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IN THE SUPREME COURT OF NEW ZEALAND
I TE KŌTI MANA NUI O AOTEAROA

SC 120/2023

[2024] NZSC Trans 10

DAMIN PETER COOK

Appellant

v

THE KING

Respondent

Hearing: 23 July 2024

Court: Winkelmann CJ
Glazebrook J
Williams J
Kós J
O'Regan J

Counsel: R E Harrison KC and A J McKenzie for the Appellant
Z R Hamill for the Respondent

CRIMINAL APPEAL

MR HARRISON KC:
Your Honours please, I appear with my learned friend Mr McKenzie for the appellant.

WINKELMANN CJ:
Tēnā kōrua, Mr Harrison and Mr McKenzie.

MS HAMILL:
E ngā kaiwhakawā, tēnā koutou. Ko Ms Hamill tōku ingoa. Kei konei ahau mō te Karauna. May it please the Court, Ms Hamill appearing for the Crown, and with me is Professor Brookbanks.

WINKELMANN CJ:
Tēnā kōrua, Ms Hamill and Professor Brookbanks. Mr Harrison? So some preliminary things, Mr Harrison. We've read the materials and having done so we're struck by the fact that a day should be adequate for this appeal?

MR HARRISON KC:
Yes, I'm – that's my thinking as well, unless we get very heavily into the, some of the case law. I think it was a second day out of caution.

WINKELMANN CJ:
Mmm. So we should have 12.30 in mind as a transition point perhaps between the appellant and the respondent.

MR HARRISON KC:

As your Honour pleases.

WINKELMANN CJ:

And some questions we have for you. We're interested as to whether you have formulated in your mind an alternative to the *Cameron v R* [2021] NZCA 80, [2021] 3 NZLR 152 section 23 formulation? Just if you address that in your submissions and I'll ask you.

MR HARRISON KC:

Yes, yes.

WINKELMANN CJ:

And the second question relates to the link between alcohol and automatism. I don't know if you want to make a note of this, but the issues that the Court would like you to address is what is the significance that, to the sexsomnia defence, that subject A is known to have episodes when drunk and on the charged occasion has consumed alcohol.

MR HARRISON KC:

Yes.

WINKELMANN CJ:

And digging into that further, the significance of whether subject A knows of a connection between alcohol and sexsomnia episodes.

MR HARRISON KC:

Thank you.

WINKELMANN CJ:

Thank you.

MR HARRISON KC:

I've prepared a two-page opening notes for the appeal. These reflect the overall summary that comes at the end of the written submissions as well. So if your Honours have that, I'll just go through it.

There are two distinct aspects to this appeal. The first is the "argument from first principles", which if accepted leads to the conclusion that a sexsomnia defence is to be categorised as a (sane) automatism defence to be rebutted by the prosecution beyond reasonable doubt; not as giving rise to a defence of insanity.

The second aspect is that, in this case, there was an absence of expert evidence before the trial Judge, directed to the question whether sexsomnia qualified as a "disease of the mind". This issue had not been addressed in the competing expert reports on which he based his pre-trial ruling that the appellant's sexsomnia defence had to be run as an insanity defence.

If we take the first point, it's my submission that it's open to the Court to take a fresh approach to the interpretation and application of the section 23 insanity defence, interpreting it afresh purposively in a modern New Zealand context. This involves drawing upon related statutes prescribing the consequences of a verdict of not guilty by reason of insanity, and secondly, the defendant's right to present a defence, including with the correct or appropriate onus of proof recognised by section 21 of the Crimes Act 1961 and the fair trial provisions of the Bill of Rights Act 1990.

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This does not do violence to the wording of section 23(2), but it applies a purposive, Bill of Rights-mandated interpretation of the crucial expression "disease of the mind", so as to allow a sexsomnia defence to be run as an "acting without conscious volition" automatism defence. This in turn avoids a Bill of Rights-inconsistent imposition of a reverse onus as imposed by section 23(1).

It's important that this argument seems to be misunderstood by the Crown submissions. The argument does not involve an argument that the reverse onus imposed by section 23(1) is Bill of Rights-inconsistent, in cases where the defendant advances an insanity defence as such, so it doesn't involve a challenge overall of a "declaration of inconsistency" type. The argument instead, in reliance on the asserted fair trial rights, is that the interpretation of "disease of the mind" which avoids the reverse onus in a case such as the present is to be preferred under section 6 of the Bill of Rights.

So in effect, over the page, the appellant's argument is that the burden of the section 23(1) presumption of insanity cuts both ways. It's not simply a burden imposed on the defendant in a criminal trial to deal with issues of sanity or insanity, and of course as in the written submissions the argument is that the presumption of sanity under 23(1) is a presumption of being not legally insane within the meaning of 23(2). So if you are presumed sane it means you are presumed legally not insane within 23(2), and that's the burden that I submit cuts both ways, thus it is for the – para 6 still – it is for the party in the criminal proceeding who raises the issue of a disease of the mind triggering the operation of 23 as triggering the operation of 23(2) to make out that contention, be it the prosecution or the defendant in the particular case. Likewise, if the trial judge sees fit to raise the issue the defendant is entitled to rely on the presumption and comes under no onus either way.

A defendant who contends that, by reason of his sexsomnia (or other parasomnia), he was acting without conscious volition at the time of the alleged offence is entitled to say he's presumed to be sane rather than "labouring under … disease of the mind", unless and until the prosecution seeking to rebut that defence proves through, or at least including expert evidence, that his condition amounted to a "disease of the mind".

These propositions lead to the second aspect to the appeal, that the trial Judge and in turn the Court of Appeal determined the classification issue without the benefit of expert evidence, instead simply relying on *Cameron* as determinative. In essence, the lack of expert evidence in this case was because neither expert

was asked directly to address the issue. Their evidence was instead focussed on the questions of whether the appellant suffered from sexsomnia, and if so, whether his conduct on the night in question was due to it.

Finally, in this case there's no doubt of the way the trial Judge directed the jury, which was that his defence of sexsomnia was only a defence of insanity, and thus if – I say if the challenge to the law as stated in *Cameron* succeeds, this is a serious misdirection and there could be no argument a miscarriage of justice has not occurred. The submissions of the Crown do not attempt to argue otherwise in relation to this point, although they do argue there was no miscarriage of justice in relation to what I've called the second aspect of the appeal.

So turning to the written submissions, and I'm going to try to master the technology and work both from my hard copy which has got some notes on it, and simultaneously an online version. So starting at the introductory section, I note the key passage from *Cameron* at page 4, identifying: "The traditional yardstick is a medical condition… 'internal' to the accused and prone to recur, so posing an ongoing danger to others."

And then there's the classification issue at para 5. It was said to be classified as "insane automatism *on the evidence in this case*", but the reasoning is not really based on the evidence other than to the extent that without elaboration the statement is made that is set out at para 5. And we note that the statement is that the "condition is so long-standing and regular that absent treatment its recurrence must be considered near inevitable". That issue of treatment or whether treatment is available, was available, and the role that the potential for treatment should play in assessing likelihood of occurrence is left hanging in the judgment, and it also has ended up I will argue a loose end, to put it mildly, in the evidence in this case.

I can just perhaps try to elaborate on that a little bit. If the issue is, and I'm not accepting that this is the definitive test, but if an issue is whether the condition is likely to recur so as to pose danger in the future and that is part of the

classification exercise, then one would expect a principled approach to the classification issue by the trial judge effectively by way of a voir dire to have evidence before him or her as to the true likelihood of criminal – what would otherwise be criminal offending occurring in the future, and the treatability of the condition in the broader sense, including for example simple practical steps that could be taken to organise the sufferer's life, ought to be part of the overall enquiry that the Court should make from a fair trial perspective before simply labelling the condition as a disease of the mind.

GLAZEBROOK J:

I realise it might be a bit of a cleft stick, but as I understand it, part of the diagnosis was because of what had happened with previous partners?

MR HARRISON KC:

Yes.

GLAZEBROOK J:

And so – and which from the sound of it was criminal, but not charged?

MR HARRISON KC:

Well I don't accept that, from the sound of it –

GLAZEBROOK J:

Well it was a sleeping partner as against a sleeping unrelated person.

MR HARRISON KC:

Yes.

GLAZEBROOK J:

And so given that you have that history, unless something happens, one would expect that that behaviour and non-voluntary behaviour, accepting that sexsomnia applied, might continue or is likely to continue if it has been a long-standing condition?

MR HARRISON KC:

The – the evidence appears to support the submission that it was not until this case and his dealings with Dr Fernando that the defendant could be said to have been aware that he suffered from sexsomnia. He appears always to have had no recollection of the actions in question and then to have said that he couldn't possibly have engaged in them.

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KÓS J:

Well how many times did he have to be told, Mr Harrison?

MR HARRISON KC:

Well he needed to be –

KÓS J:

I mean he may not have understood what it was that he had, but he knew he had a proclivity?

MR HARRISON KC:

Well I can't accept that the evidence demonstrates that either, but if we – we're coming back to some of these hypothetical questions that were posed at the outset.

If hypothetically someone knows they have sexsomnia and they are advised how to deal with it in the future, then there is a variety of ways they can change their behaviour including ensuring that they don't engage in non-consensual sex with a partner. We haven't reached the point in this case where it can be said with confidence that this defendant was sufficiently aware of his condition that he should be attributed with personal responsibility for its manifestation. I don't accept that.

KÓS J:

If you have been told by one partner after another that you've engaged in unwanted sex with them during the course of the night, you do not responsibly

put an intoxicated young woman in your bed for her so-called protection and then say that you can get a get out of jail free card on the basis of automatism?

MR HARRISON KC:

Well I don't accept that that is the correct characterisation of what happened in this case, and at the end of the day it still leaves open the question of how we define disease of the mind and how we characterise the condition, because it's the condition –

KÓS J:

Well it may or may not, it may or may not, because if fault is disqualifying of automatism of whichever category, then the issue of classification perhaps does not arise?

MR HARRISON KC:

Yes, but I'm not sure of any authority for the proposition that fault is disqualifying of automatism, but that an enquiry into fault as a reason for not making the defence available would make sense, but we haven't had an enquiry into fault in this case, nor was the case presented before the jury in that way, as I understand it. The jury weren't directed as to an enquiry into fault of that sort.

WINKELMANN CJ:

Mr Harrison, can I take you back to your point about the narrative, about the factual basis for the view of the trial Judge and the Court of Appeal that this was a likely to recur scenario, you've formulated how you say the matter had to be dealt with, which seems to be fundamentally procedural, but wasn't the essential issue for the trial Judge and the Court of Appeal whether there was a factual narrative apparent on the evidence that it was likely to recur, and there was, to rephrase what Justice Glazebrook has put to you, there was a clear factual narrative available on the evidence?

MR HARRISON KC:

There was a factual narrative that enabled it to be said that with a knowing, consenting partner in the future, absent treatment, he was likely to engage in

similar behaviour in the future, but that's not to say that there was a likelihood of future criminal behaviour against non-consenting strangers.

GLAZEBROOK J:

Well the point about these women with these partners, where they were asleep they were incapable of consenting or not consenting to that particular act of sexual intercourse?

MR HARRISON KC:

Well –

GLAZEBROOK J:

I'm not saying – they didn't choose to press charges, but they were certainly not consenting if they were asleep, which is what they said they were?

MR HARRISON KC:

Well – well said they were asleep but with perhaps one exception, whose evidence was challenged in cross-examination, they –

GLAZEBROOK J:

Well she thought he was – he thought – she thought he was trying to not wake her up?

MR HARRISON KC:

They were – if I can put it, they were at least acquiescent in the sense that they acknowledged this was part of his behaviour, they dealt with it either by going along with it or interrupting his behaviour so that it didn't continue, so that when he attempted sexual intercourse they woke him or pushed him away and that was enough or they went along with it. So it can't be said that there was a clear history before this instance where he was engaging his – in past criminal behaviour.

WINKELMANN CJ:

So just –

WILLIAMS J:

Well it's – clearly section 23(3) says past history is relevant to responsibility.

MR HARRISON KC:

Sorry, section 23?

WILLIAMS J:

The insanity section.

MR HARRISON KC:

Well no, I don't accept that it –

WILLIAMS J:

Well it does. It says insanity before or after the time when she *[sic]* committed the act may be evidence the defendant was at the time non – not responsible. So at least insofar as the insanity category is concerned, that evidence is statutorily relevant?

WINKELMANN CJ:

That's to diagnosis, I guess.

WILLIAMS J:

So the question is whether it's relevant as well to sane automatism.

WINKELMANN CJ:

It's the *R v Kamipeli* [1975] 2 NZLR 610 (CA) line of authority, isn't it?

MR HARRISON KC:

Yes. It's – I'm not suggesting it's irrelevant. We're – at the moment we're debating what is affected. He relied –

WILLIAMS J:

Section 23(3) is in your favour.

MR HARRISON KC:

Yes. He relied on the past history to support his diagnosis of sexsomnia, so it has to be, the evidence then has to be at large to be used in other ways as had been put to me.

KÓS J:

That's right. Well that's the cleft stick, because it establishes a propensity and an awareness of a propensity. That's the cleft stick that Justice Glazebrook identified earlier.

MR HARRISON KC:

We have established the – that the acts took place, you've established little if anything as to his direct knowledge that he had a condition that required to be managed, let alone that he knew that that condition was sexsomnia. If it's an enquiry into fault, as I'm repeating myself, that enquiry was not something the jury was directed to undertake. If the outcome of this Court's decision is that fault is a material consideration then well and good, but the appeal then succeeds because the jury weren't directed as to fault.

WINKELMANN CJ:

Anyway, I'm a bit anxious that we've taken you – well actually I think you launched off course with the element of recurrence because we were in the first principles section, weren't we?

MR HARRISON KC:

Yes, yes. So over – just dealing with –

WINKELMANN CJ:

The hypothetical.

MR HARRISON KC:

Well, yes, and I got onto that without touching on intoxication. So talking about the – just in the introduction section that at page 2, para 7 we have a reference to the Judge's ruling which is – can be accessed through footnotes, the link at footnote 7. It's a very brief ruling and is basically that he was bound to follow

Cameron, but strangely the trial, a re-trial, had already commenced and the Judge by then had already directed the jury as to the sexsomnia defence being one of "insane automatism". The – when the Judge refers to the material before him at that stage of the trial the experts had not given evidence so he was plainly relying on the content of the expert, the two expert reports only.
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So the – continuing on, para 11 and 12 I summarise the evidence, the expert evidence, on sexsomnia at the trial with reference to the summing up as well, which further summarises the content. I come back to this evidence later.

So the submission is that it's not possible for purposes of the classification issue simply to focus on sexsomnia because sexsomnia is simply, as my para 13, sexsomnia is simply one form of parasomnia, and that there are other forms of parasomnia with the potential to cause harm, either to the sufferer or to a third party (or to property). So the broader question that this appeal raises is how do we treat parasomnias generally, the common feature of all parasomnias being that the sufferer acts without conscious volition, which on the face of it is the classic description of the automatism defence, and also backed by the fundamental principle that involuntariness is a key element of criminality.

So turning to my submissions at page 4, I deal with automatism with some extracts from *The Queen v Cottle* [1958] NZLR 999, Justice Gresson, and then at 18 I take us to section 20(1).

This section plus the effect that I say ought to be ascribed to section 23(1), the presumption of sanity, appear to have been largely overlooked in *Cameron* when it came to defining disease of the mind –

WINKELMANN CJ:

It was referred to in Cameron, wasn't it, but you were saying it wasn't brought back to mind at the critical part?

MR HARRISON KC:

Yes, well I'm saying that really that section 21 and section 23 need to be read together in the way I've argued, because section 21 preserves the common law defences including automatism or lack of voluntariness, leaving section 23(2) as a codification of the previous common law insanity defence.

So as I say at 20, while you've got a definitive prescription of the insanity defence in section 23, it doesn't mean that any other common law defence available is curtailed thereby. So we're left with the, if you like a – not exactly a collision but a line-drawing exercise between the fundamental principle that "action without conscious volition" is crucial to criminal liability, serious criminal liability on the one hand, and the codifying effect of and territorial effect if you like of the insanity defence, which for practical purposes and in this case at least turns on the threshold question of whether the condition claimed by the defendant qualifies as a disease of the mind.

So we've got para 21, we've got parasomnia behaviour as a classic, within the classic *Cottle* definition of automatism, and there is then a judicial policy choice whether to label such behaviours insane automatism, as I say, so that they have to be dealt with under the Procrustean bed of the section 23 insanity defence, and there is no – from the text of section 23(2) itself there is no guidance, in my submission.

So I note at para 23, and this is a truism I know, that the M'Naghten rules were formulated by way of answers to hypothetical questions as long ago as 1843. The questions posed were a response to a delusional attempt to shoot a politician, plus ça change one might say, and that is a far cry from a condition now recognised as parasomnias and sexsomnia, and so what we've got are these difficult expressions, disease of the mind, natural imbecility and the question is, what to do with this as a matter of statutory interpretation.

So the point I make at 26 is that the defendant who has suffered, who has acted without conscious volition, doesn't have the ability to say, to have said of him that his mind was incapable of understanding the nature and quality of the act

charged. The enquiry is simply misplaced, in my submission, and I refer here to, para 27 to Justice Gresson in *Cottle* where his Honour noted at the top of page 7 that: "It is almost impossible, and certainly highly unsatisfactory, to apply the principles … to cases where there has been no consciousness of the act at all …". And as his Honour goes on to say: "The M'Naghten formula takes account only of the cognitive failure and presupposes that the doer was conscious of his actions."

The question then is whether an interpretation of section 23(2) that overrides that difficulty is justified as a matter of interpretation textually and proposedly.

WINKELMANN CJ:

Well isn't there just a plain English interpretation available that does make section 23(2)(a) apply, which is that it's only at the time that they do the act, and that in fact if you're unconscious you're incapable of understanding the nature and quality of the act or omission.

MR HARRISON KC:

You're not, that is a possible interpretation, but I argue against it textually in the submissions that I am coming to. In my submission the, when subsection (2) talks of labouring under disease of the mind to such an extent as to render him incapable, that contemplates an enquiry into the extent of the effect of the disease of the mind, and the extent of the incapacity.

KÓS J:

It's a filter. You must be right on that I think. Not every person incapable is excused under section 23. The filter requirement is there be natural imbecility or disease of the mind.

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MR HARRISON KC:

Yes, yes, and so the textual issue is developed in my submissions from para 28 on –

WINKELMANN CJ:

I should say that I'm not persuaded at the moment that you must be right, so.

MR HARRISON KC:

No, quite, the text –

WILLIAMS J:

You still have just under two hours, Mr Harrison.

MR HARRISON KC:

The text, the text is one part of the argument, and –

GLAZEBROOK J:

Well can I just – the first part is that this isn't a disease of the mind so the rest of it doesn't apply.

MR HARRISON KC:

Yes.

GLAZEBROOK J:

It's only if there's a disease of the mind that you look at those two things, and one of the – possibly one of the reasons you say it isn't a disease of the mind is that you're incapable of doing anything because you're unconscious and that is the classic automatism defence?

MR HARRISON KC:

Yes, well in my sub – in my submission –

GLAZEBROOK J:

And it hasn't been brought into the section 23, it hasn't been subsumed by section 23, as I understand it.

MR HARRISON KC:

Exactly, but when the meaning and extent of disease of the mind takes colour from how it is to – how its consequences are then to be addressed under (2)(a) and (b), so –

GLAZEBROOK J:

Yes.

MR HARRISON KC:

If you classify something –

GLAZEBROOK J:

Yes, I understood, I understood that is your argument.

MR HARRISON KC:

– a disease of the mind when it's – it then – you're in an immediate dead end rather than the condition being then able to be assessed under either (a) or (b).

GLAZEBROOK J:

That's what I'd understood is your argument.

MR HARRISON KC:

Yes, that's, that's the point here, or a point. So that – and I, I note in 29 that in effect that starting with section 23(1) is important because we've got the presumption of ins – of sanity at the time until the contrary is proven. As I argued earlier, this is a presumption the alleged offender was not legally insane at the time, not a presumption of voluntariness, there's no such presumption under New Zealand law, so that the effect, if you read section 23 overall, particularly subsections (1) and (2), all elements of 23(2) are to be treated as absent, including in particular any potential disease of the mind until the contrary are proved, and as I argued earlier, that reverse onus is not imposed on the defendant alone, it has to cut both ways.

Now as I note at 31, that that raises – that's a reverse onus of proof that raises Bill of Rights considerations, but the Bill of Rights consideration seems, with respect, to be misunderstood by the Crown. It is not that the onus of – the reverse onus of proof is wrong where the defendant seeks to advance an insanity defence, it is that where the defendant disavows an insanity defence and in effect raises an automatism defence and then the question is but do you have a disease of the mind, the onus lies on the party contending that there is a disease of the mind because of the section 23(1) reverse onus.

