms of any recognisable method. The interpretive provisions in ss 4,5 and 6 are barely mentioned.

68. Methodology is not an end in itself, but when invited to determine whether Parliament (in s 23 of the Crimes Act 1961) has made law that is consistent with the NZBORA, the application of orthodox legal method is not formalistic. Rather it ensures the Court fulfils and does not exceed its constitutional function. The respondent's submissions under this heading will follow the path illuminated by this Court, particularly in *R v Hansen,* and *Fitzgerald v R*, to address the interpretation of s 23(1) of the Crimes Act which is the primary focus of the appellant's argument as to inconsistency.

69. The crux of the appellant's argument is that regardless of the underlying cause, he says he was unaware of what he was doing and should have been able to offer this to his jury as evidence negating mens rea, and obtained an outright acquittal if the prosecution could not prove otherwise beyond reasonable doubt. The law that prevented that is not simply s 23 of the Crimes Act but the limits of the sane automatism defence. Put another way, the appellant argues automatism should be seen as a defence that applies to all states of "lack of conscious volition". But cause is also relevant to the scope of

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106 Submissions of counsel for the appellant at [28], [31], [33], [52] – [55].

sane automatism as a defence—it applies when lack of conscious volition was caused by an external event or some unforeseen circumstance. But where automatism arises due to a disease of the mind, "the defence of insanity prevails".[107] Similarly, evidence that supports an insanity defence cannot be offered to negate mens rea on a general basis of lack of intent.[108]

Section 23 Crimes Act – interpretation

70. The *R v Hansen* methodology, set out in the judgment of Tipping J[109] is not universal,[110] but it is helpful when the submission is that the plain meaning of enactment is inconsistent with a guaranteed right that is capable of demonstrably justified limitation.

71. In *Fitzgerald v R* this Court clarified that when reading the enactment for its plain meaning at the start of the exercise, it is logical to exclude s 6, otherwise it would be counted twice.[111]

72. The relevant parts of s 23 are subsections (1) and (2). Subsection (1) contains the presumption of sanity "until the contrary is proven". The parts of s 23(2) that the appellant asks the Court to interpret is "disease of the mind" and "incapacity". As the appellant correctly notes,[112] disease of the mind is an antiquated phrase with little connection to modern notions of mental illness. It re-enacted s 43 of the Crimes Act 1908. But the phrase "natural imbecility" could now be read as referring to intellectual disability, and disease of the mind can be broadly characterised as a mental disorder. That said, and as the legal tests developed by the courts have recognised, its definition does not solely concern a defendant's mental state but also takes account of its cause and the prospect of recurrence.[113]

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107 *Rabey v R* [1980] 2 SCR 513 at 524, citing *R v Cottle* [1958] N.Z.L.R 999 at 1007.

108 See for example *R v S* [1979] 2 N.S.W.L.R. 1 at p 61, where the Court held, "If the jury were required to take into account all the evidence, including that relating to insanity, in determining whether the prosecution had established its case beyond reasonable doubt, including the intention alleged as an element of the offence which is denied by the accused by reason of insanity, the first limb of the rule in *McNaughten's* case disappears. It is absorbed into the case for the prosecution." See also *Hawkins v R* ((1994) 179 CLR 500 (HCA) at 517: "Evidence of mental disease that is incapable of supporting a finding of insanity or that does not satisfy the jury that the accused was insane when the incriminated act was done, is inadmissible on, and must be taken to be irrelevant to, the issue of whether the act was "voluntary and intentional" within the meaning of those terms in s 13 of the Code."

109 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [92].

110 *Fitzgerald v R* [2021] NZSC 131; [2021] 1 NZLR 551 Winkelmann CJ at [46].

111 *Fitzgerald v R* at [45].

112 Submissions of counsel for the appellants at [24].

113 In Canada, where the term has been amended to "mental disorder" in the legislative provision providing for the defence, "mental disorder" is defined in the interpretation section as "disease of the mind".