KÓS J:

Well hang on, I don't understand that. You're disavowing an insanity defence, you're avowing an automatism defence?

MR HARRISON KC:

Yes.

KÓS J:

That's a section 20-based defence, common law defence?

MR HARRISON KC:

Yes, yes.

KÓS J:

Disease of the mind doesn't arise in that, you're not ever asserting a disease of the mind, you're forced into that because it's treated as a matter of classification, insane automatism, and so you're driven there and your objection is to being driven there, as I understand it?

MR HARRISON KC:

My – the position is that in practical trial terms I'm saying I've got an automatism defence, I'm not running an insanity defence, then either the Judge or the prosecution say aha, but really, your condition is a disease of the mind, I say reverse onus, prove it.

WINKELMANN CJ:

Your point is, your argument hinges on a point which you have not yet articulated I think which is the Court of Appeal confirmed in *Cameron* that it must be assessed on a case by case basis, so the jury should have been directed that the onus sits upon the Crown to persuade the jury that this is a situation in which it was a disease of the mind, blah blah blah.

MR HARRISON KC:

Well that's a fundamental issue which I have pondered in terms of how I should approach it because the classic understanding is that it's for the trial judge to rule on whether there was a disease of the mind or not.

WINKELMANN CJ:

Mmm.

MR HARRISON KC:

Now I've taken that premise and run with it by saying well, yes, but to do that you need a proper enquiry and expert evidence which isn't definitive but should be adduced to know whether there's a disease of the mind, and the recurrence issue, future violence, is part of that so all of that gets addressed.

An alternative way of looking at this would be indeed to say well it's – there's a filter for the trial judge but ultimately it's for the jury to decide whether or not disease of the mind, but that's not how we've, we've approached this down to this pointing, I understand.

WINKELMANN CJ:

So how do you say then, in response to Justice Kós's question, how do you say this argument fits in with the overall way the trial ran in your argument?

MR HARRISON KC:

Well the argument – the point I'm making operates in two ways. First of all I'm saying that the imposition of an onus of proof on the defendant who raises automatism and doesn't raise insanity in effect to establish that he doesn't have

a disease of the mind is – goes to interpretation. If that is the received approach to this issue it is wrong and a Bill of Rights interpretation would warrant limiting the true reverse onus of proof to cases where the defendant raises an insanity defence. Not this case. Although, that's at the interpretation level that secondly it comes into what I've called my second aspect where I argue that the exercise in this case of classification miscarried because the onus was in effect placed on the appellant to prove that it wasn't a disease of the mind and/or the evidence, in particular the expert evidence, was missing. Instead, the trial Judge simply relied on *Cameron*, despite the fact that *Cameron* rightly says that it is a question of the evidence including the expert evidence in the particular case. So it comes in in two ways, in my submission.

So I'm still dealing at page 8 with my interpretation point. So, and the onus point, the point at 33 is worth emphasising. If the trial judge rules that a defence advanced by the defendant is an insanity defence, that effectively imposes on the defendant an unfair and unjustifiable reverse onus burden of proof. The defendant will then be faced with the burden of establishing he had a "disease of the mind" and the other elements when the central focus of his defence is to contrary effect. The defendant, faced with that ruling, in effect moves, has to move from asserting that he's got no disease of the mind, to asserting he has a disease of the mind with the consequences in (2)(a) or (2)(b).
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KÓS J:
Well you must be able to name your defence. You did not assert a defence of insanity. You asserted a defence of automatism.

MR HARRISON KC:
Yes.

KÓS J:
From the outset the trial judge told the jury they were dealing with a case of insane automatism, therefore you were bracketed into insanity, a defence you weren't asserting.

MR HARRISON KC:

That's correct, and the onus, with the onus on the defendant to assert the very contrary of what he started by asserting. So the reverse onus works perfectly well under 23(1) where the defendant is raising an insanity defence, but my submission is it's an unfair and, in Bill of Rights terms, unjustifiable limitation on the onus of proof beyond reasonable doubt in the scenario I'm describing.

WINKELMANN CJ:

So how do you say it should work in this scenario though with a mixture of the trial judge and the jury?

MR HARRISON KC:

Well again, I'd be hard-pressed to find it, but I think in one or two of the Canadian cases there are statements to support the proposition that this should actually be a jury question, and I'm happy to go that far, although it does run contrary to a lot of New Zealand law, which has always proceeded on the basis that the trial judge makes the preliminary warning, and the jury is stuck with it, and that's the way this trial was run, and that's my fallback. Even under that fallback I still say what happened here is wrong and that the imposition of the reverse onus burden is a justification for interpreting disease of the mind more narrowly rather than more broadly as has been.

So that's – the textual arguments are at para 35 and following. I won't take your Honours through that, bearing in mind the time. Looking at the, what I call the two insanity defence gateways under (2)(a) and (b), paras 39 and 40, I look at each of those. My point, as I say in 41, is that if you act without conscious volition due to sexsomnia it's impossible to pass through that gateway and, as I say, the only way around the logical and practical difficulty is to interpret 23(2)(a), as indeed your Honour Justice Winkelmann put to me earlier, as satisfied by a total lack of understanding, but I submit that that is not a viable interpretation.

So I then go on to look at statutory context and purpose, and argue that taking into account the consequences, the statutory consequences of a verdict of

not guilty by reason of insanity, purposively it's appropriate to read down the expression "disease of the mind" so that it deals with only particularly serious medical, mental disorders where –

WINKELMANN CJ:

So there could be situations in which section 6 requires an expansive reading of section 23 and others where it requires a narrow reading?

MR HARRISON KC:

That's not my argument.

WINKELMANN CJ:

No, but isn't that a possibility because it could be seen, section 23 could be seen as protective of those who are mentally unwell so that they are not dealt with in the criminal justice system.

MR HARRISON KC:

Well it's a classification exercise. The focus in this case, of course, is on classification of parasomnias, sexsomnia in particular. All I'm really arguing is that that particular category of mental condition, or behavioural condition, falls outside disease of the mind which should therefore be naturally falls outside, purposively falls outside, so that's the appropriate interpretation. Some other mental condition, the definition of disease of the mind might be more broadly interpreted for that condition. So yes your Honour unusual though it may be. Because it's such an open-ended condition it might, open-ended concept, it might expand to cover particular categories of mental disorder, but contract in relation to others.

WILLIAMS J:

Or even potentially within those categories.

MR HARRISON KC:

Potentially, although that's not my argument here.

WILLIAMS J:

Well from what I read of the psychiatric evidence and the learned psychiatric articles, there is a great deal of imprecision about what the drivers of sexsomnia are. Some of them might be diseases of the mind, even on that contracted view of it, others might not.

MR HARRISON KC:

Yes, it seems to be a condition that can have a range of sources, or causes if you like, and the diagnostic approach is to try and cumulate these, for example, hereditary sleep apnoea, stress, and if you tick all these boxes, plus you have a history, a personal history of repetition, but certainly in our current state of knowledge it is not possible to just tick one box and say that's the cause.

WINKELMANN CJ:

I mean the purpose of the legislation, tell me if you say this is wrong, the purpose of section 23 is to ensure that those who are who are not to be regarded as morally culpable because their conduct was, is explicable by mental health issues, or mental health or disability issues, are not subjected to the criminal justice system, they're rather subjected to the appropriate health care system?

MR HARRISON KC:

But equally that ties into my purposive approach to disease of the mind which is to say giving it a modern-day interpretation we must ask what are the consequences of a finding of not guilty by reason of insanity. You then dealt with, this is my para 46, 45-46, you're dealt with under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the options there are inapt to deal with a sexsomnia sufferer, which is a good reason why disease of the mind should not be interpreted to include that condition.

WINKELMANN CJ:

Well why are they inapt, because –

MR HARRISON KC:

Well I developed this at page 11. The consequences are spelled out in section 25 of that Act.

WINKELMANN CJ:

I mean, because it actually, it's got a very broad discretion, hasn't it? Including ordering immediate release of the defendant.

MR HARRISON KC:

Yes, it has, and basically that is the most likely thing that would happen to a defendant, a sexsomnia defendant found not guilty by reason of insanity, but that's such a pointless exercise, that why would you subject such a person to the finding of guilt.

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WINKELMANN CJ:

Well, I mean even on your submission it's not necessarily pointless because he could have his condition explained to him, he could agree to a treatment programme where he has counselling about the kind of conduct he must avoid, it may be that there is medication that he can take, I don't know because I'm not a doctor, but it's not beyond the realms of imagination, is it, that there could be a therapeutic intervention?

KÓS J:

Well why do you – why do you say it's a pointless finding of guilt? It's an acquittal.

MR HARRISON KC:

Yes.

KÓS J:

But a qualified acquittal.

MR HARRISON KC:

Yes, yes. Well the reality is, as I've argued earlier, that we're not going to get to this point because the practical difficulty of it satisfying the section 23(2) test means that he's not going to get this verdict, but looking at the – shall we say the incongruity –

GLAZEBROOK J:

Well if you say that you have absolutely no volition then I would've thought you quite clearly meet the section 23 test, because the extent to which you can do that is zero. So if the jury had been satisfied that he was acting because of sexsomnia I wouldn't have thought they would've had any difficulty in saying he met that test?

MR HARRISON KC:

The –

GLAZEBROOK J:

And I understand the reverse onus issue, but…

MR HARRISON KC:

Well the –

GLAZEBROOK J:

And for you to say the Crown should've been excluding that rather than him being required to prove it, but…

MR HARRISON KC:

The jury, the jury is directed that they have to be satisfied that sexsomnia, a sexsomnia defence has to be addressed as an insanity defence and they must be satisfied that the defendant had a disease of the mind which qualified under 2(a) or (b). The problem is going to be getting the jury to accept that sexsomnia is a disease of the mind, and then in turn that it goes to either gateway (a) or gateway (b). Practically speaking, there's such a degree of incongruity that that's just not going to happen.

My point is then that there is incongruity at the stage the test is purportedly applied to sexsomnia and incongruity in the hypothetical situation where it is applied, and we get to dealing with the defendant under the Mental Health (Compulsory Assessment and Treatment) Act. So at both stage there's a total incongruity, and this is just advanced in support of my interpretation argument.

WINKELMANN CJ:

Yes. So it's not a disease of the mind, it's not really a treatment thing, it's effectively a mal – a misfunction of an ordinary human thing, sleep, which in this case had terrible consequences?

MR HARRISON KC:

Yes, and it's, it's a paradigm case of acting without conscious volition, paradigm case, and the only reason it isn't run as a defence and dealt, adjudicated on that way is the extent of the – the way we interpretate and interpret disease of the mind. There's a choice, that interpretation choice, whether to class – say to classify it or not, and I am arguing that it's not appropriate to classify it.

KÓS J:

Well – well actually it's cruder than that. You ran a defence of automatism. The classification was insane automatism because the cause was internal. We don't worry about disease of the mind, the question is simply was the cause internal or external? Internal equals insane automatism. Now are you saying there is no overlap between the two defences? In other words, if we are dealing with a disease of the mind that takes you out of automatism and takes you into insanity, or could it trigger both defences?

MR HARRISON KC:

That is a question I have pondered. I would like to say it could be run both ways. I don't think I can.

KÓS J:

No.

MR HARRISON KC:

I think that the statutory scheme reading section 20 with 23 of the Crimes Act is that it's either/or, and what is determinative is whether there, the condition qualifies as a disease of the mind. If it does, then it has to be run as an insanity defence.

WINKELMANN CJ:

Well that takes you to the first question I asked, which is we have formulation in *Cameron* so what would you say is the formulation that should be taken, if you have a positive formulation.

MR HARRISON KC:

The – I did have a formulation somewhere.

WINKELMANN CJ:

Take your time to find it, because I think it's kind of the crux of the case in a way.

MR HARRISON KC:

Can I come back to that?

WINKELMANN CJ:

Yes.

MR HARRISON KC:

So the submission at page 12 then relies on the right to present a full defence including a defence based on lack of voluntariness. There's, I refer then to the section 25 rights, which we've been discussing in para 52. In footnote 36 I refer to *Fahey v R* [2018] 2 NZLR 292, [2017] NZCA 596 and note that footnote 36 is wrong, it should read paragraph [41(a)], and just taking you to *Fahey* if I may, I can find the passage. So if you've got *Fahey* up at 41(a) it refers to the rights to minimum standards of process, and these protected rights: "(a) They confer on the defendant a power of decision over central rights: how to plead, what defence to present, how to challenge the prosecution witnesses, and what

evidence to call." So that's the *Fahey* formulation that I'm relying on there, and I dealt with the reverse onus argument.

I go on, with an eye on the time, page 13, to critique the *Cameron* traditional yardstick. To review the decisions relied on in *Cameron* as allegedly supporting the orthodox approach, and in effect what I say about each of them, my paras 58 and following, are they are not upon analysis supporting of any particular orthodox approach, and so without necessarily going into the detail of those, that's the analysis in the submissions.

So at 59 I note that *Cameron* at 71, we've seen this already, "identifies as the 'traditional yardstick' the existence of a 'mental condition' 'internal' to the accused and prone to recur, so posing an ongoing danger to others."

KÓS J:

Which is obviously not per se disease of the mind. They're different tests.

MR HARRISON KC:

Yes, yes your Honour. All mental conditions are internal to the accused but not all can amount to a disease of the mind. So to just say that the existence of a mental condition internal to the accused, that's the internal/external distinction. In my submission it is a contradiction in terms. I mean I may be chronically insecure, that's a mental condition personal to me and internal, but it doesn't, it's a meaningless –

WINKELMANN CJ:

You're not saying it's a contradiction in terms, you're saying it's insufficient, it's not sufficient?

MR HARRISON KC:

Yes, sorry, yes.

GLAZEBROOK J:

Or too wide is it? Too inclusive?

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MR HARRISON KC:

Well it's just a meaningless enquiry to say that a mental condition is or is not internal to the accused. Every mental condition is internal to an accused, but there are so many different mental conditions that it doesn't help assist with the classification.

WILLIAMS J:

Well yes, that's true, and also every mental condition that I've ever been aware of as a judge anyway, is external to the accused, because there are external drivers. In this case, one of them is stress.

MR HARRISON KC:

We could get into a semantic argument about whether external drivers make the condition external, rather than internal.

WILLIAMS J:

Well the problem is, from what I've read of the material, that there's a lot of evidence about correlation, not a lot of evidence about cause, not in this particular case, but the phenomenon of sexsomnia, and you've said yourself there's a tick box of items that tend to suggest that people have a credible argument about sexsomnia, but this is correlative evidence, not causative evidence when the test is a causative test.

MR HARRISON KC:

Yes, I accept that that is true of the evidence in this case. So in any event I'm just looking at the two legs, the internal/external and the prone to occur ongoing danger. So – and then I've critiqued *Cameron*, and probably sufficiently, and I note that paras 64 *Cameron* cites a number of the sleepwalking cases where it's said that sleepwalking is sane automatism and the Court of Appeal then says, well, overall these authorities are far from establishing that sleepwalking or sexsomnia or parasomnias generally should be treated as sane automatism, but equally the converse is true if they don't establish that any of these

conditions should be treated as insane automatism. There are a couple of cases that do hold that, but the authorities surveyed do not, and I just refer your Honours to footnote 47, the New South Wales case of *R v DB* [2022] NSWCCA 87 and the paragraphs there. That case involved a particular New South Wales statutory provision, but in the lead-up it was a sexsomnia case. In the lead-up to dealing with the particular statutory provision, the common law in relation to sleepwalking was decisions, that previous decisions were canvassed in detail. So that's another source of prior decision.

But as I really say over the page in para 65, adopting an argument from first principles approach, little benefit appears to emerge from conducting a head count of previous cases. At the end of the day can you find authority for any number of propositions in this area. We are dealing with a New Zealand statute, New Zealand context, and New Zealand fair trial rights.

So as I note just in para 66 that you really cannot, in my submission, hive off sexsomnia and ignore other forms of parasomnia. As I say in 67, other forms of parasomnia may result in a criminal charge, and I give some instances there.

So my submission at 69 is that adopting the internal/external test is artificial and illogical. Then I go on to look at cases where that issue – that external factor test is criticised.

So then at 71 I look at the second test or factor, which is a mental condition is prone to recur posing an ongoing danger to others, and I submit that certainly if simply applied without more, that that is, that test is an unacceptably blunt instrument when applied to the field of parasomnias.

So it ends up being, the prone to recur ongoing danger to others is, in effect, I say, a public policy justification and the Crown accepts that really that's what it is, and I canvas the statement of Justice Fisher in *Police v Bannin* [1991] 2 NZLR 237 set out at 74. If you're "predisposed to disassociation" you may "**lose control of his conduct**… **likely to be** a continuing danger… **assumed**

to be a high risk" and as I say this, at 75, this reasoning bristles with unsupported assumptions.

So I note in terms of the public policy issue that it seems, my para 77, to reduce to a concern that a sexsomnia sufferer who has committed what would otherwise be a rape while completely unconscious should not get off scot-free because of the hypothetical risk of again involuntary repetition of the conduct in question. But the law in other, of sexual violation in particular, recognises in other respects that it's not sufficient to establish unconsented violation, as I say at 79, the law recognises not only a defence of absence of intent, it recognises a defence of belief on reasonable grounds that the victim was consenting, even when consent was not present, and so the public policy, the countervailing public policy, which is the basis for that defence, places the interest in a just outcome of the subjectively innocent sexual violator over the interests of the victim for criminal liability cases. But this countervailing public interest, the interest in a just outcome for the subjectively innocent sexual violator, is overlooked in *Cameron* and by the Crown in their submissions.

Now if we are going to address these fears, these public policy issues, it should not be by the blunt instrument that has been adopted, but by some other means entirely. Perhaps as Justice Kós has raised, an enquiry into fault defined in some appropriate way as capable, being capable of disentitling an automatism defence.

KÓS J:

That's really an underlying policy behind the intoxication automatism cases.

MR HARRISON KC:

Yes indeed, and likewise the reasonableness aspect of the belief in consent. Again we're coming back to a fault issue. So at page –

WINKELMANN CJ:

Mr Harrison, I might take you back to this after the break, but you've made a process, part of your argument is a process argument about the Judge being

ruled that it was an insanity defence, so is to be treated as an insanity defence, and he did so on the basis of the briefs of evidence, but not the evidence over all, that had been filed.

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MR HARRISON KC:

He did it – I'm open to correction from my junior. There were, there was one report from Dr Fernando which was in existence and disclosed.

WINKELMANN CJ:

Mmm.

MR HARRISON KC:

There were two reports from Dr Dean, one is a very short supplementary support, and I understand that those were before the trial Judge and it was simply on the basis of those reports which were going then to be the basis of their trial evidence that he decided. Is that correct? Yes, Mr McKenzie says that's right.

WINKELMANN CJ:

Right, thanks. Thank you.

O'REGAN J:

You say that an alternative would be an enquiry into fault. You're saying that is effectively a law reform proposal, not that that's what should've happened?

MR HARRISON KC:

Well no, we're in common law territory, your Honour. I mean we're – we're formulating the scope of the insanity defence via disease of the mind and thereby formulating the common law defence of automatism not involving disease of the mind. So no, I don't think it's a pure law reform territory. It would be open to this Court to craft such a rule without engaging in statutory reform.

WINKELMANN CJ:

But probably not in this case since it wasn't raised at trial and argued on appeal? Or you think it could?

MR HARRISON KC:

Well I mean if we're looking at an overall balancing of the interests of the subjectively innocent accused and the public interest, then such a test or formulation as a qualification on the ability to raise a pure automatism defence is one mechanism for achieving the balance. What I'm submitting is that the current test, the *Cameron* test, does not achieve that balance. I'm not sure when your Honour wants to take the break, do I carry on until 11.30?

WINKELMANN CJ:

Yes.

MR HARRISON KC:

So at page 19 I look at some contrasting overseas decisions and really I'm not looking at them in any way to be comprehensive, but just to see, to illustrate some trains of reasoning that have occurred in other jurisdictions.

So you've got *R v Burgess* [1991] 2 QB 92 which – is a holding that the sleepwalking defence there was – had to be an insanity defence and I have critiqued the reasoning in that briefly.

We then go to *R v Parks* [1992] 2 RCS 871. This is page [*sic*] 86. In *Parks* the Supreme Court of Canada had the Court of Appeal decision in *Burgess* before it. As I note at 87, the joint judgment of the Chief Justice and Justice Cory accepted the evidence showed the respondent was not suffering at the time from any mental illness and that "medically speaking, sleepwalking … is not … an illness." And so they upheld on the evidence that was before the Court, including which they emphasised the expert medical evidence, and upheld the automatism defence.