73. As observed, in *Cottle* in 1958, Gresson P described "disease of the mind" as "a term which defies precise definition and which can comprehend mental derangement in the widest sense".[114] The legal tests developed by the Courts and applied in *Cameron*, focussing on an internal cause and the manifestation of recurrent behaviour, support the clear statutory purpose of s 23—that persons whose cognition is sufficiently disturbed by a mental disorder should not be made criminally responsible for their actions, but nor should they be given an unqualified acquittal that would put the community at risk again. Further, sanity is presumed until the contrary is established on the balance of probabilities.

Is this meaning of disease of the mind consistent with s 25(c) and (e) of the NZBORA?

Section 25(c) The presumption of innocence

74. There is no limit on the right to the presumption of innocence in section 23(2) of the Crimes Act, which contains the phrase "disease of the mind". This subsection describes the defence of insanity but says nothing about where the burden of proof lies.

75. It is s 23(1) that sets out the presumption of sanity, which the Crown accepts causes a *prima facie* limit of the right to the presumption of innocence guaranteed by s 25(c) of the NZBORA, insofar as it applies to an accused person who seeks to displace it by relying on a defence of insanity.[115]

76. The meaning "disease of the mind" developed since at least *Cottle* is not in itself inconsistent with s 25(c). Nor is the application of the words "incapable … of understanding the nature and quality of the act" to a lack of conscious volition (as opposed to only conscious delusions). Indeed, reading down both terms would have the effect of excluding some people from establishing that they should not be criminally responsible for their actions, without necessarily expanding the availability of the sane automatism defence. As observed, medical science does not recognise so rigid a distinction in consciousness as the law does; it speaks of levels of consciousness rather than binary

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114 *R v Cottle* [1958] NZLR 999, Gresson P at 1011.

115 There does not appear to be any New Zealand decision to this effect, but equivalent provisions have been found to be a prima facie limit of the presumption of innocence in the United Kingdom (*Foye v The Queen* [2013] EWCA 475) the ECHR (*Salabiaku v France* (1988) 13 EHRR 379) and Canada (*R v Chaulk* [1990] 3 SCR 1303).

alternatives of a complete lack of conscious volition or full (but delusional) consciousness.[116]

77. Applying the well-established meaning of the phrase "disease of the mind" and "incapacity" is not inconsistent with s 25(c).

Section 25(e) – right to present a defence

78. Section 25(e) of the NZBORA has been interpreted generously to cover any impediments to the accused having a full understanding of the charges against them, notwithstanding any physical or mental infirmity or language difficulty.[117] The authors of *Butler & Butler* suggest it should extend to access to the evidence, a reasonable opportunity to replace counsel who withdraws close to a hearing and the opportunity to put forward their best defence.[118] But in each of these respects what is being described is a procedural right. Section 25(e) does not constrain or guide Parliament or the Courts in setting or adjudicating upon the substantive content of criminal law, whether as to the elements of an offence or any defence that might be raised at trial.

79. It is the right to the presumption of innocence that is limited by s 23 rather than the right to present a defence and an apparent inconsistency would only arise if s 23(1) and 23(2) are read together for this purpose.

Is the limit demonstrably justified?

80. To the extent the reverse onus on a defendant under s 23 is a limit on the presumption of innocence, the respondent submits it is a demonstrably justified one.

81. In *R v Hansen,* Tipping J's structured approach at step 3 framed the utilitarian balancing that s 5 requires in terms of the *R v Oakes*[119] analysis: is there a sufficiently important social objective to which the measure in question is rationally connected, and which impairs the right no more than is necessary to achieve it. In *D v New Zealand Police*[120] and *Moncrief-Spittle v Regional*

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116 See *R v Stone* [1999] 2 SCR 290 at 367. Likewise, Dr Fernando spoke of a "spectrum" of consciousness with regard to sleep: CA evidence 239.

117 *Abdula v R* [2011] NZSC 130; [2012] 1 NZLR 534 (SC) at [43].

118 *Andrew Butler and Petra Butler* The New Zealand Bill of Rights Act: A Commentary (2nd ed, LexisNexis, Wellington, 2015) at [23.7.9] to [23.7.11].

119 *R v Oakes* [1986] 1 SCR 103.

120 *D (SC 31/2019) v New Zealand Police* [2021] NZSC 2, [2021] 1 NZLR 213.