And I refer in 88 to the joint judgment of La Forest, L'Heureux-Dubé and Gonthier, Justices, as emphasising the distinguishing between the two concepts requires "more than the evidence; there are overarching policy conditions as well [although] the evidence in each case will be highly relevant". And the – their Honours considered that the Crown is entitled to raise issue of the insanity, but (despite the presumption of sanity) "the prosecution then bears the burden of proving … the condition … stems from a disease of the mind", which is of course part of my argument, and then as I say at 89 there's a discussion of the various theories, and I can take that as read, but this is relied on as part of my critique of the *Cameron* approach.

So – and they come back then in *Parks* to the point I've made, this is para 90, that you, at the end of the day as part of the classification exercise, you've got to take account of the fact that an effect of the classification exercise is either to uphold or to negate a fundamental precept of the criminal law, the voluntariness principle. So I suppose if I was going to ask your Honours to adopt any particular authority, which isn't really the way I'm arguing the case, it would be to follow the *Parks* approach.

Now I then go on to look at *R v Stone* [1999] 2 SCR 290 which is not only a very difficult case –

WINKELMANN CJ:
Parks has sort of a straightforward approach to illness or disease of the mind that Justice Kós had suggested doesn't it really?

MR HARRISON KC:
Yes, yes, and by contrast *Stone* is huge in volume, quite unmanageable to analyse really.

WINKELMANN CJ:
More a boulder than a stone.

MR HARRISON KC:

But I tried to in my submissions, so if I can just touch on that. What you had in *Stone* was, at my para 91, a fairly implausible automatism defence alleged with, together with provocation. It wasn't a sleepwalking automatism case. It was treated as a psychological blow automatism case, the psychological blow being the wife's insulting treatment of the accused and understandably, when you're faced with a case of that nature, you tend to limit the scope of any automatism defence along those lines. So it was a five to four division, with two diametrically opposed camps. The majority relied on the presumption that people act voluntarily, which is not our law, and then formulated a two-step approach.

GLAZEBROOK J:

Well is that quite right because isn't criminal conduct based on the fact that conduct is voluntary?

MR HARRISON KC:

Yes, but we don't apply a presumption that people intend a natural and probable consequence. I mean that's the old, that's the old common –

GLAZEBROOK J:

Well you say that has to be proved, is that the –

MR HARRISON KC:

Yes.

GLAZEBROOK J:

Okay, I understand.

MR HARRISON KC:

Yes, it's subject to proof beyond reasonable doubt.

GLAZEBROOK J:

Yes, yes.

MR HARRISON KC:

And there's a section of the *Cameron* judgment that analyses that, which I do rely on. So the majority say, first, you need to establish a proper foundation for automatism calling, confirming psychiatric evidence. I have no problem with that. I say that that is the case and it's an important safeguard to ensure that a sexsomnia defence, for example, isn't abused by someone just saying just that without confirming evidence of previous behaviours or psychiatric report.

WINKELMANN CJ:

Would you – so you would apply the same kind of requirement that there be a sufficient narrative on the evidence before the Judge allows it to go to the jury, you'd accept that?

MR HARRISON KC:

Yes, that is part of, early in my submissions I expressly accept that, and indeed I adopt it as a supporting argument because it's, because of that safeguard is there it's part of the safeguard that means you don't have to channel parasomnias through the insanity defence.

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So then – what they then said was once a proper foundation is established, the trial Judge determines whether it's mental order [*sic*] automatism, equal disease of the mind automatism, or non-insane automatism. Now what then is radical about *Stone* is they – if it's "mental disorder automatism" it's an insanity defence. The radical bit, if it's "non-mental disorder automatism", there's an onus, the same onus, as for an insanity defence imposed on the defence. So mental order – "mental disorder automatism" goes through a M'Naghten rules-type analysis. "Non-mental disorder automatism" gets to be run but the defence has to prove it on a balance of probabilities, and indeed –

GLAZEBROOK J:

Well the Crown is not arguing for that –

MR HARRISON KC:

No, but –

GLAZEBROOK J:

– and it clearly can't be right under our law, so.

MR HARRISON KC:

It's – but the point is, this is, this is why *Stone*, although an automatism rejection –

WINKELMANN CJ:

It has a dissent from Justice Binnie, doesn't, it?

MR HARRISON KC:

– case, is unhelpful. But it also is relevant because of the onus of – the onus of proof arguments I am running. When we compare what the majority said with the minority judgments which I rely on, so there's a – as I say in 94, there's a radical departure from previous authority, applying the reverse onus of proof despite the Canadian Charter of Rights provisions, including proof beyond reasonable doubt. And there's a telling criticism in the minority judgment, and again over the page the minority judges in *Stone* dissented and discussed, my 96, the concept of "disease of the mind".

WINKELMANN CJ:

So I'm just seeing the time.

MR HARRISON KC:

Yes. I would like to take your Honours to a few passages from the minority in *Stone* because I rely on –

WINKELMANN CJ:

Okay, we can do that after the break.

MR HARRISON KC:

Yes, yes.

WINKELMANN CJ:

I just – I just was thinking about the process that the Court of Appeal seems to contemplate in *Cameron,* and it seems to contemplate that some cases, that there has to be a decision on a case-by-case basis. I just wonder what that decision would be. Is it the decision that sleepwalk – that sexsomnia could sometimes be sane automatism, or is it that it just wouldn't be allowed? I'm not quite clear on the judgment what the decision the Court's contemplating.

MR HARRISON KC:

Yes, no, it's unclear and a bit, with respect, unworkable really –

WILLIAMS J:

Or very workable.

MR HARRISON KC:

– for a criminal justice system as a whole.

KÓS J:

I thought – I thought it was very clear. It's simply the old internal/external analysis and it –

GLAZEBROOK J:

Yes, and likely recurrence.

WILLIAMS J:

That's right, yes. It's very bluntly workable.

WINKELMANN CJ:

No, but I'm saying is – but does that mean that sexsomnia would always be?

WILLIAMS J:

Always –

GLAZEBROOK J:

No, no.

KÓS J:

Yes, always –

WILLIAMS J:

Well you see, it says two different things. It says sexsomnia is always internal –

KÓS J:

Correct.

WILLIAMS J:

– proper sexsomnia, but you assess each case on a case-by-case basis. That's the problem.

WINKELMANN CJ:

No, that's what I'm asking. That's what I'm – yes, that's what I'm identifying and asking you to address because I did think that that was an issue that wasn't explicitly pinned in your submissions, and it seems – anyway, well you can deal with that after the break.

COURT ADJOURNS: 11.33 AM

COURT RESUMES: 11.51 AM

MR HARRISON KC:

We were at page 23 of my written submissions, and I was going to take your Honours to the minority judgment in *Stone*, a judgment of Justice Binnie. If you have the electronic version of my submissions, and you go to footnote 76, you will access that judgment starting at page 330. But the first reference I want to make is at page 340, paragraph numbered 79. If your Honours have that, this is a partial answer to the first question your Honour the Chief Justice posed to me, what is my formulation. His Honour says: "The existence of a 'disease of the mind' is a threshold question."

KÓS J:

Sorry, which paragraph please?

MR HARRISON KC:

Para 79, page 340. The existence of a disease of the mind threshold question. "The real question … is whether 'the effect of a disease is to impair these [mental] faculties so severely as to have either of the consequences referred to' in" the equivalent of our section 23(2), "namely whether the disease rendered the accused 'incapable of appreciating the nature and quality of the act or … knowing that it was wrong." So the link I've argued for between severe or serious disease, which conceptually is capable of impairing the faculties in the way that either of the two (a) and (b) gateways contemplates, is the test, and then his Honour goes on, the minority go on, 80: "It is clear, in other words, that 'the consequences referred to' in s. 16 are directed to issues other than voluntariness." And there is a reference to Professor Stuart, the first two sentences of that quote. "A 'disease of the mind' is only one requirement of the legal defence of insanity. If that defence fails *for any reason*, surely justice dictates that the jury may consider sane automatism."

Then carrying on over the page we see that halfway down there's a paragraph beginning: "The difficulty of subsuming …". In effect Justice Binnie takes up the point I made about the prescient comment of Justice Gresson in *Cottle* about the difficulty of subsuming the issue of voluntariness into the different issue of mental disorder. So there's a reliance there.

Then at the top of page 342: "The s. 16 question has an air of artificiality in the case of someone who claims to have been unconscious at the material time. If true, he or she not only failed to appreciate 'the nature and quality of the act' but also failed to appreciate that the act was taking place at all."

Then at 84: "At the same time, where as here medical expert for the prosecution and the defence agree that there is no 'disease of the mind' known to medicine," because they actually address that issue as distinct from us in this case, "and the only justification offered in support of attributing the conduct to mental disorder is the inability of an accused to identify an 'external' cause, there is, in my view, an insufficient basis for (i) shifting the persuasive burden of proof," the

defence, “and (ii) taking the issue of non-mental disorder automatism away from the jury.”

Now I then want to just, I don’t want to belabour this, but just to take you to what I call the helpful summary within my footnote 76 starting at 346, and this is under the heading “5. Conclusion on the Automatism Issue.” It says: “In the result I believe the appellant was entitled to have the plea of non-mental disorder automatism left to the jury in this case in light of the trial judge’s evidentiary ruling that there was evidence of unconsciousness.”

And he gives reasons: “Firstly, I do not accept the Crown’s argument that a judge-made classification of situations into mental disorder automatism and non-mental disorder automatism can relieve the Crown of the obligation to prove all of the elements of the offence including voluntariness.”

I missed secondly. “Thirdly, the ‘internal cause’ theory, on which the Crown rested its argument, cannot be used to deprive the appellant of the benefit of the jury’s consideration of the voluntariness of his action, once he had met the evidential onus, without risking violation … of the *Charter*” provision, beyond reasonable doubt provision.

WILLIAMS J:
What paragraph are you reading from?

MR HARRISON KC:
This is at the top of page 347, beginning “Thirdly”.

WILLIAMS J:
Thanks.

MR HARRISON KC:
Do you have it?

WILLIAMS J:

Yes, thank you.

MR HARRISON KC:

"That's: "Thirdly". So I'm relying on the thirdly reasoning. "Fourthly, it was wrong of the Courts to require the appellant to substitute for his chosen defence of voluntariness the conceptually quite different plea of insanity. One of the few points of agreement between the defence and Crown experts at trial was that the appellant did not suffer from anything that could be described medically as disease of the mind. He was either unconscious at the time or not telling the truth … This was a question for the jury. The statutory inquiry into whether he was 'suffering from a mental disorder'" or equivalent of disease of the mind, "that rendered him 'incapable…" et cetera, "are qualitative assertions that are not really responsive to his allegation that he was not conscious of having acted at all."

WINKELMANN CJ:

There's something in that point isn't there? That really this isn't the case about insanity, it seems like, as you say, Procrustean task, making the jury try to consider it in that context.

MR HARRISON KC:

Yes, I rely on this line of reasoning. Then there's the final point: "Finally, the evidence established there are states of automatism where perfectly sane people lose conscious control over their actions. At that point, it was up to the jury, not the judge, to decide if the appellant had brought himself within the physical and mental condition thus identified." So I do rely on that reasoning, I have just done a few selected highlights.

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Moving on to what I would call the second aspect of the appeal, which is the absence of expert evidence, I note my critique of *Cameron* which has already been advanced. At page 24 I refer in para 100 to the trial's brief ruling I've referred to earlier and we don't need to go over that again but, as I said, the

proposed evidence was the two competing expert reports which I'll come to and, of course, just to remind you, the last sentence of my para 100, it would not have been permissible for the experts at trial to address the question whether, in their view, sexsomnia was a "disease of the mind" because the trial judge had already ruled on that. So any attempt to lead evidence from, say, Dr Fernando by the defence at trial to argue that sexsomnia was not a "disease of the mind" would have been improper because contrary to the Judge's ruling. So that's why we don't get any evidence at the trial stage directed to the point at issue.

I argue, at para 103, that if you've gotten expert evidence and there's a sexsomnia defence, there are three interrelated aspects to the expert's role: (i) a description of the condition itself expressed in medical and in particular psychiatric terms, including offering an opinion on whether it should from that perspective be treated as a "disease of the mind"; (ii) an opinion whether the defendant suffers from sexsomnia; and (iii), possibly, although I have some trouble, I have some difficulties with this, an opinion whether the defendant's alleged actions were due to his sexsomnia. Certainly, the experts were allowed to pronounce on that. It is, of course, an ultimate issue for the jury and I'm familiar, of course, with the evidence. We're familiar with the Evidence Act provisions which I refer to in my footnote 83. So there's no rule that the expert can't pronounce on the ultimate issue but…

GLAZEBROOK J:

It may be, however, that it would be unfair to allow them to do so rather than give the foundation for the jury to decide themselves whether that was the case, given that there may well be too much reliance on an expert's view on that.

MR HARRISON KC:

Yes, certainly Dr Dean, claiming to be a forensic psychiatrist, was allowed somewhat greater leeway to pronounce on this third aspect than might have been appropriate.

GLAZEBROOK J:

Well, of course, that was probably due to the fact it was an insanity defence and in an insanity the experts do look at the particular actions for obvious reasons because they are opining on whether the particular insanity test is met in those particular circumstances, which is a different thing altogether, I would suggest –

MR HARRISON KC:

Yes, well, Dr –

GLAZEBROOK J:

– to where the – if it wasn't – if it was sane automatism, whether they should be allowed to do so.

MR HARRISON KC:

Yes, well, we're getting into the discussion which I have at page 25 of the written submissions and I have summarised the key bits of the evidence, and at 105 I refer to Dr Dean and he doesn't seem to have concluded that the diagnosis of sexsomnia generally for the appellant was wrong. He qualified it, he hedged his bets and said, as I've set out in 105: "The diagnosis of sexsomnia at the material time (even if present at other times, in the past) is excluded using sleep disorder diagnostic criteria because of the level of intoxication," such that "intoxication remains the most likely diagnosis and sexsomnia should be excluded."

Now that proceeded on what I submit was a challenged, but one assumes unsuccessfully challenged, false premise, namely that you needed to be able to diagnose sexsomnia on the night in question using the DSM-5 criteria which was – or, no, an expansion of them in a separate document said you can't diagnose sexsomnia if alcohol consumption is present.

So the emphasis of Dr Dean's evidence is to say: "Well, he'd been drinking on the night, therefore I can't diagnose him with sexsomnia on the night." The real issue ought to have been, as Dr Fernando proceeded: "Can we diagnose him with sexsomnia by reason of a whole lot of sources and factors? Yes, we can.

Is it likely that his conduct on the night, which I have familiarised myself, was a consequence of that sexsomnia? Yes." Dr Dean simply limits himself to saying: "Well, he was intoxicated, therefore sexsomnia should be excluded," which was not, in my submission, a valid or safe way to reason, but, in any event, the – perhaps returning to my present point, at 107, in his report Dr Fernando does not directly address the question whether sexsomnia should be regarded as a "disease of the mind" but Dr Dean initially offered his psychiatrist's opinion that it is not. Just looking for the reference to that, I think it's in footnote 87. Yes, at page 294 he refers to sexsomnia and at the second paragraph the diagnosis of sexsomnia generally, then at 395 under the heading "Automatism" he says: "Automatism is a state," et cetera. "Sexsomnia has been determined by the court to be a non-insane condition and if accepted leads to a decision of not guilty."

WINKELMANN CJ:

So he's proceeding under a wrong legal test?

MR HARRISON KC:

Yes.

WINKELMANN CJ:

And then he's corrected at trial?

MR HARRISON KC:

Yes.

WINKELMANN CJ:

306.

MR HARRISON KC:

Yes, as I noted in my footnote.

O'REGAN J:

He's not diagnosing it though. He's just saying that's what courts have found.

MR HARRISON KC:

Yes. So other than that opinion, read however one likes, of Dr Dean, there is neither – as I say in 107, neither experts in any way suggest that sexsomnia is a "disease of the mind" or indeed that it is not, nor do they suggest that there's an available psychiatric or other treatment for the sexsomnia condition.

WINKELMANN CJ:

I'm interested as to how courts are meant to approach this whole area because you're asking us for a rethink and what you're seeing here is a disconnect. Psychiatrists are being asked to proceed, are applying a legal test without any kind of medical basis. They're saying one moment: "Well, I'm proceeding on the basis the law said it's not," and then: "I'm corrected. I stand corrected now, it is". I'm interested in what you say should be the connection between psychiatric perceptions of mental, a disease of the mind which is not a psychiatric term, and section 23?

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MR HARRISON KC:

Well the way the law seems to be currently understood is that whether or not the meaning of disease of the mind and whether or not a particular condition is a disease of the mind is ultimately a legal question for the judge, but that it should be informed by expert opinion directed to that very issue. So what – in practical terms, at the very least there should be a voir dire-type hearing before the trial judge, if the trial judge's function is to give the ultimate and binding ruling contrary to the minority in *Stone*, and at that voir dire hearing, the classification hearing, experts should give evidence on that question, whether the sexsomnia generally, and specifically if possible, the defendant's sexsomnia condition is or is not a disease of the mind so that there is expert evidence. This is what *Cameron* itself said should be happening, but it didn't.

GLAZEBROOK J:

Can I just check, because in *Stone* both of the experts said it wasn't a disease of the mind. I suspect that would be the case here because I suspect that the

psychiatrist would be giving evidence in accordance with the Mental Health Act definition of disease of the mind.

MR HARRISON KC:

Mental disorder I think, yes.

GLAZEBROOK J:

Now is – is that the definition that should be used for whether it's a disease of the mind, or is disease of the mind broader, and if it's broader, what is the definition?

MR HARRISON KC:

Well –

GLAZEBROOK J:

Because they will be looking at it from a medical and psychiatric perspective which, as I say, would likely align with the Mental Health Act definition rather than, well – and what is the definition of disease of the mind if it isn't that Mental Health Act definition?

KÓS J:

Well I think they don't –

WINKELMANN CJ:

Because it must be broader than mental disorder, mustn't it? Yes.

KÓS J:

Absolutely, yes.

GLAZEBROOK J:

Well it might be, but how – what is it, is what I'm asking?

MR HARRISON KC:

Well that's – I would put that as the second of two issues. And if I may, the first issue is: is expert evidence on the question "disease of the mind or no?"

admissible, and indeed required, for the Court to make an informed decision, particularly expert evidence whether the defendant's condition of whatever, parasomnia, is a disease of the mind, the Canadian cases and *Cameron* itself all say that expert evidence is required. No such expert evidence was given here.

That's – so my – the first question is, is that evidence admissible and indeed required? I say yes. This next question posed by your Honour is, well if so, how should that evidence be given and what should it address –

GLAZEBROOK J:
No, no, I'm not actually asking that.

MR HARRISON KC:
Oh, I'm sorry.

GLAZEBROOK J:
I'm asking what the definition of disease of the mind is that either the expert evidence would be directed to, or alternatively, that the judge would be deciding after hearing the expert evidence, and the reason I'm asking that is because the cases seem to say that you're looking at internal causes and recurrence –

WINKELMANN CJ:
So it's back to the first question.

GLAZEBROOK J:
– you say that's nonsense, but what do you look at as the –

WINKELMANN CJ:
Yes.

GLAZEBROOK J:
What is the test, was the question?

WINKELMANN CJ:

That's the first question I asked you today, yes.

MR HARRISON KC:

Yes, well, the test is hopefully going to be formulated by your Honours, whatever test – no, I mean in answer to Justice Glazebrook –

GLAZEBROOK J:

No, what I'm asking you is what do you say the test for a "disease of the mind" is because you say it's not recurrence and it's not internal/external, so what is it?

WINKELMANN CJ:

I think we are entitled to seek your assistance on that, Mr Harrison.

MR HARRISON KC:

Yes, well, I was looking for where I covered it off and it's in my paragraph 20 which is probably the best I can do, 120, the characterisation of the key concept of a "disease of the mind" as being something which one "labours under", and this strongly suggests a necessary requirement of serious mental illness. So that would tie in to, for example, asking an expert to comment on levels of seriousness of particular behaviours, for example, those listed in DSM-5, because DSM-5 notoriously covers a whole range of conditions and behaviours.

WINKELMANN CJ:

Do you gain anything by adding in the word "serious" though because isn't the seriousness – if it's a mental illness which causes either (a) or (b) then it's serious?

MR HARRISON KC:

Well, that's why I said that the passage from Justice Binnie in *Stone* that I took your Honours to originally is reflective of the way I say "disease of the mind" should be interpreted.

WILLIAMS J:

Interestingly, the definition of "mental disorder" in MH(CAT) invokes seriousness both as to danger and as to the wellbeing of the person.

MR HARRISON KC:

Yes.

WILLIAMS J:

So if you read "disease of the mind" as if it meant "mental disorder", so you align the two –

MR HARRISON KC:

And then had adopted that definition.

WILLIAMS J:

But if that were the case, repetitive sexual, non-consensual sexual encounters while asleep might well meet that definition.

MR HARRISON KC:

That is the behaviour rather than the condition.

WILLIAMS J:

"Poses a serious danger to the health or safety of that person or of others."

MR HARRISON KC:

But that's the behaviour.

WILLIAMS J:

But you see what "mental disorder" does is use those as indicators of mental disorder.

WINKELMANN CJ:

Can you read out the first limb again?

WILLIAMS J:

In relation to any person, means an abnormal state of mind characterised by delusions, disorders of mood, perception, cognition – I can't read it properly – to a degree that poses a serious danger to the health and safety of self or others, seriously diminishes the capacity of that person to take care of self or others – sorry, no, of self.

KÓS J:

What's that from?

WILLIAMS J:

The Mental Health (Compulsory Treatment) Act [*sic*]. So this is –

MR HARRISON KC:

My suggestion is that the condition itself has to be a serious mental disorder. The definition, which incidentally is set out in footnote 105 of the Crown submissions, the definition focuses on posing a serious danger. So I'm saying the condition itself needs to be a serious mental disorder. This is saying the consequences of the condition must be such as to pose a serious danger.

WILLIAMS J:

This does have the advantage of being transparent about why you impose this reverse onus, because of the seriousness of danger.

MR HARRISON KC:

It's an improvement on…

WILLIAMS J:

On what we've got.

MR HARRISON KC:

On what we've got.

WINKELMANN CJ:

Well, what, I suppose, you would say is that *Cameron* is continuing expanding the divergence between the clinical concept of "mental disorder" and the legal concept of "disease of the mind", section 23.

MR HARRISON KC:

I would say that, yes.

WINKELMANN CJ:

And the point that it's entirely divorced, it can't be sustained. That's your submission?

MR HARRISON KC:

Part of it and –

GLAZEBROOK J:

And on a logical basis in terms of repetition and internal/external I think you'd also say, wouldn't you?

MR HARRISON KC:

Yes, I would.

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GLAZEBROOK J:

So it's not only expanding, but it's expanding it on the basis of a logicality?

MR HARRISON KC:

Yes, yes, I would, but of course I'm dealing at the moment with my second aspect, which was the –

WINKELMANN CJ:

Lack of evidence.

MR HARRISON KC:

The lack of evidence, but also that –

GLAZEBROOK J:

Yes. Oh, no, I –

MR HARRISON KC:

That ties into again 20 – an eye on the time, page 26, that ties in para 209 to my point about the reverse onus of proof, so that if – if expert evidence ought – about the issue of disease of the mind ought to have been adduced, the – it was, the onus of proof was on the prosecution to adduce expert evidence to the effect that the appellant's sexsomnia qualified as a disease of the mind, or at the very least –

WILLIAMS J:

The irony of that argument, Mr Harrison, is that the worse the condition the harder it is to get the benefit of justification.

MR HARRISON KC:

The benefit of?

WINKELMANN CJ:

You don't mean "justification"?

WILLIAMS J:

Well insanity, right? So if you are suffering from a disease of the mind, the consequences or nature of which are serious, you've got an extra hurdle, a reverse onus. If your condition, whatever it might be, is something less than serious you don't have that extra hurdle. There's an illogicality in that, isn't there?

MR HARRISON KC:

No, because the – the more serious condition should be addressed through the insanity defence. The less serious condition I'm arguing should be assessed more charitably, shall we say, and in the case of sexsomnia should be excluded from the defence.

WILLIAMS J:

Yes, but another way of looking at that is the less well you are, the harder it is for you to obtain the advantage under section – under the law, generally, the less well you are.

MR HARRISON KC:

If – it's not an advantage to qualify for the insanity defence if your alternative is to put forward a lack of voluntariness defence. This is my point. The person who wants to put forward an automatism, lack of voluntariness defence doesn't want to be saddled with an insanity defence, so it's not an advantage.

WILLIAMS J:

Well they might have – in logic might have available both, depending on the seriousness of the sexsomnia?

MR HARRISON KC:

Well the received, the received view is that you can't run both together, although you could, if there was intoxication, you could be running an intoxication automatism but you're not allowed to run a sexsomnia automatism alongside it. And of course this is, comes back perhaps to the question, it's artificial, it's what happened in *Cameron* in effect, *Cameron* – *Cameron* was saying "I'm a sexsomniac plus I had way too much to drink". I think I've got the facts right.

KÓS J:

Mmm.

MR HARRISON KC:

And he wasn't allowed to say, well, that "the cumulative effect of those two meant that I ended up with a total lack of consciousness defence, I got a defence, cumulatively it was one or the other or both in combination, this is my defence", he couldn't run that, he had to run his sexsomnia as an insanity defence and his intoxication as at best if the trial judge permitted an automatism defence.

WILLIAMS J:

Do you, as a very experienced counsel, do you really think it would make a difference to 12 of the great and good?

MR HARRISON KC:

I may be experienced but not necessarily that experienced with the great, the 12 great and good, but I, I do make some points –

WINKELMANN CJ:

Well can I just ask you before we move on?

MR HARRISON KC:

Yes.

WINKELMANN CJ:

So Justice Williams is essentially saying to you that what you're proposing disorders the legal system because if you are, if a person who is unwell and therefore not morally culpable, they – if they want to say "I'm unwell, I'm not morally culpable, I need treatment, not punishment", they bear this onus of proof, but if someone wants to say "I have this thing in my brain which when I go to sleep I do this thing and therefore I'm not morally culpable", they don't bear that onus of proof, and that's a – it introduces incoherence into the order and that's what Justice Williams is saying to you. So do you have something you have to say to us on that?

MR HARRISON KC:

Well I don't accept that the issue, that the defendant is saying I am not legally culpable, and the defendant is opting to advance a defence which he considers is most fitted to the facts of this case as he wishes to put them forward. So he opts for one or the other, as ought to be his fair trial right.

WINKELMANN CJ:

Okay, but you're not really responding to the incoherence point though. Is your point that they're two distinct things and therefore it's not incoherence?

MR HARRISON KC:

Yes. Certainly it's two distinct things and it is the reason they are distinct is that it's a defence choice which thing to pursue.

KÓS J:

Well in that case why shouldn't the mentally – why shouldn't the insane automaton have the right to run a defence of automatism? The equally unconscious and lack of volition. So why should they not be able to have the easier route of ordinary automatism?

MR HARRISON KC:

Well because ultimately, and I'm not arguing otherwise, ultimately the classification has to occur. Is this a disease of the mind or not. I mean it's not open slather, I can, I'm an epileptic or a paranoid schizophrenic, and I want to run whatever defence I can. The trial judge is going to say, well, I will classify this and you've got to run this particular mental condition as an insanity defence. But it depends on the variety of automatism and the expert evidence, where we end up. It's not open slather.

GLAZEBROOK J:

Which comes back to what's the test, and you say it's serious mental illness, is that your final answer?

MR HARRISON KC:

Yes, that it's serious illness of a kind which is capable of being placed on the Procrustean bed of section 23(2).

WINKELMANN CJ:

So I think your answer to the coherence question is not that it's a matter of defence choice, which that is in itself is problematic. I think your answer is that Parliament has chosen to create a special regime that applies in a certain circumstance, and it's not for us to expand it beyond that circumstance, in search of some sense of coherence, it actually just adds incoherence.

MR HARRISON KC:

Well yes, but also as a matter of interpretation it is to be read…

WINKELMANN CJ:

Yes, my point.

MR HARRISON KC:

Read in the way I've argued.

WINKELMANN CJ:

Yes, that's imbedded in the point I've just made.

MR HARRISON KC:

Right so I've dealt with the second aspect. I have summarised my conclusions from page 27 on and I don't think really I can add to that but I hope to be in a position, depending on how the Crown submissions go, to spend a little time in reply on some of the cases I have, they are citing and I have not got to. So those are my submissions your Honour.

WINKELMANN CJ:

And you had two minutes to spare Mr Harrison. Well done.

MR HARRISON KC:

Thank you.

WINKELMANN CJ:

Ms Hamill.

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MS HAMILL:

Thank you, your Honour. I just want to start by briefly summarising where I hope to go during the course of my submissions, and the starting proposition for the Crown is that if the internal and external risk of recurrence test articulated in *Cameron* is applied to Mr Cook, the result is that Mr Cook's condition would be insane automatism, and as I understand my learned friend, he doesn't

necessarily take issue with that basic proposition, he takes issue with the test itself.

So what I will be spending the bulk of my submissions dwelling on is the nature of the test and its purpose and its function, and again just to run your Honours through the brief outline of where I hope to go on that, the Crown submits that the *Cameron* formulation recognises a traditional approach that has been adopted in Canada and England as very comparable jurisdictions, and is one which formulates the definition of disease of the mind very broadly, but does draw limits to it where essentially the cause of a condition that a person has suffered is not due to an internal condition that they suffered, but rather essentially some random accidental external event.

The internal and external cause and risk of recurrence words are deceptively simple and can appear very blunt, but underneath them lie a relatively complex and nuanced range of social and forensic legal factors that those tests take into account.

The breadth of the disease of the mind condition is a broad one, and an ordinary aspect that would be relatively protective of defence interests because it would allow for quite an open textured and nuanced assessment by the Court of what is a mental disease, or a “disease of the mind” as defined in section 23, and the issue then becomes one of classification, and that is one for the Court to determine based on the evidence before it. That is at the heart of the issue that my learned friend has raised, which is what does the classification exercise involve, and in the Crown submission it involves a legal question that the Court must first determine before the issue goes to the jury.

So I'm going to cover this with reference to a bit of more discussion about the nature of the two defences, how they’ve been dealt with in Canada and England, as well as in New Zealand, and to look at the rationale for the reverse onus that exists in section 23. Now I do this because on one view of my learned friend’s argument it really comes down to a desire to avoid that reverse onus. That appears to be one of the driving factors in advancing sane automatism

rather than insane. That's a brief outline of where I intend to go throughout my submissions.

Now, I won't dwell extensively on my opening proposition, which was that under an orthodox, as the *Cameron* court put it, application of the internal/external test Mr Cook was an insane automatism, but just briefly to run through some of those points –

WINKELMANN CJ:

I do actually think that issue is taken but with the application to Mr Cook because it said that there was no evidence to make that classification.

MS HAMILL:

The issue, as I understood it, my learned friend took was not that there was no evidence as to the nature of his condition, but rather evidence as to the nature of, from the experts, their own opinion on whether this was a disease of the mind or not.

WINKELMANN CJ:

That's probably fair.

MS HAMILL:

So I will come back to that in terms of addressing the specific issues that my learned friend says lacked in this trial. Again, just by way of a very broad précis of how the evidence would fit with the internal/external cause analysis, and risk of recurrence, there was evidence from three of Mr Cook's partners about what seemed to be a relatively persistent pattern of conduct during the night. The witness for the Crown in particular described it as unwanted conduct, and conduct that could happen almost nightly. The evidence from Dr Fernando, who was the sleep psychiatrist called by the defence, was that this is a sleep disorder diagnosed through the DSM-5, the *Diagnostic Manual of Mental Disorders*, and that it is something that can be hereditary and occurs in the stage of non-REM sleep. So it is, as described by the experts, a particular disorder experienced by a relatively small number of the population.

Now again that's just a very broad outline of how the evidence in this case would fit within those internal and external diagnostic or frames of analysis, but that's not really the issue here. As I said, the issue is whether those tests are appropriate and whether they properly capture the issues that need to be determined.

So to speak to that I want to turn now a little bit more to the distinction between sane and insane automatism and the meaning of "disease of the mind".

So the distinction between conscious behaviour that's caused by a "disease of mind" and that which is not is something that the Courts in this country and Canada and England and indeed Australia have long recognised, and here I am referring to paragraphs 25 and onwards of the Crown's submissions. I won't take your Honours in detail through those submissions because they are before you but the cases referred to there, for example, include *Bratty v Attorney-General for Northern Ireland* [1963] AC 386 as one of the cases talking about this distinction in 1963 and, of course, there was the seminal case of *Cottle* of New Zealand's Court of Appeal. A distinction has also been recognised in Canada and in *R v Falconer* (1990) 171 CLR 30 in Australia.

Now at 27 of my submissions I have quoted Justice Devlin in drawing the distinction between sane and insane automatism as one that lies between whether the disease of mind is present or not, and there his Honour said: "If disease is not the cause, if there is 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 …" this may happen again.

WILLIAMS J:

Kind of begs the question though, doesn't it, what's a disease? Because there are disorders –

WINKELMANN CJ:

There are behaviours happen over and over –

WILLIAMS J:

Behavioural disorders that I don't think medicine would treat as a disease.

MS HAMILL:

No.

WILLIAMS J:

But on this analysis they'd be diseases.

MS HAMILL:

Behavioural disorders are generally not caught within the realms of "disease of the mind" and that is not something that I have specifically referred to by way of authority in my submissions and can provide your Honour –

WILLIAMS J:

But is it not arguable that sexsomnia is a behavioural disorder?

MS HAMILL:

It's a sleep disorder.

WILLIAMS J:

Yes, a behavioural disorder.

MS HAMILL:

Well, a behavioural disorder is one in which a person – and here I'm speaking off the top of my head –

WILLIAMS J:

Do your best.

MS HAMILL:

– so please bear with me. A behaviour disorder is one in which a person is generally considered to lack the moral compass that others might normally be expected to have, so makes conscious decisions but doesn't make them on the basis of, as I understand it, of – there's no issue with their consciousness. They're just choosing to –

WINKELMANN CJ:

I think that might be a very narrow drawing of it but that's one aspect of it.

MS HAMILL:

Yes, and, your Honour, I think it would be helpful for me to confer with Professor Brookbanks on this issue before I really pinned my colours to the flag on the definition of "behavioural disorder".

WINKELMANN CJ:

Do you mean "behavioural disorder" as it sounds in criminal law which is really only…

MS HAMILL:

Yes.

WINKELMANN CJ:

Ok.

MS HAMILL:

The short point is though, as I understand the law, "behavioural disorder" does not ordinarily fall within "disease of the mind" and it might be helpful to look at the way that the Courts have referred to "disease of the mind", and here I am referring to the definition in *Cottle* which is referred to in paragraph 33 of my submissions.

WINKELMANN CJ:

The fundamental problem you have to address with us is that there's nothing wrong with his mind. He just does something when he's asleep, on his case.

MS HAMILL:

Yes.

WINKELMANN CJ:

And that's the difficulty we're all having.

MS HAMILL:

Yes, and again I think the answer to this is to work sequentially through the tests as they have been discussed in the cases and the rationale for the distinctions that have been drawn, because at the heart of a lot of these issues lie, as I think the Bench has already discussed with my learned friend, the dissonance between medical science and what it has to say about a person's consciousness, their various levels of states of consciousness, and what can be considered a mental disorder or otherwise versus the legal construct of how this gets formulated and how it translates into a defence in the criminal law.

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WILLIAMS J:

So it's the widening gap between the 19th century and 21st century because the test is an 1843 test and we know lots more than they did then.

MS HAMILL:

We know lots about the nature of mental states and how they function, and that –

WILLIAMS J:

The nature of ourselves, yes.

MS HAMILL:

Yes, and that is perhaps best illustrated by sleepwalking, because sleepwalking was always quoted in obiter in courts of the 19th and early 20th centuries as being a paradigm case of automatism essentially based off a popular conception that a person is walking around unconsciously in their sleep.

Medical science, arguably, is what has brought it within the framework of insane automatism because it has spoken of the cause and the pattern of behaviour that it can generate. So medical science is what has established sleepwalking as not just some random event that happens to an individual, but rather as a sleep disorder.

WILLIAMS J:

Well judges leapt to that analogy because it was so common, and it is so common.

MS HAMILL:

It is so common, particularly amongst small children it's extremely common, but it is relatively uncommon, and this is the evidence in this case too, for an adult to continue to exhibit sleepwalking or sleep-talking behaviours. It's relatively uncommon.

WILLIAMS J:

What do you mean by "relatively"?

MS HAMILL:

Well it depends on the nature of the parasomnia, which is why I speak in broad terms.

WILLIAMS J:

I'm talking about sleepwalking.

MS HAMILL:

Sleepwalking generally, I'd have to refer back to the evidence to give your Honour a specific –

WINKELMANN CJ:

Quite common amongst drunk young men, I think.

KÓS J:

I just don't understand why we're going here. It seems to me to be a byway. It's much easier not to focus on disease of the mind but to focus on consciousness and volition, and we know when someone is unconscious, and lacks volition, and if they are unconscious and lack volition and commit what would otherwise be an actus reus, they have the defence of automatism available to them, but, we say, aha, but if you fall into a particular category of unconsciousness or lack of volition whereas you qualify as a disease of the mind, unfortunately you don't have automatism available to you, you've got to do insanity, and what I need to understand from you today, soon, is why we make that distinction as opposed to simply saying if the man is unconscious and lacks volition, that's it, the defence is available. He's got to lay – he or she has got to lay an evidential foundation for that and the jury will probably be sceptical in the way that Justice Fisher suggested in *Brannigan* [*sic*], but that seems to me the simpler course.

MS HAMILL:

Well it may at face value, but in my submission it potentially falls victim to the same dissonance between medical science and the law. The law recognises a difference between states of consciousness as either unconscious, lack of volition, or some degree of consciousness, but medical science is more equivocal on that subject, it speaks of layers of consciousness. And that's something that Dr Fernando spoke to in this trial, and here I'm referring to paragraph 38 of my submissions, 37 and 38 address this issue of consciousness, your Honour.

WINKELMANN CJ:

So I suppose on the – if we take the *Cameron* approach, if a person's evidence is that they don't normally do this but they did it on this occasion and that is their evidence, they would be allowed to run that defence as sane automatism, but a person who says "look, I've had this happen many times therefore I've got a reasonably good defence and this is what happened on this occasion", they will be dealt with as an insane automatism, and that just seems to me to be problematic?

MS HAMILL:

The – as *Cameron* said, it will come down to the evidence and there are conceivably cases –

WINKELMANN CJ:

No, but I'm asking you about how that, how is that coherent, how is that coherent, how can that be what section 23 is aiming at?

MS HAMILL:

Well if I may again answer your Honour's question just through a series of propositions that I hope will assist the Court?

WINKELMANN CJ:

Okay, you do that.

MS HAMILL:

Thank you, your Honour. Just again to start, to pick up on my earlier point which is one to do with levels of consciousness that your Honour Justice Kós raised, and that is addressed in paragraphs 37 and 38 of my submissions.

There, as I say, medicine does not easily align with the legal concept of a lack of consciousness – and on one medical view, would classify *all* automatism as a mental disorder, and there I have footnoted respective authorities for that proposition. Likewise –

WILLIAMS J:

I know you're laying out your trail, and I'm not going to interrupt that except to say that these are questions of fact, deep questions of fact. Sometimes you'll have nuance such as, I was asleep, but the evidence is some level of consciousness. That's not unknown in sexsomnia and other somnambulant cases. That's the sort of spectrum that that doctor is talking about, and juries seem to cope with that, because they are fact-focused, not label-focused, and they don't seem to have any real difficulty coping with it. They're as sceptical as hell about these sorts of arguments, and they don't succeed very often. In many ways the burden is irrelevant because the juries make the call.

MS HAMILL:

With the greatest of respect I would dispute the proposition that by putting forward the theoretical possibility of a lack of conscious volition due to a sleep disorder that juries would necessarily be deeply sceptical of that.

WILLIAMS J:

But they are. I mean we know that. That defence, that argument, whether it's defence or not, that response to charges hardly ever succeeds, usually because there's some evidence to suggest it's rubbish and where the evidence is, there's a lot to this, it will succeed, but there are very few cases where that's the case.

MS HAMILL:

Well that, again, as your Honour rightly says, will depend on the state of the evidence before the jury.

WILLIAMS J:

Precisely, exactly as it should.

MS HAMILL:

And the state of the evidence before the jury, and what is necessary to raise the defence, is something I'd like to come back to. The point that I was earlier trying to simply make was if we draw the line between consciousness as a

qualifying distinction between automatism as a concept, and insanity, there are also medical issues with doing so. You can't simply ask the experts to say this person had this much level of unconsciousness, and this person had this much level of unconsciousness. There are some bright line distinctions that might be fairly obvious such as the category of person who is relying on subsection (2)(b) of section 23 of the Crimes Act. A person who can't distinguish between right and wrong. We're not talking about their state of consciousness there, and there will be plenty of defendants who within section 23 are quite obviously conscious in the sense that we understand it popularly. But again my point is that where it comes to those harder definitions, law and medicine don't necessarily relate quite so simply as we would think either.