Facilities Auckland Ltd[121] the Court adopted a less structured balancing when discretionary powers of decision and administrative decision-making were examined, but the *R v Oakes* framework remains useful in the interpretation of legislation as in *New Health (New Zealand) Inc v South Taranaki District Council*.[122]

82. The *Oakes* analysis was applied to the insanity defence by the Canadian Supreme Court in *R v Chaulk.*[123] By a majority the Court held the reverse onus limited the presumption of innocence, but the limit was justified on application of the *Oakes* analysis. It identified two features that impacted on the presumption of innocence: first, that the provision presumed something (sanity) which was essential to guilt; second, that the reverse onus meant a person could be convicted despite reasonable doubt about their insanity. These limits on the normal onus and standard that attached to the Crown in criminal cases were justified because "Parliament wished to avoid placing on the Crown the impossibly onerous burden of disproving insanity and to thereby secure the conviction of the guilty (who are not 'sick') by defeating acquittals based on a doubt as regards insanity".[124] The reverse onus was not an intrinsic feature of insanity, rather "a purely evidentiary section whose objective is to relieve the prosecution of the tremendous difficulty of proving an accused's sanity in order to secure a conviction."[125] This objective also reflected the fact that medical science could not conclusively determine whether someone was legally insane.[126]

83. The way the Supreme Court of Canada framed the insanity defence is also relevant to its analysis of the presumption of sanity. As previously observed, the Court saw the insanity defence as sitting at the end of a continuum which started which an irrebuttable presumption against capacity for criminal intent in young children, and ended with the presumption of insanity for those of-age, which was rebuttable on the balance of probabilities.[127]

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121 *Moncrief-Spittle v Regional Facilities Auckland Ltd* [2022] NZSC 138; [2022] 1 NZLR 459.
122 *New Health New Zealand Inc v South Taranaki District Council* [2018] NZSC 59; [2018] 1 NZLR 948.
123 *R v Chaulk* [1990] 3 SCR 1303.
124 *R v Chaulk* [1990] 3 SCR 1303 at 1337.
125 Ibid.
126 *R v Chaulk* [1990] 3 SCR 1303 at 1337-1338.
127 *R v Chaulk* [1990] 3 SCR 1303 at 1319-1320.

84. President North made similar observations about the presumption of sanity in *R v Burr*:[128]

> It is therefore desirable, I think, to begin by looking at the way the law views responsibility for crime in a general way. As I see the matter, in the interests of society, the law has found it necessary to adopt a pragmatic approach to responsibility for crime. Some doctors who no doubt have a far more intimate knowledge of the workings of the mind take a different and broader view, but our law proceeds on the basis that everyone is presumed to be sane until the contrary is shown and accordingly a man is presumed to intent the natural and probable consequences of his acts. Now, in my opinion, it is only in that way that the criminal law could ever be satisfactorily administered from the point of view of society. Nevertheless Judges and lawyers have long recognised it was necessary to make provision to meet the case of insane persons. But they were never willing to allow insanity as such to be a defence for crime. Hence the formulation of what is known as the McNaghten [sic] rules.

85. While the precise rationale for a reverse onus having been adopted in the M'Naghten Rules themselves is not clear,[129] it was expressly recognised as a "definite exception" to the normal onus on the Crown in *Woolmington v DPP,*[130] and this "pragmatic approach" continues to prevail across cognate jurisdictions. The American trend in reform towards reducing the onus to an evidential one was largely reversed in more recent years.[131] Australian criminal law still retains the standard even in states where the insanity legislation has been reformed. Likewise, England retains the reverse onus. In Canada, since *Chaulk*, the Supreme Court in *R v Stone* in fact extended the reverse onus to *all* automatism defences, while also imposing a rebuttable presumption of insane automatism.

86. In *Rabey v R* and *R v Stone*, the Canadian Supreme Court identified the ease with which conditions such as automatism might be feigned as another operative social concern.[132] As can be seen in the American example, social concerns persist (justified or otherwise) that the insanity defence is too readily available. Indeed, as the Law Commission identified, the oft-cited argument against reform is that it might inadvertently "throw open the

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128 *R v Burr* [1969] NZLR 736 (CA) at 743.

129 *Cameron* at [52]. See also Jones T.H., "Insanity, Automatism and the Burden of Proof on the Accused" (1995) 111 L.Q.R 475 at 479 where the learned author observed that at the time the M'Naghten rules were formulated, many defences would have carried a reverse onus, such that "it is doubtful that the judges in the *M'Naghten* case would have taken the view that they were 'definitely and exceptionally' placing the burden of proof upon the accused".

130 *Woolmington v DPP* [1935] AC 462 (HL) at 475.

131 See Law Commission *Mental Impairment Decision-making and the Insanity Defence* (NZLC R120, 2010) at [7.10]. This was a result of an insanity acquittal for an attempted assassination of President Regan, which raised considerable public outcry and saw the defence either narrowed or in some states abolished altogether.

132 *Rabey v R* [1980] 2 S.C.R. 513 at 546; see also *R v Stone* [1999] 2 SCR 290 at 378.

defence to a wide range of persons with mental abnormalities", beyond its currently recognised limits.[133]

87. To the extent that reform on this front was considered in New Zealand by the Law Commission in 2010, it was rejected. The Law Commission identified workability with CPMIPA as a central problem for reform, as reasonable doubt about a defendant's mental state would not adequately justify detention in a psychiatric facility.[134] The Law Commission also cited the "largest objection to a proposal to alter the burden of proof [as] a pragmatic one, about the difficulty of proving the sanity of any person beyond reasonable doubt".[135]

88. These strands of commentary and analysis show there is a prevailing public interest in recognising but confining the exemption from criminal responsibility because of an internal mental condition; and rigorously scrutinising those cases that fall within its ambit. The legal expression of these interests lies in the presumption of sanity, which can be rebutted by proof of the circumstances described by s 23(2) as interpreted by the courts. The legal tests developed by the courts operate within the same paradigm to give expression to the social interests—both of the defendant, but also society—reflected in the insanity defence, and which by their nature extend to automatism deriving from the same "internal" cause.

89. As noted by the Law Commission, the balance of probabilities standard carries over to and infuses the relationship between s 23 and CPMIPA. The insanity acquittal, which requires the jury to be satisfied on the balance of probabilities about the defendant's state of mind, is what triggers the application of CPMIPA, which at its most restrictive allows for indefinite detention orders based on public risk.[136] The same balance of probabilities standard applies to the alternative route to CPMIPA, fitness to stand trial.[137]

90. Thus s 23 and CPMIPA reflect a symbiosis that recognises and itself reflects the underlying purposes of a qualified acquittal: provision to acquit because an individual's personal characteristics take him or her outside of the normal

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133 Law Commission *Mental Impairment Decision-making and the Insanity Defence* (NZLC R120, 2010) at [4.28].
134 Law Commission *Mental Impairment Decision-making and the Insanity Defence* (NZLC R120, 2010) at [7.3] and [7.4].
135 Law Commission *Mental Impairment Decision-making and the Insanity Defence* (NZLC R120, 2010) at [7.9].
136 Law Commission *Mental Impairment Decision-making and the Insanity Defence* (NZLC R120, 2010) at [7.3] and [7.4].

expectations about rationality and choice, but with consequences of oversight attached. Parliament has determined that the threshold for this—in cases of both insanity and fitness to stand trial—is evidence of the requisite mental condition to the standard of balance of probabilities. A reasonable doubt about a defendant's mental state will not suffice to avoid either a criminal trial, or a potential conviction.

If s 6 is reached is a rights-consistent interpretation available?