WILLIAMS J:

But facts and medicine probably do because in that sort of situation where you have half consciousness, often reflected in evidence such as a bumbling comment, or a telling comment, depending on the view the jury takes of the comment the defendant makes, would lead a jury to conclude the person was conscious enough to appreciate the significance of what they were doing.

MS HAMILL:

Well in the case of sexsomnia, for example, you've got very purposive seeming acts. So in Mr Cook's case he fell asleep underneath separate bedcovers from the complainant, and in order to have sex with her he had to rearrange the bedding such that he could get under her covers.

WILLIAMS J:

Yes, I get that.

MS HAMILL:

He had to unbutton his fly.

WILLIAMS J:

Mind you Mr Parks drove 23 kilometres.

MS HAMILL:

Mr Parks did drive 23 kilometres to his in-laws' house, which he was able to find apparently in a state of sleep.

WILLIAMS J:

Yes, but the jury had no truck with Mr Cook's argument, probably because of the points you make.

MS HAMILL:

Well I'll come back to *Parks* and the state of the evidence there, which is quite different to the evidence in this case. It was a different set of facts that led to Mr Cook's lack of conscious functioning it seems. It's relatively murky about the degree to which it was due to sleep or it was due to almost a sleep equivalent of the psychological blow phenomenon that was precipitated by a number of life stresses that had accumulated for him, so there were a lot of complicating factors for Mr Parks, and indeed in other cases that aren't sexsomnia there often are. The line of authorities referred to in the Australian case *DB* that my learned friend referred to, post-war, late 19th century cases involving members of the armed forces apparently, what would appear today to be suffering expressions of PTSD, so it's very difficult to say all parasomnias follow a particular pattern. It is based on the evidence. The evidence in sexsomnia cases is reasonably specific. You don't have a person who just got up and started wandering around the house, and they may have unconsciously bumped into and didn't mean to, they were just sleepwalking.

1250

What you have, as I said before, is a particular pattern of quite purposive acts that require a number of complicated acts to achieve. They require locating a bed partner and having sex with them. In Mr Cameron's case, if he was to be believed, it required moving through a room of sleeping whānau and identifying his 15-year-old close relative as opposed to other members of the family. So the evidence again is of what appears to be very purposive acts occurring in what is or ought to be a stage of non-REM very deep sleep. So the evidence in sexsomnia cases is something that probably ought to be considered directly

as evidence of sexsomnia rather than the way it might apply to all other parasomnias, including Mr Parks. *Parks* –

WILLIAMS J:

I don't understand the logic of that, I'm afraid.

MS HAMILL:

Well, the logic of that comes down to again *Parks* itself. In *Parks* the Supreme Court had reference to the Court of Appeal UK case, *Burgess*, that was being heard around the same time, and they acknowledged in that case the UK was treating Mr Burgess' violent parasomnia as an episode of insane automatism and they said the evidence in that case is just really different from the evidence in our case. The evidence in that case, and again I'd have to bring myself back to that specific part of my submissions that I was hoping to adduce later, the evidence in that case was that this was part of a parasomnia that was a sleep disorder Mr Burgess suffered, if I have it correctly, that was prone to occur and that there was good treatment options for – effectively, and the Court in England said the evidence that we have supports the proposition that this is insane automatism; it should be classified accordingly. *Parks* said in other – in other cases such as *Burgess* that is the appropriate outcome and indeed, as medical science evolves, it may be the appropriate outcome in future cases. *Parks* did not seek to establish the parameters of sleepwalking as sane automatism. It spoke to the evidence specific to its own case, and the evidence in sexsomnia cases is also, typically, if we look at what we're dealing with with Mr Cook and what was very similar with Mr Cameron, is an often hereditary sleep disorder that exhibits itself through recurrent behaviour, usually sexual, sometimes more broadly than that, and is a particular type of parasomnia that occurs in the non-REM phase of sleep. So that's what we have to consider.

WILLIAMS J:

So if Mr Parks, seems an unfortunate name give that that's the very thing he wouldn't do, was prone to driving around while asleep, it's insane automatism?

MS HAMILL:

That comes back to the various social and other factors that go into the test.

WILLIAMS J:

Exactly, but doesn't that lead you to conclude that it's not the actual activity but the specific facts that tell you whether there's a disease of the mind in operation or something else, not the label, not sexsomnia, or somnambulance for that matter?

MS HAMILL:

Yes.

WILLIAMS J:

But the particular facts, and what the law should not do is say if it's sexsomnia it's a disease of the mind.

MS HAMILL:

No, and that's not what *Cameron* explicitly does either.

WILLIAMS J:

No, not explicitly.

MS HAMILL:

Cameron says it will always turn on the evidence of the case, and so, to take a hypothetical, if somebody does not experience a sleep problem and takes a new type of sleep medication that brings on – and obviously I'm just making this up, whether it's medically sound or not I don't know – but experiences essentially some kind of sexsomnia episode and the medical evidence is that was caused by a drug, the effect of a drug, unfortunate effect of a drug, then that is a different proposition to this person has a longstanding pattern of behaviour caused by a specific sleep disorder that is internal to them. It's something that's part of their own make-up.

WILLIAMS J:

The irony of that is that you end up with cases that if it's fresh and new, and therefore from the point of view of the 12 unlikely to be believed, it has a lower standard. If there's a pattern of it and more likely to be believed, one would have thought, it's more difficult to get.

WINKELMANN CJ:

I must say I've listened to your submissions and become more and more troubled because they seem to suggest that the meaning of section 23 is very perambulatory and it just responds to societal risk to manage it rather than to any coherent sense of what the section 23 words mean, that it's to be deployed by judges to manage social risk.

MS HAMILL:

Let's go to the definition of "disease of the mind".

WINKELMANN CJ:

Yes, that would be helpful.

MS HAMILL:

So I'm going to refer your Honours to paragraph 33 of my submissions, just for your reference, and there I have quoted President Cottle – sorry, Gresson in *R v Cottle* and his definition of "disease of the mind" which he described as "a term which defies precise definition and which can comprehend" medical [*sic*] "derangement in the widest sense", and it may be caused by "some condition of the brain itself" so as to "have its origin within the brain, or whether due to some effect … on the brain" by "something outside the brain".

So the starting proposition is, yes, your Honour, it is a very broad definition as recognised in *Cottle,* but it does have limits, and sane automatism is one of those. It is different, he said, from "[t]he adverse effect" –

WINKELMANN CJ:

But that doesn't tell us anything.

MS HAMILL:

No.

WINKELMANN CJ:

Well carry on, yes.

MS HAMILL:

It is different from "[t]he adverse effect upon the mind of some happening", such as "a blow, hypnotism, absorption of a narcotic", and "extreme intoxication all producing … effect" that is "more or less transitory", and which "cannot be … regarded as amounting to or producing 'disease of the mind'".

And the reason for the breadth of that – that definition, the Courts have said, is because of the imprecision, and here I am referring to para 34 of my submissions, "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'", and "this is accomplished by adding the 'legal or policy components' to the enquiry". So it is not a medical definition only, it is a legal definition, and it does take into account broader social objectives as well as medical science.

So in answer to your Honour's question it is potentially perambulatory and it is a legal and social-based test.

WINKELMANN CJ:

And medical.

MS HAMILL:

But it is also medical, and in *R v Chaulk* [1990] 3 SCR 1303, the 1980s decision of the Supreme Court of Canada, the Court talked about the rationale for having an insanity defence and it was, I think, also what your Honour expressed, Justice Winkelmann, earlier, which is that people who suffer a particular condition internal to them, they may commit criminal acts but because they are not doing so in the kind of state of conscious and rational autonomous choice

that the law recognises is what criminal sanction ought to attach to, because that is not a feature for them they should be taken outside of the criminal law and not punished by way of a conviction and a sentence, instead –

KÓS J:

That's true of any automatic state.

MS HAMILL:

It is, and in the case of insanity what it comes down to is that it is an internal condition experienced personally to the accused that has led to this state of incapacity. That's what is recognised by insanity.

KÓS J:

Can you offer any justification for the distinction other than the ability to treat, because there are different consequences of an acquittal on the basis of insanity?

MS HAMILL:

The rationale frequently put forward, particularly earlier on by the courts, was that a person who has a capacity to repetitively perform these acts is at risk of doing them again, and so if they are not subject to a particular insanity verdict then there is no means for the court to have any oversight over their treatment. So that is one of the fundamental rationales that apply.

KÓS J:

Is there any other rationale? It's the only one I can see.

MS HAMILL:

That is the central rationale for the distinction.

KÓS J:

Right, so we've got to the point of it. That's the point.

MS HAMILL:

Yes, whereas in the cases of sane automatism, like I said, it is effectively an accident, a random event, that could happen to anybody. It's not about your internal make-up as a person and what it is that incapacitated you. It's about something that could happen to anybody.

Now again, the distinction in medical science might not be quite so easy to draw because anything that causes a state of unconsciousness is, has a degree of internal component and that was one of the things that the majority in the Supreme Court of Canada in *Stone* recognised in essentially attempting to do away with labouring under the internal and external cause theory, as they put it, and instead taking a more holistic approach and they saw the key there, which is not being advocated by the Crown, but they saw the key there as just making the reverse onus the same across both sane and insane automatism.

1300

WILLIAMS J:

It would make life a lot easier.

WINKELMANN CJ:

Is it really that problematic to frame it in medical terms because I'm sure once upon a time, when the M'Naghten rules were brought in, it was directly connected to mental illness and the question was what level of mental illness would be allowed to excuse, in the section 23 insanity defence sense excuse, offending? So it wasn't that you just put anything in there that society might want to manage. It was that it was for the mentally ill.

MS HAMILL:

Yes, and the breadth of the definition is not necessarily contrary to defence interests if the defendant wants to run an insanity defence. For example, the condition of arteriosclerosis has been included as a disease of the mind because of the way it has an impact on the brain, and that is a relatively broad concept of "disease of the mind" but if –

WINKELMANN CJ:

So it probably captured mental illness and degenerative diseases of the brain, I suppose, because it was put more broadly than – or it may just be archaic language and I'm sure that Professor Brookbanks would know the answer to this. But it's still linked. What I'm asking you, I suppose, is whether it's open to the courts to just expansively interpret it.

MS HAMILL:

Well, the expansive interpretation is one that, for starters, has been around for an awfully long time, as *Cottle* recognised, but the second is not necessarily contrary to the defence interests if the defendant is putting forward a condition that can broadly be captured as a "disease of the mind", putting aside questions of automatism and levels of consciousness.

KÓS J:

Yes, that's great, but if they can't put forward something that qualifies as a disease of the mind, and it's internal and recurrent, then they have no defence because they don't qualify for insanity because it's not a "disease of the mind", but it's internal and recurrent so it has to be treated as insane automatism. They don't have the remnant defence under section 20 of automatism in that context even though they are just as unconscious and just as lacking in volition as the person who suffered the "disease of the mind". It's the gap that's the problem.

MS HAMILL:

Well, the gap is not made much better, just to offer this observation, by restricting "disease of the mind" to a serious mental illness either.

KÓS J:

No, I accept that.

MS HAMILL:

The more –

GLAZEBROOK J:

Isn't there not a gap under the Crown submission because the Crown submission would be if it's internal and subject to recurrence then it would be a "disease of the mind" in that broad sense that it's been interpreted in the cases for years and that otherwise you'd have sane automatism and that would then just go in terms of voluntary or not voluntary?

MS HAMILL:

As they work at the moment there is essentially a symbiosis between the two. Where one operates the other does not and vice versa for the vast majority of cases. So if a condition, when it – you offer your condition. If your condition is recurrent and it poses ongoing risk of harm and it has some kind of internal make-up then it will be an insanity defence because it will qualify as a "disease of the mind" but if it falls outside of that in the sense that it has a hidden impact on your cognition to the extent where you don't know what you're doing but it's an external factor that brought it about then you may offer a sane automatism defence.

GLAZEBROOK J:

So there isn't a gap, that's what I'm suggesting because it's either sane or insane and if it's insane there's a "disease of the mind", if it's sane there's not.

MS HAMILL:

Yes.

GLAZEBROOK J:

And it just comes under the normal defence with the Crown having to disprove intent or voluntariness.

WINKELMANN CJ:

I'm just looking at the time and I'm also just looking at the question trail. When you look at the question trail it does seem to me the factual issues are there. The real issue is the burden of proof?

MS HAMILL:

Yes.

WINKELMANN CJ:

So anyway, we'll take the adjournment. Are we doing okay for time? We'll stop harassing you so much.

MS HAMILL:

Not at all, your Honour, and yes, we are doing okay for time.

COURT ADJOURNS: 1.04 PM

COURT RESUMES: 2.18 PM

MS HAMILL:

I just want to start back by picking up again on that issue of consciousness as being a point of distinction between automatism and insanity, and if I can just quote a passage of the evidence in this trial which was – can be found at page 239 of the case, Court of Appeal evidence bundle, but I'll just read out the salient passages to the Court as well.

And this is in answer to cross-examination given by Dr Fernando about states of consciousness, and he says in answer to the proposition that one of the witnesses, the former partners of Mr Cook thought he was awake at the time of the act, he says: "If she says that he was awake that's her perception if she was awake but talking about the dichotomy, 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 meaning some people can be perceived as, I know they're awake because they're mumbling but" actually now they're "moving into" the state "of unconsciousness and the problem with parasomnias in general", and he goes on to describe that people have different perceptions about what sleep and wakefulness looks like.

And the purpose of reading out that passage is again just to illustrate the difficulty with pinning the colours to the consciousness mast in drawing the distinction.

1420

Another way the point could be illustrated is by taking a different example of what might be categorised as sane automatism, which is the effect of an intoxicating or anaesthetic drug. That was – reference was made in *Cottle* to that kind of example. And so for example when someone is coming out of a state of anaesthesia, acts might occur, or a sedative state, people might perform acts that they're not particularly consciousness of – conscious of at that time, but nor can they really be said to be completely unconscious. In fact, at that point in time they have moved into a state of consciousness, but it's a clouded state of consciousness.

That again aligns to the fact that in medical science there isn't really this rigid distinction between the idea of comatose unconsciousness and then different levels of consciousness. That's the distinction medical science draws, it's not quite the same as the one drawn in law.

All of these points are made to illustrate the difficulty with simply advancing a theory or a distinction between consciousness levels as a means to distinguish between sane and insane automatism, and again it's a problem that comes in part down to the fact that the idea of sane and insane automatism are legal constructs rather than medical ones, and so what goes into that test, that legal test, is informative as to how the line should be drawn.

And that comes back to our discussion earlier about what comprises a disease, the disease of the mind as a concept and what falls out of it, and there I return to my remarks made earlier about *Cottle* which was to say that it is a necessarily broad test that can take account of medical or mental abnormalities in a wide sense, but that draws the line based on other factors, including in particular whether it was a condition that can be said to be internal to a person and whether it therefore also carries a risk of ongoing repetitive conduct, and those

are judicial policy considerations and they're ones that take into account factors that aren't just simply medical, they also take into account other factors such as risk to the public.

So take Mr Cook's example, if he has a recurring pattern of sleep disorder that means he will have sex with people in his sleep, and on one witness's evidence it could be nightly, then Mr Cook could find himself in the position of pleading sane automatism at a criminal trial repetitively with the consequences of simply going free, and that is the conundrum that the internal/external and risk of recurrence tests somewhat seek to grapple with. So they are crude perhaps on one level, but they also recognise legitimate social purposes in terms of the consequence of these kinds of conditions.

And that is where it is very difficult to simply rely on medical ideas of what mental illness might be or what states of consciousness might be, because the test for the Courts is more than simply that.

WINKELMANN CJ:

Yes, but my point which I go back to I think is that the test, section 23 was connected to the medical and I'm asking if it is okay for us just to carry on developing what's the statutory test as a matter of judicial policy?

MS HAMILL:

Well you would be following in the footsteps of a long line of authorities if your Honours did do so, and the basis is again by focussing on the gateway of disease of the mind and what that means for a person's defence.

So if the defence is "I have a disease of the mind that has caused this conduct" and there are these other factors that the Court takes into account, then that is dealt with along one path, as opposed to "I had an accident, something random happened to me that could happen to anybody", that is sane automatism, that's the distinction that is drawn. And on those, that analysis your level of consciousness isn't really an issue, it's more as the House of Lords in *R v Sullivan* [1984] QC 156 I think it was put it, you just don't know what you're

doing, that's what that question is, that part of the test, the section 23 test can be seen as posing, the incapacity to understand the nature and quality of your acts can amount to simply not knowing what you were doing, which is another way of looking at sane automatism – or, sorry, looking at automatism as a concept.

WINKELMANN CJ:

I suppose there's – it's not just divorced from the medicine, it's actually divorced from how anyone would read that test and there is a, you know, a rule of law implication in that, isn't it, when the judicial construct gets so far removed from what the plain words of the statute say, access to justice, people don't know what the law is by reading the section.

MS HAMILL:

The words are undoubtedly very old-fashioned and there's been repetitive criticism of the wording.

WINKELMANN CJ:

But they do, nevertheless, convey something wrong with your mind.

MS HAMILL:

Yes, and in Canada, interestingly, the way that that has been approached is to redefine the test as mental disorder, a plea of mental disorder, not guilty due to mental disorder, but mental disorder is then defined in the Canadian Code as disease of the mind. So the Canadians have adopted an approach –

WILLIAMS J:

Well that's helpful isn't it.

MS HAMILL:

That's right.

KÓS J:

This is the gap point that I was worried about before. If we have a person who is, let's assume, unconscious at the time of the commission of the offence, while – and it's an internal source, are they then going to face an argument from the Crown that what appears to be insane automatism actually isn't insanity because it's not a disease of the mind? That's the gap. Or is there or isn't there a gap?

MS HAMILL:

So as I think your Honour Justice Glazebrook observed, on the current settings there is no gap.

KÓS J:

Right.

MS HAMILL:

Whereas there is a risk of gaps occurring when these parameters are adjusted and that is a difficulty as recognised by the Law Commission in 2010 when it looked at this issue, and it looked at modernising language in particular.

WINKELMANN CJ:

So why is there no gap?

MS HAMILL:

Because if we just work through –

KÓS J:

If it's internal it's treated as insane automatism.

MS HAMILL:

Yes. If you –

WINKELMANN CJ:

What if it's the case I mentioned where it's, if it's the first occurrence, say it occurs in the first occurrence on your analysis it wouldn't be caught by the section.

MS HAMILL:

Well the difficulty that that scenario encounters is that it may not be possible to find an expert who is prepared to say you have sexsomnia, so that might be more of an evidential threshold problem than an availability –

WINKELMANN CJ:

Well there may be witnesses who can confirm information which suggests that the person was asleep.

MS HAMILL:

Well in that case you might find that what you're talking about is a pattern of sleep disorder behaviours that make it not your first time. So it could not be your first time of full-blown sexual intercourse in your sleep, but you might have a pattern of sleep behaviours that an expert would be prepared to say, form the basis of a potential diagnosis of sexsomnia.

WINKELMANN CJ:

But it could be the case that you were meant, your first presentation of mental illness leads to your serious offending, and we've had that in New Zealand's criminal law, where the first time everyone knows someone's mentally ill, anyone knows someone's mentally ill, is through criminal offending, but that wouldn't meet the test. It just seems to me that, you know, the recurrence is not a particularly good test. It's something I'm sticking on.

MS HAMILL:

If you could just allow me a moment just to just confirm something with Professor Brookbanks before I answer your Honour's question… What I was just attempting to confirm with Professor Brookbanks before I spoke out of turn, is that not all instances of diseases of the mind being put forward such as,

for example, paranoid schizophrenia, the formulation of that doesn't necessarily turn on this risk of recurrence because they are self-evidently, the way, the place the Court has got to is that these are serious mental illnesses that it has no difficulty as recognising as a disease of the mind. The issue with recurrence appears to primarily feature with this distinction to be drawn where, between sane and insane automatism, or cases more of that nature. So it's not something that will always arise in every case.

WINKELMANN CJ:
On the peripheries.

MS HAMILL:
Yes.

WILLIAMS J:
It does seem to be muddling the evidential question, whether there's enough of a factual basis to advance the proposition, which you'll almost always need some prior evidence of, or experience of, except in the *Parks* case, where there's a sentinel event in the life of the person, could be very, very rare.
1430

MS HAMILL:
Yes, and that is sometimes the case for those psychological, for the parts, obviously not strictly speaking a psychological blow case, but for the psychological cases that can be part of the framework. Those are difficult cases. They are cases where the distinction is drawn between a degree of burden an ordinary person would be expected to bear, and one that an ordinary person would not expect to bear, the latter being an example of sane automatism and the former being an example of insane, and those are difficult cases that throw up difficult propositions.

WILLIAMS J:
It's the problem with having fundamentally different tests that prove, depending on what these things are which exist on a fuzzy spectrum in fact.

MS HAMILL:

Yes, and the answer to that question was specifically answered in *Stone* by the majority by saying let's just do away with the distinction inoperative parts and take a holistic approach to the question, which is to say, we do look at the cause. We look at the internal factor, as they put it, and we look at the risks of recurrence, but we also look at other things like would the criminal justice system be brought into disrepute if someone got a complete acquittal as a result of pleading their condition.

WINKELMANN CJ:

Well that's really picking up section 23 and using it for policy purposes, isn't it. Taking that –

MS HAMILL:

That's right, and that's –

WINKELMANN CJ:

It might be unmooring it from its original statutory…

MS HAMILL:

Well I'm not suggesting the Court should adopt the *Stone* approach, specifically speaking, but it is an example of what the Courts elsewhere have done in response to these particularly thorny issues such as that.

WILLIAMS J:

The experience is that whether you treat is as an evidential or persuasive burden doesn't seem to make much of a difference to the results, because juries are pretty competent dealing with this. No matter what the lawyers argue about in apex courts all over the common law world.

MS HAMILL:

Well I think perhaps it's a good point to come to what the juries might be asked to do when they're dealing with it through the two different means, so take for example, just for a moment, a different proposition like the anaesthetic one.

If the defence is, I indecently assaulted the surgeon because I was coming off the effects of an anaesthetic drug, the evidence before the jury is likely to be expert evidence about the effects of the drug, and that it can cause this kind of disinhibited effect and so on, and that a person wouldn't necessarily be particularly aware of what they're doing. It's not necessarily going to be evidence about the defendant themselves, it's about the effect of the drug on what could be anybody. It doesn't require a diagnosis as such. When you are talking about external events, that's – in a way what you are talking about, you're talking about something happened to me that could happen to anybody, and so your evidence is probably going to be something along those lines. This thing happened, and it can have this effect, and I was – the jury, their exercise will be to look at, well when did it happen? It happened five minutes after they came to, or it happened the next day and after they had 18 beers, probably not the sedative drug effect. So the jury are able to assess that within their common experience, and they're able to assess that with aid of the expert evidence, and they're also able to assess it without necessarily requiring some information about the defendant that's very personal to their internal makeup. It's an external event that happened to them.

When you're asking the jury to determine what can be made of sexsomnia, you are asking them not just to understand that sexsomnia is a phenomenon that's out there and could apply, maybe, to a sleeping person. That's probably not what you're going to ask the jury to decide. You are asking them, you're putting evidence before them that says, I have this condition. I could have had this condition at the time of the offending. That's effectively the exercise that needs to be undertaken, and the reason for that is that sexsomnia on the evidence of people like Mr Cook, is that it is an internal condition. It's a sleep disorder that he experiences. So he has to put evidence to the Court along those lines. That is, this is something I experience, and that's a different conceptual question that the jury are then being asked to assess, to just did I take a sleeping pill that has that effect that can make me experience a one-off episode of sexsomnia. It's quite a different proposition.

Then looking at that along the insanity framework, in my submission, it actually fits very well within that framework because that is essentially what the jury are being asked to determine in the context of an insanity defence. Those are the questions for the jury "does this person have a disease of the mind?" translates as it did in the question trail as "does this person have sexsomnia?", and if they do, was it operative at the time?

So, just conceptually when you're asking the jury to rely on a condition internal to you it fits better within that framework. And here I want to take the Court to a case that was filed in a supplementary bundle which hopefully the Court will have before it, *Foye v The Queen* [2013] EWCA 475.

WINKELMANN CJ:
Sorry, what was the case?

MS HAMILL:
Foye, F-O-Y-E. I have hard copies if there are –

GLAZEBROOK J:
I don't seem to immediately have that.

WINKELMANN CJ:
I can't see – no, I don't seem to have it.

GLAZEBROOK J:
Oh hang on, yes I might, sorry.

KÓS J:
It's called "supplementary".

WILLIAMS J:
It's in the J drive.

GLAZEBROOK J:
So what was it again sorry?

O'REGAN J:

Yes it was, it was emailed to us yesterday.

WILLIAMS J:

It's supplementary Crown bundle, it's in the J drive, yes.

GLAZEBROOK J:

Yes, I saw that.

WINKELMANN CJ:

Oh yes, I see it, mmm.

GLAZEBROOK J:

It was just "supplementary" on mine without thing.

WILLIAMS J:

Yes, there's two cases in it.

WINKELMANN CJ:

Yes, got it. Be useful if it was in the authorities file, wouldn't it.

GLAZEBROOK J:

So which one are you taking us to, sorry?

MS HAMILL:

Foye and paragraph, starting paragraph 35 of the judgment, which is page 13 of it. If I can just confirm that the Court does have the case before it?

WINKELMANN CJ:

Yes, we got it.

MS HAMILL:

Thank you. So this is a case concerning diminished responsibility, which in the UK carries the same reverse onus, and here the Court was essentially considering a similar issue which is the rationale for having a reverse onus

attached to diminished responsibility, and in paragraph 35 and also paragraph 36 the Court sets out essentially what could be called forensic or legal reasons why the reverse onus is workable and necessary in the context of that kind of defence, and it draws an analogy with insanity too.

And the point made by the Court there, and I'll let this Court also have an opportunity to read it, is essentially that a difficulty arises in cases of insanity which have to do with a person's internal condition where if they simply offer that as a mere prospect there is an inherent difficulty that arises in the Crown disproving that beyond reasonable doubt. And it's not just a conceptual difficulty, it's also a practical difficulty because the Court – the defendant is not required to submit, for example, to a Crown psychiatrist for further analysis. The defendant's not required to produce medical records for the Crown to scrutinise, and in the *Foye* Court's view, nor should it be required, nor should the defendant be so required.

WILLIAMS J:

But –

MS HAMILL:

What this means is that the defendant is left in a position where this is information that only the defendant really has control over and knows about, his or her own internal mental state, and that, first of all, lies for the defendant to put forward as by way of a defence, but it also is available to the defendant to only take it so far and stop right there, to just put the proposition out there and leave the Crown in a position where it really lacks the means to disprove it.

WILLIAMS J:

That's not how it'll work out in reality. I mean, if you're running an automatism case and you refuse to submit to a discussion with a psychiatrist then you don't take anything further.

GLAZEBROOK J:

It's not that easy to hear you, so I'm not sure… Yes.

WILLIAMS J:

Oh sorry. That's not usually the case with me.

GLAZEBROOK J:

No.

WILLIAMS J:

In theory that appears to be the case but we're dealing here with juries who are inherently sceptical about these things and all of the experience across all common law jurisdictions, as far as I can see from the research, they're not going to be – they're going to need some convincing, and if the defendant doesn't want to play ball they'll be found guilty. I mean, we can trust juries to get that right. The lawyers don't have to take over.

1440

MS HAMILL:

That may be so in many cases but it will depend on the facts and it will also depend on the evidence available to the jury and the point made in *Foye* is that the reverse onus really operates to ensure that sufficient evidence is before the jury by requiring it to be proved to a certain threshold.

WILLIAMS J:

Sure, but in the areas where there isn't a reverse onus and the knowledge is in the mind of the defendant and in any context that might be relevant to what's going on in the mind of the defendant, we don't have this problem.

MS HAMILL:

We don't but we don't rely on medical evidence necessarily to establish that in a diagnostic way. So the two examples that come to mind for me are self-defence with a subjective component and honest belief in the context of indecent assault.

WILLIAMS J:

Yes, in rape.

MS HAMILL:

And both of those can be advanced without the defendant necessarily having to give evidence and can be advanced just on the evidence available as part of the Crown case, and if it is advanced it is essentially the defendant saying: "This is what I thought," and the jury – those kind of factual scenarios are well within the jury's experience so they can assess that without necessarily needing expert evidence and it doesn't require them to reach a determination on whether or not someone has a condition or anything like that. It doesn't go to their psychological make-up. It just goes to: "In this fact scenario this is what I believed. Do you think that that's made out?" Here, the jury aren't being asked that kind of question. They're being asked to determine whether or not someone has a particular condition and, if they do, is it operative.

WILLIAMS J:

Yes, but the evidential burden really does mean something. It's not a form-filling exercise.

MS HAMILL:

It's not but it –

WILLIAMS J:

If you don't get this issue in the case up and running, the jury's not going to give the argument much oxygen, is it? That's our experience.

MS HAMILL:

It may be hard to disentangle that though from the fact that the reverse onus does apply. So, for example, in this case there was quite a lot of evidence before the jury but it was in the context of a reverse onus. If we –

WILLIAMS J:

But even on the reverse onus these cases fail in the vast majority of instances.

MS HAMILL:

Well, lacking the statistics and the ability to do an analysis of that I'm reluctant –

WILLIAMS J:

But there is statistical material in the authorities that were provided that shows that whichever way the onus sits the result is roughly the same across all 50 American States, Canada, and I'm not sure whether it was Australia, but certainly American states and Canada. It makes no difference.

MS HAMILL:

Well, the onus across virtually the entire common law world is the reverse onus.

WILLIAMS J:

But not in the states. It's a mix.

MS HAMILL:

It was not. It's still a mix but it is the vast majority now, as I understand it, and again I'll look at Professor Brookbanks so he can shake his head vigorously if I'm wrong.

WILLIAMS J:

Well, I may have misread the material but the impression I got from the research was comparing the no reverse onus states with the reverse onus states produced no material difference which suggests that juries have got this.

MS HAMILL:

Well, two points about that. One is that America shifted its onus following the attempted assassination of Ronald Reagan where those states that had experienced law reform and removed the reverse onus promptly put it back because of the public outcry with the – essentially in the opposite direction which sometimes attaches –

WILLIAMS J:

That's not really helping you, is it, because you're talking about actual non-reverse onus states and –

MS HAMILL:

Yes, so what I'm talking about is the point is that there was a moment when the US departed from that. It now has brought that back in line and virtually everywhere the reverse onus attaches. It does in Australia, the UK and Canada.

WILLIAMS J:

But again that doesn't help you because the evidence is that where there is no reverse onus the outcomes aren't materially different.

MS HAMILL:

Again, I would be reluctant to make submissions about that because I do not have the information before me. However –

WILLIAMS J:

I may have got that wrong but I was reading it late last night, so…

MS HAMILL:

And I'm not seeking to directly contradict your Honour but, like I said, I'm not in a position to make submissions.

WILLIAMS J:

Sure, okay.

MS HAMILL:

But one thing I would say is that there are many forms of insanity defence and sane automatism. The classic example of sane automatism was a swarm of bees. That's got an obviously entirely different fact scenario attached to it than a paranoid schizophrenic who doesn't appreciate right from wrong. So the spectrum of insanity cases, I think, makes it quite hard to draw bright lines from a statistical analysis about what the reverse onus might mean to juries. There might be some cases where it really fails to have any significance because the issues are so stark before them that one way or another you would be looking at making a finding firmly in one direction or the other. There may

be cases where it is more marginal. Sexsomnia is a defence that has been on the rise in recent times. There's been journalistic articles about the fact that it tends to get run more and more these days, and –

WILLIAMS J:

Does it tend to succeed is the question?

MS HAMILL:

It can succeed, as I recall the article saying, but again I'm reluctant to give evidence from the Bar.

WINKELMANN CJ:

Well we've looked at our case law though.

MS HAMILL:

Yes, so that's why I'm reluctant to take this issue particularly far, is that I don't, I'd prefer not to –

WINKELMANN CJ:

We haven't done a major analysis. So we probably need to let you get on with your submissions.

MS HAMILL:

Yes, thank you your Honour. I'm working my way through them, so don't…

WINKELMANN CJ:

We shouldn't be too anxious then.

MS HAMILL:

Don't be too anxious.

WINKELMANN CJ:

Or perhaps I've lost where we're at.

MS HAMILL:

Where we are now at is a discussion of the rationale of the reverse onus, and that's the purpose –

WINKELMANN CJ:

We're with *Foye*?

MS HAMILL:

Yes of looking at *Foye*. So I've covered *Foye*, which is probably the best articulation of the specific practical and legal issues that arise in the context of a defence that turns on a person's mental state. These are also issues that have been dealt with by the Canadians in *Chaulk* and also in *Stone* which picked up on some of the comments made in *Chaulk* and there the Court was considering it in the context of the presumption of innocence for the purpose of their Canadian Charter of Rights and Freedoms, and they took the position that it did prima facie limit the rights by a majority ruling, but that it was essentially a necessary function of the law because of the difficulty that I already articulated through *Foye* with the defence being able to raise this issue, and the Crown being in a position of having to disprove it beyond reasonable doubt, but lacking the means, essentially, to do so.

WILLIAMS J:

It's in that context that Justice Wilson said: "Well if you look at the surveys, there is no problem here." She was relying on the American material, saying you're making up a problem. Juries don't have the difficulty you're suggesting they might have, and the world won't end. I think that was her point.

MS HAMILL:

I see. Thank you your Honour. Now while it hasn't been expressly dealt with here the Court in *Cottle* did pick up on a comment made by the English Court in *Hill v Baxter* [1958] 1 QB 277, which was effectively to the lines that insane automatism/sane automatism can get very blurred at the meeting point. There are cases in which the distinction starts to become incredibly blurred, and there the Court in *Cottle*, this was Justice Gresson, made the observation

without taking it any further, that it would make sense, like the *Stone* court has now done, to have the same evidential threshold attached to both questions, given how similar they were. But in light of *Woolmington v DPP* [1935] AC 462 (HL) the Court took it no further. *Woolmington* itself is an express recognition of the reverse onus being an exception to what it otherwise calls the golden thread in the criminal trial process. The Law Commission too in –

WINKELMANN CJ:

Whereabouts are you in your written submissions?

MS HAMILL:

I am in the section that deals with the New Zealand BORA, I'll just bring your Honour to the specific paragraph.

WINKELMANN CJ:

Okay, I understand where you are then.

KÓS J:

Round about 87.

MS HAMILL:

Yes, thank you your Honour. So I'm really just working my way through these points. The reason why I took your Honours in particular to *Foye* was because that wasn't set out in quite so much detail in these passages. But finally to refer to the Law Commission, it essentially recognised similar issues, as I've already articulated in *Foye*, those being with the difficulty of the Crown disproving beyond reasonable doubt a person's mental state when they put it in issue absent a burden of proof.

The other point made by the Law Commission was the relationship with Criminal Procedure (Mentally Impaired Persons) Act 2003, which is a slightly different and quite practical implication issue, which is that as the law currently stands the insanity verdict triggers CP(MIP) and disposition options are available all the way through to a special patient order under section 24 of

CP(MIP) and the Law Commission's point at one part of its report was that this would be difficult to apply if the question the jury had resolved was just someone might have been insane, it was reasonably possible that they were, that has a difficult overlay with the CP(MIP) which can result in their indefinite detention.

1450

The CP(MIP) itself, as a related point, and here I am really speaking to paragraph 90, has a similar standard that applies within the context of fitness to stand trial. So there the Court itself makes that determination and it makes that determination on the balance of probabilities.

So outside of the criminal context, the context of a criminal jury trial that is, where the ordinary burden and standard always lies on the Crown to the highest standard, questions of mental health don't – are capable of being subjected to the burden of balance of probabilities, as the CP(MIP) shows.

And as a related but separate point to address my learned friend's concerns around treatment and treatment availability for a condition like sexsomnia under CP(MIP), as I said, section 24 is in theory available to anyone who poses an ongoing risk essentially to the public, and it doesn't – it does not necessarily turn on that person meeting the criteria of mental disorder in the Mental Health Act. And it is conceivable that if someone for example was a Mr Parks with different evidence, violent, prone to homicidal sleep behaviours that they might qualify for a special patient order regardless of whether they qualify as a mentally disordered person under the Mental Health Act. Conversely, it is likely to be deeply troubling for the public and the courts alike if those people – there is simply no means to oversee them and they are able to avail themselves of a complete acquittal as a result of pleading a sane automatism defence.

I'm going to now turn on that note to my learned friend's arguments in terms of the desire to be able to run that defence, the sane automatism defence, which is where he says that his rights are potentially infringed under both section 25(e) and section 25(c) of New Zealand BORA. And I understand that he has indicated he doesn't take issue with the reverse onus operating where a person

wishes to avail themselves of an insanity defence, but takes issue with it operating or applying a person being forced down that route if they do not wish to do so.

But the question of whether they may offer a sane automatism defence or one under the insanity provisions is a legal question for the Court. At the heart of it, what the defendant is saying is "I want to say that I was not responsible because I have sexsomnia", and then it becomes a question, a legal question for the Court of what that means. There is two issues the defendant must do. First, they must provide enough of an evidential foundation to actually run the defence in the first place, and the second is the question of how it then gets run. They're not being deprived of the ability to say "I have sexsomnia and that was the cause of my offending". The legal question for the Court is the classification question, is it sane automatism because it was an external event and something that could – a one-off that could happen to anybody, or is it a disease of the mind, a disease of the mind that meant that they could – they lacked capacity to understand the nature and quality of their acts.

WINKELMANN CJ:

Well it does change the nature of the defence, doesn't it, because it's – it moves it from a defence, it moves it from a defence which would see you walk free to one where you're subject to the compulsive powers of the state?

MS HAMILL:

Yes, it does. It has – I certainly don't shy away from the fact it has significant implications both in terms of the onus that you must satisfy and the consequences of it, but if it amounts to simply "I should be able to run whatever defence I want", that's not normally a sufficient basis on which to be able to run a defence. The issue is "I want to say that my sexsomnia was what meant that I did not know what I was doing", that's the proposition that the defendant wishes to explore.

And that then triggers the legal question that the Court must determine, which is what is this defence, and the way the courts have always dealt with that is to

consider the classification exercise of “is this a disease of the mind?”, and to do so with reference to the tests that we’ve already discussed. The rationale again for that is that it takes account of not simply the cause of the condition but it also takes account of the other issues, such as does this person need oversight? If the cause is that something happened because of your internal make-up and you could do it again then we need to have oversight of how to manage that. That’s a recurring risk aspect.

But the cause is also relevant not just simply as a sheer social justice issue but it’s relevant because, like I said before, of the way that the nature – the evidence is going to end up in front of the jury. The question that the jury will be asked if it’s about the cause is: “Do I have this condition and did it operate so that I didn’t know what I was doing?” whereas if it that’s not the issue then the question the jury are asked is: “Did this thing happen that made me incapacitated?” and you can’t really say: “Did sleep happen and it made me incapacitated?” More is going on than that. Something else is happening here. It’s a condition, a sleep disorder known as sexsomnia.

WINKELMANN CJ:

Yes, I’m not following the submission. What makes a difference to how it ends up in front of the jury?

MS HAMILL:

What makes a difference is, like I said, the question – the genesis, the cause, means that the way it’s going to be put before the jury is either really properly fitted, it’s the submission I made earlier, within this insane automatism insanity framework, or it’s going to fit properly within the sane automatism framework.

WINKELMANN CJ:

Can we look at the question trail because I found it very instructive to look at the question trail?

MS HAMILL:

Yes. I have it before me if your Honour had anything particular you wished to take me to.

WINKELMANN CJ:

No. Well, 260 and 261, isn't it, of the Case on Appeal? So Mr Harrison's submission was that it doesn't really fit what this man is arguing, which is the Justice Binnie point.

MS HAMILL:

So if we can also look at page 256 which deals with the insane automatism direction in more detail, and there it says – it explains essentially the legal concepts to the jury and says what "insane automatism" is and that in this case sexsomnia is a "disease of the mind" as part of his explanation of that, and then it goes on to set out what the defence must prove. In my submission, that is essentially what the defendant is trying to say in a case of sexsomnia which is –

WINKELMANN CJ:

Yes, I must say I think this question trail is more helpful because he breaks it into a factual thing, doesn't he? He says, on the issue of intent, the first question – at 2.1.

MS HAMILL:

Yes.

WINKELMANN CJ:

Right.

MS HAMILL:

And again in the Crown's submission those questions ask the appropriate questions of the jury.

WINKELMANN CJ:

And you say they fitted his defence. They said to him effectively your defence is not complete and you bear the onus. They fitted what he was saying. It's just he had to accept the legal classification.

MS HAMILL:

That's right.

WINKELMANN CJ:

People always have to accept the legal classification.

KÓS J:

They'd have some difficulty at 256 though, the middle of the page: "In this case, sexsomnia is a 'disease of the mind'", and the next paragraph requires the defendant to prove on the balance of probabilities that he was unable to understand the nature and quality of his actions. So you have both a statement it's a "disease of the mind" and then a pregnant issue as to whether actually he meets the requirement for insanity.

MS HAMILL:

Is your Honour referring still to page 256?