91. This Court refined the approach to s 6 of the NZBORA in *Fitzgerald v R* and confirmed that it is not a statutory embodiment of the principle of legality; it is a mandate to presume that Parliament had a rights-consistent purpose and, if available on the text and in light of the purpose of the enactment may use the full extent of the interpretive mechanisms available to it.[138] But textual availability and consistency with the purpose of the enactment are important constraints to ensure that the exercise remains interpretive and does not conceal an amendment to the legislation, as the Court has acknowledged whenever it has addressed s 6.[139] The Court's resort to s 6 may also be tempered by its institutional limitations, if assessing the suitability of a rights-consistent alternative would involve complex questions of social policy that would yield only to parliamentary examination.[140]

92. As this Court recognised of virtually identical statutory wording in *Hansen*, the presumption contained in s 23(1) can only be interpreted as a legal (rather than evidentiary) reverse onus, requiring the defendant to prove his insanity on the balance of probabilities. The appellant does not seek to suggest otherwise, but instead argues for an alternative interpretation of s 23(2) so that it does not capture as many states of mind within the insanity defence. For the reasons set out above, this interpretation may have the unintended consequence of limiting the availability of the defence without broadening the categories of sane automatism, and without directly engaging the inconsistency in s 23(1) itself.

93. A sane automatism defence was not put to Mr Cook's jury because the trial

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137 CPMIPA, s 8A(3). The same standard applies to the determination of a defendant's involvement: s 10(2).
138 *Fitzgerald v R* [2021] NZSC 131; [2021] 1 NZLR 551 Winkelmann CJ at [55] and [56].
139 *Fitzgerald v R* ibid at [66]; *R v Hansen* [2007] NZSC 7; [2007] 3 NZLR 1.Tipping J at [156]

Judge ruled that to the extent that his sexsomnia deprived him of conscious volition, it was insane automatism and applying the rule developed in *Cottle* and *Bratty v Attorney-General for Northern Ireland*[141] and applied most recently in *Cameron* it could only be advanced by way of a defence of insanity.

94. This is not so much an interpretation of s 23 of the Crimes Act (or the M'Naghten Rules) but of the boundaries of the defence of automatism recognised in *Cottle* and continuing to apply as a common law defence by virtue of s 20 of the Crimes Act. The result of applying that defence to a person whose involuntariness arises not from an unforeseen circumstance, but a mental illness or disorder is that they would receive an acquittal that paid no regard to the continuing danger they posed. The Courts developed the defence of automatism to prevent that outcome, by forging a distinction between sane and insane automatism and confining the common law defence to cases of sane automatism.

Common law rules and the NZBORA

95. The Courts are bound by the NZBORA but the relationship between common law rules and the NZBORA has not been fully addressed.

96. In *Hosking v Runting*[142] the Court of Appeal accepted that a tort of breach privacy as part of the common law could only be recognised if it was consistent with freedom of expression (and then divided as to whether it was). All members of the Court noted that any encroachment of a common law rule on a guaranteed right must meet the test of demonstrable justification in s 5 of the NZBORA.[143]

97. In *Doré v Barreau du Québec*[144] Abella J reviewed the Supreme Court of Canada decisions that had applied the Charter to developments in the common law and noted that they did not see *R v Oakes* as the vehicle for balancing whether Charter values had been sufficiently taken into account.

98. The NZBORA does not demand any difference in the common law method, by

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140 *Fitzgerald v R* ibid at [69].
141 *Bratty v Attorney-General for Northern Ireland* [1963] AC 386 at 410.
142 *Hosking v Runting* [2005] 1 NZLR 1.
143 For example, Gault P at [111].
144 *Doré v Barreau du Québec* [2012] 1 SCR 395 Abella J at [39] to [42].

which change in the law is incremental and has always been assessed against fundamental values. Where a case for change is based on inconsistency with a guaranteed right, the Court can have regard to whether any limit on that right is demonstrably justified by the existing law without imposing the burden of justification on either party or using the *R v Oakes* machinery.

99. Having regard to the justification analysis already described, the existing law as applied in *Cameron* does not cause any unjustified limit on the right to the presumption of innocence or the right to present a defence.

No miscarriage occurred

100. The appellant also contends that case-specific errors amounting to a miscarriage of justice should allow his appeal. These include the absence of expert opinion on whether sexsomnia is properly classified as a disease of the mind, particularly from the Crown's witness, and the absence of a fully reasoned decision on classification in his case. The appellant contends the trial Judge's brief ruling suggests an overly legalistic application of *Cameron*, as effectively factual as well as legal precedent, which failed to consider the evidence at trial. The same error is alleged against the Court of Appeal.

101. The response to these points is largely subsumed in the submissions above, regarding the nature and operation of the defence at law, and the proper classification of Mr Cook's case. Two further points may be made here.