KÓS J:

I am.

WINKELMANN CJ:

So effectively they're being directed it's a disease of the mind and then they're being asked to find if it's a disease of the mind.

KÓS J:

Exactly.

GLAZEBROOK J:

I don't think so. They just say was he suffering from sexsomnia at the time.

WINKELMANN CJ:

So 256.

MS HAMILL:

Yes, so your Honour's correct. It comes together at 260, so the earlier 256 is explaining the nature of the test and explaining the concepts to the jury and telling the jury that in this case sexsomnia is a "disease of the mind" because that is how it's so classified. So then the issue for the jury in the question trail proper shifts to, did he have sexsomnia.

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WINKELMANN CJ:

It's the second question, I think, which seems to take you back into the –

MS HAMILL:

It does, and that's – but that's in a definitions –

O'REGAN J:

That's what section 23 requires, though, it has to be a disease of the mind that causes you to be unable to understand?

WINKELMANN CJ:

Which doesn't really – in 260 they don't – he doesn't really take you into that, does he?

MS HAMILL:

No, he puts it more directly.

WINKELMANN CJ:

Mmm.

MS HAMILL:

And I would submit that the questions asked of the jury in the question trail do reflect the nature of the defence. It –

GLAZEBROOK J:

So unlike in those Canadian cases, the jury couldn't decide he wasn't suffering from a disease of the mind if they found that he was suffering from sexsomnia, because some of the Canadian cases say, well, the jury might've decided he wasn't suffering from a disease of the mind. They can't do that. They can decide he wasn't suffering from sexsomnia.

MS HAMILL:

Yes, yes, that's right.

GLAZEBROOK J:

Or that if he did suffer from sexsomnia it wasn't an operative course, if you like, of the offending?

MS HAMILL:

Yes.

GLAZEBROOK J:

They would be both open to the jury.

MS HAMILL:

Yes, yes, it's the Court's job to classify it and decide if it is a disease of the mind with the purpose of going to the jury. It's the jury's job to decide if he actually has the condition.

And that brings me to another point made by my learned friend, which was that there ought to be evidence from the experts, he says, about classification and whether or not it is a disease of the mind, and that that ought to be something – but that was something that was lacking here, but that is not something that the Court has tended to require in cases like this, and I'll just pull up a reference in *Cottle*, and here I'm referring to – I'll just read it to your Honours, it's very short, I'm referring to page 2 – 1029. The Court said it is the medical doctor's "business to describe the condition of the prisoner, and it is the business of the Judge to rule whether that condition, if it existed, is capable

of being regarded as a disease of the mind". And that's a comment that the courts have typically made of the process, it is a legal question, and as I have gone through, it is a legal question that calls on much more than simply a medical classification, it calls on these other social factors that – that is what makes it such a legal question and one for the courts, rather than just purely to be determined by medical science.

So the courts have not tended to require this of the experts. It's not to say that they cannot necessarily offer that opinion in the right case, but it's not a requirement and nor is it something that would be causative of miscarriage of justice in this case, but that's really a point that I wish to make right at the end of my submissions, which I am not far off.

Before I get there, I just want to touch very briefly back onto the New Zealand Bill of Rights Act, which I understand my learned friend to not, not necessarily be deploying across the board to section 23 of the Crimes Act but only to those cases that wish to stand outside of it, but as I understand that submission, it essentially amounts to "this can infringe my rights so I should get to choose when it applies", and that doesn't seem to be a way to reconcile the alleged infringement or limitation that is advanced, it's just trying to take more cases out of it.

WINKELMANN CJ:

Well he says you shouldn't – it's not engaged when the defendant is invoking it but when the Crown uses – chooses to use it against the defendant, invokes it. No, he's – well, he says that when the Crown chooses to use it, it bears this burden, it's for the Crown.

MS HAMILL:

Well the added difficulty of that is that the law in New Zealand, as I understand it, does not recognise that the Crown can raise the issue of insanity. Here I'm referring to the case of *R v Green* [1993] 2 NZLR 513 (CA), which is cited in my submissions at paragraph 102, footnote 47 [*sic*]. So in Canada the Crown can raise it and there are particular issues around how the Crown may do so, but

the state of the law in New Zealand is that the Crown cannot, the reason being, as I recall from that case, that it's considered unfair for the Crown to be able to seek this qualified acquittal where the defendant doesn't want it and if the evidence doesn't establish – if the evidence is sufficient to establish a sane automatism case instead. The Court can put it to the jury if it is raised on the evidence, and that's provided by section 20 of CP(MIP), but that is a different proposition than the Crown raising it itself.

The traditional position is that if evidence arises as to a mental state it's either evidence of sane automatism or it's evidence of disease in the mind and it can't be both. There are cases at the margins in which it is very difficult to determine one way or the other and in those rare cases it might be that both go to the jury and the jury actually have to decide what it is, but those kind of factual scenarios are not what we're grappling with today.

WILLIAMS J:
Doesn't that suggest it's not a legal question?

MS HAMILL:
What it suggests is that the legal question leaves it open both ways in some very rare cases. Now like I said, I'm raising the point but it's not something that we are grappling with here today.

WILLIAMS J:
Do you see the logical problem with that, that the law's not sure, you decide it as a matter of fact?

MS HAMILL:
Well, they may be, for example, where someone says: "I had a sleep disorder but I also had," I don't know, "a concussion."

WILLIAMS J:
You mean so that it potentially on the evidence satisfies both?

MS HAMILL:

Yes.

WILLIAMS J:

That's the only sort of situation so the –

MS HAMILL:

Yes, that's –

WINKELMANN CJ:

Can you take us back through that more slowly because I'm not sure I'm following you?

MS HAMILL:

Yes. I want to make sure that I don't give submissions without reference to the proper cases so that I don't put your Honours in a position where I'm giving you –

WINKELMANN CJ:

Yes, because you said that was it *Green* that says when the Crown bears –

MS HAMILL:

Yes.

WINKELMANN CJ:

Where's that new submissions…

MS HAMILL:

Paragraph 102. It's on page 29.

WINKELMANN CJ:

Yes, I see it.

MS HAMILL:

Footnote 147. So I've cited the case there and it's in the bundle of authorities.

WINKELMANN CJ:

So in this situation the Court says in relation to a defence that's sought to be raised: "Well, we've looked at this and we've categorised it as insanity"?

MS HAMILL:

Yes.

WINKELMANN CJ:

And the source of that approach to people raising defences is what case? Where does that trace back to, the notion that the Crown can say: "This is a defence of insanity whether you like it or not"?

MS HAMILL:

So the Court says this is a defence of insanity whether you like it or not, and that I believe is in my submissions but I might just need a minute or two to locate that proposition.

WINKELMANN CJ:

It's just I'm interested in the origin source of the…

KÓS J:

Presumably after the Crown objects to it being run on any other basis. It says that what's really being run here is an insanity matter. "You need to rule on this, Judge."

MS HAMILL:

Yes. Well, the Judge would presumably be capable of raising it of his or her own motion too.

WINKELMANN CJ:

I'm interested in its kind of jurisprudential origins, if I can put it that way.

MS HAMILL:

Yes. I'm facing that difficult position where I know it's in there somewhere.

GLAZEBROOK J:

I think it's probably paragraph 25 because you say there's "long recognised a distinction between unconscious behaviour caused by a 'disease of the mind' and that which is not".

WINKELMANN CJ:

That doesn't necessarily say that they can compel a defence into –

MS HAMILL:

No. It has been more explicitly stated.

WINKELMANN CJ:

Professor Brookbanks might know, or is he shaking his head with…

PROFESSOR BROOKBANKS:

I'm afraid I cannot assist with that, your Honour.

WINKELMANN CJ:

Because it seems – I mean because that's really the gravamen of what Mr Harrison is saying which is that, sure, there's all these issues of distinction but I want to say this is not insanity. I've just got a section – I'm in the interstices or…

MS HAMILL:

Here we go. Paragraph 69 and I am looking here at the footnote which is *Rabey v R* [1980] 2 SCR 513, the Supreme Court of Canada decision citing *Cottle*.

WINKELMANN CJ:

So, *Cottle*.

WILLIAMS J:

Para 69 of?

MS HAMILL:

The Crown submissions.

WINKELMANN CJ:

Footnote 107. You would say, well, the Court has to be free to do that because someone can't raise the defence – well, the thing about section 23 is it creates the defence of insanity.

MS HAMILL:

Yes.

WINKELMANN CJ:

So it wasn't enacted to constrain other defences. It was enacted to create it, and you say, well, once it's created it, it makes clear that it's not a – it's created it in limited terms so if you clearly fall between it you only have that limited defence. If you fall within it.

MS HAMILL:

Yes, and it –

GLAZEBROOK J:

But there was a common law defence of insanity.

MS HAMILL:

There was a common – yes, there was.

GLAZEBROOK J:

So it didn't create it. It just codified that particular defence as against any of the other defences.

1510

MS HAMILL:

Yes, yes.

WINKELMANN CJ:

And it's said in these circumstances you have – there are necessary compulsory –

GLAZEBROOK J:

Which supposedly codified the common law, but…

MS HAMILL:

Yes, and there is – there's a conceptual difficulty with putting them both and their different contentions and their different standards of proof, because if you are putting sane automatism first it's hard to see – which it would necessarily have to happen for it because the Crown would not have proved its case, the exercise requires the Crown first to prove its case otherwise you are entitled to acquittal. Disease of the mind or no, you – it's not, there will be no conviction. So sane automatism would have to come first which then would render the insane or insanity question more or less obsolete.

WILLIAMS J:

Well only if you –

WINKELMANN CJ:

Only if you're successful.

WILLIAMS J:

Yes.

MS HAMILL:

Yes.

WINKELMANN CJ:

Only if the jury didn't decide –

WILLIAMS J:

If you're not successful it would – there's still an angle that it's available even when you haven't satisfied the non-insane –

WINKELMANN CJ:

I think insane – yes, insane automatism would have to come first, wouldn't it, because if you weren't satisfied there was insanity then you'd go onto whether it was automatism nevertheless? Well anyway, we don't have to deal with that because that wasn't the – we're not arguing about the order of the question trail.

MS HAMILL:

No, no, we're not. Is the Court satisfied on that, that particular point of law?

WINKELMANN CJ:

Yes, thank you.

MS HAMILL:

Thank you. So just to finish up regarding the Bill of Rights Act and its application, as I said before, the way that these tests operate means that you end up in one route or the other. It's – that's how it happens. It's not – that doesn't interface particularly easily with the idea or the proposition that I just want to select a particular defence, it's the defence that I want to run is sane automatism. It operates because you are putting forward this basic evidence of what –

WINKELMANN CJ:

Your point is it's an inevitable implication of the statutory scheme that –

MS HAMILL:

Yes.

WINKELMANN CJ:

– if you fall within section 23 you must fit within the stat – section 23?

MS HAMILL:

Yes, yes. And the consistency of section 23 with the Bill of Rights Act or the reasonable justification of the operation of the reverse onus is essentially

covered by the same material as what I'd talked about before in terms of the rationale for its application, and that is also set out in my submissions.

So that's really what I want to say in terms of the broader points of law and now I want to move just very briefly to the specific issues raised by my learned friend in this, the context of this trial, unless there's anything that I can assist your Honours with on those other topics?

WINKELMANN CJ:
Go ahead.

MS HAMILL:
I have probably covered a reasonable amount of this material through that discussion. As I said earlier, the issue that my learned friend advanced was that there wasn't opinion from the psychiatrists in this case about whether it was a "disease of the mind" but the law does not require that and so the Crown's primary submission on that point is that that cannot give rise to a miscarriage of justice. Just locating that passage of my submissions.

My learned friend also advanced that the decision in this case was wrong in that it just simply applied *Cameron* as a legal precedent saying that sexsomnia must be sane automatism. The Crown's response to that is that the decision was brief but the context is important. This case had been going on for quite a long time. It was a retrial and *Cameron* loomed large over it, but more to the point the decision, the minute recording the Judge's decision, indicates that this was based on the evidence. The Judge identified that there was risk of recurrence and that factually this was very similar evidence to Mr Cameron. That's not the same as just simply saying: "*Cameron* says that sexsomnia isn't sane or insane automatism so I have to follow it." There was regard to the evidence and in any case whether or not that was a sufficient expression of that proposition this, in the Crown's submission, for the reasons I outlined at the outset of my submissions, was clearly a case that applying the traditional framework fits within insane automatism given the recurrence of it, the nature

of the sleep disorder at the genesis of it and the ongoing risk that Mr Cook posed.

WINKELMANN CJ:

So the Court of Appeal said that there would have to be a case-by-case basis. Is there a scenario in which it's sexsomnia but it's not – but it's sane automatism?

MS HAMILL:

If your case is "I have a recurring habit of doing this", probably not, but if your evidence is "I have manifested this sleepwalking activity that had me having sex in what appears to be my sleep" and it happened for this other reason like, for example, the effect of a drug, then it probably would be sane automatism.

WINKELMANN CJ:

It's interesting, isn't it, because then there would be onus of proof on the defendant?

MS HAMILL:

That would be because the defendant was saying: "Something happened to me," and the evidence would be: "This drug can have that effect, can have that effect on anybody." The defendant in that scenario is not saying: "I have a sleep disorder." So when you're saying: "I have a sleep disorder," and it's got these features attached, it probably will be insane automatism in almost every case, but every case has to be considered on its own facts.

The only other point that I wanted to make, I will just refer your Honours to the fact that the Crown has addressed an order for retrial in its written submissions and won't detain your Honours on that point any further.

But the only other point I wanted to make was the one about alcohol and its impact which your Honour raised at the outset of this hearing and just as a matter of the evidence in this case. The evidence in this case was that Mr Cook had been drinking and so alcohol is discussed by the experts, and there were

really two propositions that Dr Dean put forward in his evidence about the effect of alcohol. One of them was that he described it as "fragmenting sleep" meaning that you actually don't get the good quality sleep that you need after you go to sleep in an intoxicated state, and in that respect it probably doesn't give you the non-REM sleep that you would get, that you would experience the sexsomnia episode in but what it does do is it exhausts you like sleep apnoea does. So sleep apnoea is a trigger because you don't sleep very well and you get more and more sleep deprived and as you get more sleep deprived you get into a state of exhaustion in which you enter that really deep non-REM phase of sleep. So these things contribute but they don't contribute in the sense that this happens and then immediately it causes an episode of sexsomnia, and what's more Dr Dean's evidence was that if you have the presence of alcohol intoxication it can give you all the same symptoms of someone who has a sexsomnia episode. So you can not remember, you can appear to be stumbling and slightly incoherent and you can be disinhibited and make choices that you otherwise wouldn't normally do, such as having sex with an unsuspecting stranger, and for that reason the diagnostic manual suggest that it should not be diagnosed in the presence of alcohol intoxication. So alcohol and its contributing effect in terms of it can cause –

WINKELMANN CJ:

But that's a diagnosis, isn't it, of course, as opposed to a factual finding on the facts of the case?

MS HAMILL:

Yes, that's right. So I simply draw your Honours' attention to that because in this case, as I see it, it's not a case of alcohol equalling sexsomnia in a way that might give rise to the issues that were pitched by the Court at the outset of the hearing.

KÓS J:

I raised the question with Mr Harrison as to fault and the fact you had repetitive events here and some knowledge, at least objectively, of a propensity to this. Do you say anything about that subject?

MS HAMILL:

That is recognised as an excluding factor of the defence in the UK but it is not, as I understand it, resolved in New Zealand. It's left open in *Kamipeli* but the law in New Zealand hasn't explicitly allowed for that prospect. That being the case, it leaves open the possibility that essentially someone could set themselves up to repetitively offend but for the fact they're in an automatic state, which poses again some issues in terms of the broader social policy consideration of ongoing risk.

GLAZEBROOK J:

That would only apply if it wasn't held to come under section 23, wouldn't it?

MS HAMILL:

Yes, that's right. And, of course, as the Court observed at the outset, Mr Cook was on a reasonably significant amount of notice about the fact that he experienced this condition. He just appeared to be in best case scenario denial about it.

1520

I'm just going to speak briefly to Professor Brookbanks before finishing my submissions. … Unless your Honours have any questions those are the submissions for the Crown.

WINKELMANN CJ:

Thank you. Thank you very much, Ms Hamill. Mr Harrison, anything by way of reply?

MR HARRISON KC:

Yes, thank you, your Honour. All I propose to do, your Honours, basically is to make some observations on some of the cases my learned friend has referred to which I haven't yet covered, those will be brief, to address the Bill of Rights challenge submissions and briefly to address the "no miscarriage of justice" submission that relates to what I have called the second aspect of the case.

So if I can take your Honours to paragraph 28 of my learned friend's submissions and 29, she is there referring to the Supreme Court of Canada case of *Chaulk* and the point immediately to be made about *Chaulk* is that it was a pure insanity case. That was what the accused was wanting run, an insanity defence, but his argument before the Supreme Court was that the reverse onus, section 21(1), was contrary to the Canadian Charter and basically the Court split with the majority holding that it was a justified limit in terms of the Charter *R v Oakes* [1986] 1 SCR 103 analysis, the minority saying not, but the discussion at 28 and 29 that's summarised there was occurring in that particular context and if it's read as a whole rather than bits picked out as the submission does, it can be seen that really that's of no assistance to the Court in this case.

In paragraph 31 of the submissions the emphasis is on defining sane automatism. My submission is that the legal issue is not really defining "sane automatism". It is defining the meaning and limits of "disease of the mind" which is the focus and if that is the focus then the observations of Justice Gaudron, with respect, set out in paragraph 31 are unhelpful. It is not helpful, I submit, to decide the issue by reference to normal persons or their assumed experiences, but rather using the analytical tools that I have put forward. Now moving on to paragraph 53 there's –

GLAZEBROOK J:

I'm not quite sure I understand the submission.

MR HARRISON KC:

I beg your pardon?

GLAZEBROOK J:

Well, a "disease of the mind" presumably is something – well, I'm presuming that what's been meant here is that if actions relate from a disease of the mind they wouldn't be actions that would happen to anybody which I think is the point made by the Crown. So there has to be some abnormality to have a disease of the mind. What do you say to that? Do you say that's not right or…

MR HARRISON KC:

It's a necessary but not a sufficient condition of disease of the mind is I suppose what I –

GLAZEBROOK J:

Okay, so what else do you need?

MR HARRISON KC:

Well what I have, what I have argued for which is a serious condition that is capable of being assessed in terms of the overall section 23(2) gateway including the ability to consider the condition in question in terms of the two alternative (a) and (b) categories. So you've got to have a condition which is capable of passing through those gateways. It will be a serious mental condition and if the condition in question or the behaviour in question does not so qualify, then it falls outside. I suppose I'm content to rest on the proposition that parasomnias and sexsomnia in particular fall outside disease of the mind rather than attempting to formulate a comprehensive definition of what does fall in within it.

WINKELMANN CJ:

Because I was going to say, that problem – the problem with how you've just formulated, it would mean – be that it probably would capture sexsomnia because if it's a serious condition of the mind which really – and that's – to determine whether it's a serious condition of the mind you look at the (a) and (b) criteria, then it does tend to fit that criteria.

MR HARRISON KC:

Well no, I –

WINKELMANN CJ:

It's something, something the mind is producing. But your point, your fundamental point is it's a disease of the mind, so something going wrong with the mind?

MR HARRISON KC:

And seriously wrong.

O'REGAN J:

Where do you get “serious” from? Where – what authority is there for the idea that it’s only a disease of the mind if it’s serious?

MR HARRISON KC:

Because you’ve got to be labouring under it and there has to be a consequent incapacity.

O'REGAN J:

But is there any authority – is there any authority that says that?

MR HARRISON KC:

No. I’m – we, but what we have is a completely open-ended, undefined expression which I’m inviting the Court to interpret in its modern-day context.

O'REGAN J:

Well it’s been interpreted since 1843, so it’s not that open-ended?

MR HARRISON KC:

It’s, it is – it’s open-ended and out of touch so it’s got, it’s really got to be interpreted I submit purposively and with due respect for not really protection of – not just protection of society, but also the rights of the defendant to run a defence based on fundamental principle, such as “I lacked conscious volition”. I mean I don’t think I can –

O'REGAN J:

But we – I mean we’ve – there’s a lot of jurisprudence on the *M’Naghten* rules and the statutory equivalence, and what you’re saying is no one has ever said that in order to qualify as a disease of the mind it has to be a serious mental illness?