102. First, there is no requirement for the experts to opine on whether the condition in question is a disease of the mind, given it is a multifactorial legal question.[145] What the court required was evidence that informed that test. Contrary to the appellant's position, that onus did not fall on the Crown,[146] as the Crown may not pursue insanity as a verdict.[147] What the court had was ample evidence to support a conclusion, in fact and law, that the appellant's condition (as alleged by him) was a recurrent sleep disorder that manifested in sexual intercourse with those sleeping near him. Judge Garland was correct that "on the basis of the proposed evidence, the present case was

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145 See for example *R v Stone* [1999] 2 SCR 290 at 386-387.

146 Appellant's submissions at [109].

147 *R v Green* [1993] 2 NZLR 513 (CA). Canadian law (c.f. the appellant's reference to *Parks*, takes a different position—see the discussion contained in *Green*).

indistinguishable from *Cameron*. There was no evidence of an external cause".[148]

103. Second, context is informative in response to the appellant's criticism of the brevity of both the District Court and Court of Appeal decisions. On the latter, the issue before the Court of Appeal was whether it could or should depart from its own recent authority.[149] It appropriately determined that issue. As for the District Court, it is clear that classification had been a live issue for some time, and the trial had been delayed in order for the law to be settled on this issue.[150] The minute recording the Judge's classification determination captures a subsequent discussion between bar and bench, and not the full exchange. But it also records that the basis for that conclusion was "the proposed evidence" in the present case—not merely the application of *Cameron*. In any event, for the reasons already outlined, the classification was appropriate, and no miscarriage occurred as a result.

If the appeal is allowed, a retrial should be ordered

104. If the appeal is allowed, the respondent seeks an order for retrial.

105. This is not an obvious case for an order of acquittal rather than retrial. This Cout upheld the flexible approach in *Reid v R*,[151] which "direct[s] the appellate court to focus on a factual inquiry as to where the interests of justice lie."[152] The examples this Court cited[153] do not readily apply to Mr Cook. If this Court were to allow Mr Cook's appeal, it would be due to legal error rather than reasonable doubt about his guilt.

106. Nor is the evidence anywhere near establishing that reasonable doubt was the only conclusion available to the jury. It was open to the jury to conclude on the evidence of what happened that evening that Mr Cook's actions were not consistent with any alleged sexsomnia, and to be sure that he intentionally sexually violated the complainant.

107. And while Mr Cook will soon be eligible for parole, there remains a further

148 CA case book at [2].
149 C.f. both parties' submissions in the Court of Appeal.
150 Minute of Judge A D Garland dated 25 June 2021.
151 *Reid v R* [1980] AC 343 (PC), applied in *H v R* [2022] NZSC 22.
152 *H v R* [2022] NZSC 42 at [38].
153 *H v R* [2022] NZSC 42 at [36] and [37].

five years of his sentence (as matters currently stand) to be served, either on parole in the community or in prison. This alone is an insufficient basis to militate against a retrial.[154]

108. Accordingly, if the appeal is allowed, an order for retrial should follow.

Summary

109. Medical science about sleepwalking has come a long way since the popular conception of the condition in the 19th and 20th centuries. Where (as is now frequently the case) there is evidence that it is the result of an internal disposition towards a specific sleep disorder, and especially when prone to recur, the conclusion reached by the courts has tended towards classification as insane automatism. It has done so on the application of longstanding tests that take account both of evidence about the defendant's mental state but also its significance as a public risk. The appropriate dichotomy is not between automatism and "insanity"; it is between internal conditions that pose ongoing risk, as against external events that could happen to anyone. This is what the distinction between the defences of insane and sane automatism recognises.

110. There is no basis to depart from these tests that have been developed and applied across the common law world. They were properly applied to Mr Cook and produced the correct result in classifying his alleged condition as insane automatism. The appeal should be dismissed.

6 June 2024

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Z R Hamill
Counsel for the respondent

TO: The Registrar of the Supreme Court of New Zealand.

AND TO: The appellant.

[154] *M (CA663/08) v R* [2010] NZCA 302 at [47].