MR HARRISON KC:

Well with respect, it has been, it has been said in some of the Canadian cases, the judgment of Justice Binnie that I took the Court to earlier, I consider says much what I'm saying. The issue though here is, alright, we have the *M'Naghten* rules and different jurisdictions have made what they can of it, our leading case has been *Cottle* where Justice Gresson was, if I may say so, very perceptive about the problems that the expression disease of the mind and the section posed. He raised concerns about its applicability to a total absence of conscience, consciousness case, said it – there's really no fit there but at one part of his judgment at least he says, well, it's already been ruled on. I'm inviting this Court to go back to basics, apply tools of statutory interpretation, apply a Bill of Rights analysis, apply a purposive analysis, and come up with a different result.

1530

GLAZEBROOK J:

Aren't you really arguing that automatism is – should always be sane, because it's a total lack of knowledge about what you're actually doing?

MR HARRISON KC:

I don't have to go that far and I don't go that far, although I have to say that –

GLAZEBROOK J:

Well – but what I, what I can't understand then is what your distinction is?

WINKELMANN CJ:

Somnambulism would always be sane, sleepwalking would always be sane, sleep conduct would always be sane?

MR HARRISON KC:

Yes, yes. It –

WINKELMANN CJ:

Because it could be that you're an automaton because of some degeneration of your brain, which would be – fit the characteristic completely?

MR HARRISON KC:

Yes.

WINKELMANN CJ:

It would be disease of the mind?

MR HARRISON KC:

Yes, yes. Arteriosclerosis might produce an automatic state, as I understand, but I'm no expert on that. So no, I'm not, I'm not – I don't, as I said, I don't think I need to go that far, but I come back to my focus on the breadth of the concept of disease of the mind and then looking at that in relation to parasomnias. So I don't ask for any wider ruling than that, the Court may feel it has to, but there we are.

So I go to paragraph 53 of the Crown's submissions and I wanted just to mention the case of *R v Luedecke* 2008 ONCA 716, 236 CCC (3d) 317, if we could just look at that. The case is, as is noted, a particular result –

GLAZEBROOK J:

Sorry, I'm not sure what you're –

WINKELMANN CJ:

Luedecke, paragraph 53 of the Crown.

GLAZEBROOK J:

53.

MR HARRISON KC:

Paragraph 53 of the Crown submissions. So we can get to *Luedecke* through footnote 94, for example, but I want to take, take your Honours to paragraph 84.

This is a case said to be – well it's a sexsomnia case and the Court ruled that it was insane automatism, but the reason why it did is because of the effect of *Parks*, even if *Parks* was not a sexsomnia case.

We go to paragraph 84 of the judgment which is – well we start at 80 on page 344 where the Court discusses *Stone* under the heading: "Automatism reconsidered." Then it's summarised and the summary then reaches a point at 84 where the Court is saying that the majority, Justice Bastarache, if that's how he's pronounced or she, "took the position that anyone who committed what would otherwise be a criminal act and led evidence capable of establishing that his or her actions were involuntary was presumptively suffering from a disease of the mind. This presumption fundamentally changes the legal landscape set out in *Parks* where, it will be recalled, the non-mental disorder automatism claim succeeded because the Crown could not prove … the accused's condition constituted a disease of the mind."

Then – so that's – then at 90 to 91, a key passage: "*Stone* alters the approach to … characterisation of automatism as non-mental disorder automatism or mental disorder automatism in at least two significant ways. First, after *Stone* the trial judge must begin from the premise that the automatism is caused by a disease of the mind and look to the evidence to determine whether it convinces him or her that the condition is not a 'disease of the mind.'"

Second, 91: "Second, although *Stone* accepts the multi-factored approach to the policy component of the characterisation of the automatism set out in *Parks*, it refocuses the continuing danger aspect of that approach. After *Stone*, in evaluating the risk of repetition and hence the danger to the public, trial judges must not limit their inquiry only to the risk of further violence while in an" automatic "state. Rather, trial judges must examine the risk of the recurrence of … factors or events that triggered the … automatistic state." So the point is this is a sexsomnia ruling under the strong influence of a decision which, in *Stone*, which is quite contrary to New Zealand law. So the next point I wanted to address is –

WINKELMANN CJ:
BORA?

MR HARRISON KC:
Beg your pardon?

WINKELMANN CJ:
Was it the BORA? Are we moving onto BORA, or are we still in the case law?

MR HARRISON KC:
We're coming to BORA, yes. The – but first at paragraph 61 there's a discussion of sexsomnia and the CP(MIP)A and the question of whether there is treatment for – no treatment for sexsomnia.

I argued that the issue of treatment was not addressed in the evidence rather than making the bold statement that there is no treatment for sexsomnia. There does not appear to be a treatment for sexsomnia so far as the evidence before this Court and before the trial court was concerned.

The – paragraph 62, the reason that there is no or little direct evidence regarding treatment options at the trial is because it was a trial – pre-trial ruling, and the fact that if acquitted on the grounds of insanity there might've been evidence about treatment is in my submission beside the point. The issue to be – which ought to have been addressed, if the risk of recurrence factor is indeed relevant to classification, was the risk of recurrence for this particular defendant, and that is the area where evidence was lacking, in my submission. That's the point of it. Now turning to the Bill of Rights, it's –

WINKELMANN CJ:
Sorry, the issue which ought to have been addressed, if the risk of recurrence is indeed relevant to classification, is whether there was a risk of recurrence in relation to this defendant?

MR HARRISON KC:

Yes.

WINKELMANN CJ:

Right.

MR HARRISON KC:

And that's where the evidence was – well both the general evidence of treatment and risk of recurrence generally and in relation to this defendant, there was no expert evidence addressing that.

So then dealing with the issue of interpretation which is addressed in paragraph 72 of the submissions, the argument around interpretation is met or attempted to be met by the submissions saying at the end of 72 that the legal tests developed by the courts have recognised that the definition doesn't solely concern the defendant's mental state, takes account of the cause and prospect of recurrence. Well that begs the interpretation question by saying that the established legal test should determine it. If there's an interpretation question it ought to be resolved the way I have argued, not by simply reiterating the existing tests which are under attack.

1540

WINKELMANN CJ:

It's not a straightforward thing, is it? It's – your point is – is your point that when the defendant wants to invoke a defence which is not clearly precluded by the words of this legislation you should interpret the words of the legislation narrowly so not to preclude – well, you should interpret the words of the legislation narrowly so as not to close out an otherwise available defence?

MR HARRISON KC:

That's certainly part of the arguments that I'm advancing, yes, and that's a, that's a bill –

WINKELMANN CJ:

That's a fair trial, right to offer a defence.

MR HARRISON KC:

That's a fair trial. And particularly if the defence which is being superimposed on that defendant contains a reverse onus of proof and is otherwise conceptually – and I could add is conceptually unsuited to the defence that he or she wants to run. Now –

WINKELMANN CJ:

You could put it you should not interpret it expansively in order to do that.

MR HARRISON KC:

Yes, I can, and I'm happy with that. So, the issue at paragraph 76 is said to be that the interpretation contended for – all right, no, it's said that medical science doesn't recognise a rigid distinction in consciousness as the law does. It speaks of levels of consciousness rather than binary alternatives with a complete lack of conscious volition or full but delusional consciousness. At several points in the submission we see this formulation of complete lack of conscious volition. It's not a – that is not a test that the authorities support. It isn't an issue of establishing complete lack of conscious volition. It's simply establishing that conscious volition was not present rather than completely lacking. So, it's not as binary as argued for.

Now, the submission at 78 is that, to the extent that we rely on section 55(e), the right to present a defence. That right is really only concerned with procedural matters and does not, as is put there, does not constrain or guide Parliament or the courts in setting or adjudicating on the substantive content of the criminal law.

I don't accept that proposition. I have cited the Court of Appeal decision in *Fahey* at paragraph 21(a), and to the extent that the Butlers are to be relied on, and they are cited in footnote 118 what they say at paragraph –

WINKELMANN CJ:

That's your 118?

MR HARRISON KC:

No, that's the Crown's 118. The Crown is citing the Butlers at 118, footnote 118. If we go to that extract from their text we can see at paragraph 23.7.11 that they say: "Fourthly, the right to present a defence encompasses the right of the accused to conduct a reasonable and proper defence, and to put forward his or her best defence." And the citation is admittedly a District Court case, but I don't accept that the Butlers' text supports the proposition there being advanced. So, we do rely on the right to present a defence, but of course, we also rely on the section 25(c).

Now, there is then learned discussion of how the, whether the limit is demonstrably justified. The *Oakes* analysis is referred to at paragraph 82, and we come back to the Supreme Court of Canada case in *Chaulk* which I referred to earlier being an insanity defence case. Now the passage halfway down page 24 of the Crown's submissions raises an important issue which in my submission needs to be put in its proper perspective. *Chaulk* is saying that – or the majority is saying that the limits on the normal onus and standard placed on the Crown were justified, and I am quoting, because "Parliament wished to avoid placing on the Crown the impossibly onerous burden of disproving insanity".

Now that was also what the Court was saying in the case of *Foye*, which my learned friend took you to earlier. So the message is the – in effect that was the diminished responsibility case. The message is for diminished responsibility and for the insanity defence the reverse burden is justified because it would be an impossibly onerous burden of disproving insanity.

And again it's also said in – that this is because there is no mechanism to force the defendant to submit to any kind of medical or psychiatric examination, hence justified reverse onus because it's unfair on the Crown. Now I've got two responses to that. The first is that – one that's been canvassed more than once

today, it's unreal to, at least in a New Zealand context, to suggest that a defendant could get away with raising non-insane automatism but not putting forward, not putting himself forward for psychiatric evaluation.

I've dealt with this in my submissions at paragraph 22 where I referred to the well-established requirement that a defendant must lay a proper foundation. It's also in footnote 20 where I cited from Justice Fisher in *Bannin* saying that "independently verified evidence" would be required.

And can I add to those citations the case of *Falconer* which is among our authorities. It's authority number 15 where the printout is – unfortunately the printout is difficult to navigate but it's – at, in *Falconer* it's at page 33 of the printout. I'm not sure where it is in the report. It's a page that for some reason has a handwritten "299" at the top.

What is said there at 299 or page 33, second paragraph beginning: "The evidentiary presumption of voluntariness," second sentence: "In practical terms a claim of involuntariness which is not based on mental illness is almost certain to be treated as frivolous unless supported by medical evidence that identifies a mental state in which acts can occur independently of the will, assigns a causative explanation for that state and postulates that the accused did or may have experienced that state," and then there's a reference to Lord Denning in *Bratty*.

1550

So the first point about the unfairness of placing an impossibly onerous burden or just proving insanity is, as I think your Honour, Justice Williams was putting to my learned friend, that ignores the practical reality of these cases. The second point is more fundamental.

WINKELMANN CJ:

Although you don't dispute that it's a justified burden in terms – or you're not challenging because it's not even –

MR HARRISON KC:

Yes. The second point is the more fundamental one which is, in my argument, doesn't place that burden on the Crown anyway.

WINKELMANN CJ:

How so?

MR HARRISON KC:

The only feature of my argument as advanced is that if the Crown alleges that a lack of volition defence is a "disease of the mind" it then carries the burden of rebutting that presumption, the presumption to the contrary.

WINKELMANN CJ:

It will still have to exclude the reasonable possibility though, won't it, of sane automatism, so it does place that burden on the Crown?

MR HARRISON KC:

It places a burden on the Crown of proving beyond reasonable doubt that the acts were voluntary, but that's a burden that rests on the Crown generally.

WINKELMANN CJ:

Well, that's a little bit unreal too, isn't it? I mean that's a little bit unreal because in fact it doesn't normally rest upon the Crown because in the world the normal laws of physics and human beings is that you are acting with conscious volition but this is raising a credible factual narrative that the Crown has to rebut.

MR HARRISON KC:

Yes.

WINKELMANN CJ:

So it carries an evidential burden to exclude the reasonable possibility of it.

MR HARRISON KC:

Well, that "beyond reasonable doubt" burden only arises once a defendant has laid the necessary foundation for the issue to be put before the jury at all and I had no problem with –

GLAZEBROOK J:

But wouldn't that foundation be laid only from an exam – if they put forward psychological or psychiatric evidence it would be from an expert that had examined the defendant but was a defence expert, so there probably isn't a mechanism of forcing the defendant to undergo another psychiatric evaluation from a Crown expert, is there?

MR HARRISON KC:

There's no legal mechanism to force that examination, I would accept. There is in civil cases but there isn't –

GLAZEBROOK J:

But isn't that the point of *Foye* and those cases?

MR HARRISON KC:

But if – all that needs to be done is to adopt the stringent approach of Justice Fisher who says that he would require independently verified evidence, so that if we have a high standard test at that point, and as I say even though it's only a –

WINKELMANN CJ:

I don't think he's on his own in that. Isn't there a requirement of a credible factual narrative?

KÓS J:

But there is. There is, but what's –

WINKELMANN CJ:

For automatism. But what's the credible factual narrative?

MR HARRISON KC:

Yes, but –

WINKELMANN CJ:

So he says independent verification so I think he probably is on his own in that because I don't know that there is a – apart from Justice Fisher saying that, is there really a legal test that you support with an independent expert?

GLAZEBROOK J:

Evidential is usually a relatively minor…

WINKELMANN CJ:

Yes, because, you know, the jury will just probably reject it if it's just –

KÓS J:

What's singular about your proposition is that this is arising because the Crown is advancing that it's a "disease of the mind". So we have both hares running. We have sane automatism and insane automatism. The Crown's saying, well, this should be dealt with as insane automatism, and it then having the burden that you're describing without any capacity to compel examination.

MR HARRISON KC:

Well, there's no capacity –

KÓS J:

So a hell of a muddle for a trial judge.

MR HARRISON KC:

Well, it – if – both hares are unlikely to be running if – or, they'll only be running if my argument about the scope of disease of the mind is accepted. The –

GLAZEBROOK J:

But if your argument is accepted then the Crown can't actually argue it's a disease of the mind because you say it doesn't come within that concept. And if they did say that, the judge would have to decide that and would either decide

it was a disease of the mind or it wasn't, and it would carry on from there, wouldn't it?

MR HARRISON KC:

Yes I would think so, yes.

GLAZEBROOK J:

All right.

MR HARRISON KC:

But any – my only point at the moment is that the – my argument that the reverse onus should not apply to someone who wants to run an automatism defence isn't imposing an impossibly onerous burden of disproving insanity.

WINKELMANN CJ:

But on your analysis, which I think is implicit in this, I don't think it's a separate point, I think Justice Kós is right that there is another limb which is this is sane automatism and if the Crown wants to prove otherwise, then it bears the burden of establishing insane automatism.

MR HARRISON KC:

Well it bears the burden of proving insanity, not the burden of disproving insanity.

WINKELMANN CJ:

But –

GLAZEBROOK J:

But why is it insanity? They just have to disprove that it was involuntary, wouldn't they? If it's sane automatism.

WINKELMANN CJ:

No, no.

MR HARRISON KC:

If we're permitted to run that and that's the issue, that's the issue that they join with the defence, yes, that's all they have to do. But I think Justice Kós is saying, well, they could go further and seek to run an argument that this is a disease of the mind. But then that gets us into the territory of –

GLAZEBROOK J:

But then wouldn't the judge then, under our system, wouldn't the judge then have to decide whether it was or wasn't a disease of the mind? And if it was a disease of the mind then you're into insanity, and if it wasn't a disease of the mind then you just run it in the normal way.

MR HARRISON KC:

Well that's, that's the way it's worked in the past and worked in this case. When I say worked, the way it operated in this case, the trial judge, faced with the classification, made the decision and ran with it.

GLAZEBROOK J:

I know you say he didn't make that classification, but we're looking at what would happen –

MR HARRISON KC:

You could also, equally, if my argument about disease of the mind is correct, then the judge makes the classification in the other way, and again, the trial is then conducted on that basis only. And –

GLAZEBROOK J:

On the basis of sane automatism.

WINKELMANN CJ:

But –

MR HARRISON KC:

Yes.

WINKELMANN CJ:

But –

MR HARRISON KC:

Sane automatism and the Crown doesn't get to argue insanity.

WINKELMANN CJ:

But I – yes, if only –

MR HARRISON KC:

And my learned friend has cited authority to say the Crown can't contend for an insanity verdict. The *Green* case.

WINKELMANN CJ:

That's interesting, isn't it? Because if you are correct, Justice Kós is right, is right anyway, that the Crown would still bear the burden at that pre-trial stage. But the situation you've got is that your client actively eschews insanity and yet still, in order to run the automatism, still must subject themselves to examination to have – run any kind of defence.

MR HARRISON KC:

Well yes, and that's why I say that the, the safeguard here against frivolous claims, leaving aside Justice Williams' view of the common sense of juries, which I respectfully accept, the safeguard is there's a proper foundation test which has been stated in rigorous terms in the cases that I've been referring to, my para 22, plus Justice Gaudron in *Falconer* which I have just cited. So, that's a sufficient safeguard.

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Then I say, well, go back to section 23(1), the presumption of insanity. Surely it does mean that he who asserts, he or she who asserts, must prove. So if the Crown wants to assert that there is a disease of the mind in play here it gets to make that assertion –

WILLIAMS J:

Well it doesn't – doesn't it logically mean that the – at the pre-trial stage if the judge is the filter and it truly is a question of law then – and the defendant wants to run straight automatism, the Crown says "no, this is insanity, there's the reverse onus", you argue on that basis between you pre-trial and you get corralled into whatever choice the judge makes? The only tangling bit is if the judge says "well there's a legal foundation for both, I'm going to leave this to the jury". That is uncomfortable but it's inevitable if Ms Hamill's view of the availability of the dual path in one trial is correct?

MR HARRISON KC:

It will, generally speaking, be an either/or but it –

WILLIAMS J:

Well it will depend on the facts?

MR HARRISON KC:

But in theory it mightn't, might not be.

WILLIAMS J:

Mmm.

MR HARRISON KC:

Yes. But that, that doesn't mean any – none of that means that my arguments, my Bill of Rights-based arguments, impose an impossibly onerous burden on the Crown –

WINKELMANN CJ:

Well can I ask you about the Crown's response to your notion that there is this shifting burden so that it's on the – it may be on the defendant in some circumstances but if the Crown wants to raise it it's on them, and she says well that just isn't right in the matter of law, *Green* – and the reality is that it's never on the Crown, the Crown does – is precluded from raising insanity, it's for, it's a defence or the Court issue.

MR HARRISON KC:

Yes, the – the case of *Green* has featured very little and there was no – you weren't taken to analyse it. What the submission is at paragraph 102 of the Crown's submissions is that, citing *Green*, the Crown may not pursue insanity as a verdict. Now that might very well be so, but it doesn't – *Green* isn't, was not concerned with the pre-trial classification contest to be conducted before the judge, and I think my learned friend accepts that in this case and in others if a defendant is saying "automatism defence, non-insane", the Crown is entitled to say "no, no, this is a disease of the mind case". So *Green* does not preclude that.

WILLIAMS J:

Well that's what happened in this case?

MR HARRISON KC:

Yes, and *Green* does not preclude that. At worst, if correctly decided in light of current statutory provisions, I'll come to that in a moment, *Green* simply says you can't before the jury advance an insanity defence which the defence has not raised or which is not colourably before the Court so that the judge directs, and –

WILLIAMS J:

What do you say to Ms Hamill's argument that what the Judge said in minute number whichever one it was that the facts in this case are materially indistinguishable from those in *Cameron*, "I consider myself bound as a matter of law to choose insane autonomy as a result – automatism as a result"?

MR HARRISON KC:

Can I just come back to that for a moment, I think it's a –

WINKELMANN CJ:

Mmm, because I'm interested in running down the ground this prior point, which is it seemed to me a critical submission of the Crown, which is that your shifting burden issue she says just is not supported by the legal framework, which is

that it's the Crown – the Court which is required to make this designation, and just because the Crown argues that as a matter of law this is the appropriate designation doesn't somehow shift the onus onto them?

WILLIAMS J:

I didn't think that's what you were arguing?

MR HARRISON KC:

It –

WINKELMANN CJ:

I think it is what he was arguing.

WILLIAMS J:

Well, the – not now.

MR HARRISON KC:

Can I just –

WINKELMANN CJ:

No, but I've asked him about that.

MR HARRISON KC:

Can I just finish with the *Green* point before we go onto anything else. The – *Green* was decided before the enactment of the Criminal Procedure (Mentally Impaired Persons) Act and section 20 now addresses in considerable measure what is to happen when insanity is raised. So *Green* is no longer necessarily going to be governing because we have a statutory provision which governs the position in various ways, including in subsection (5) where it's said: "If it appears from the evidence that the defendant may have been insane at the time of the act or omission …, the Judge may ask the jury to find whether the defendant was insane, even though the defendant has not given evidence as to the defendant's insanity or put the question of the defendant's sanity in issue," and there are other subsections there.

The regime seems to be much more that insanity, if it is in issue, sanity or insanity is in issue, then it does get before the jury for a finding whether the defendant was insane or a verdict can be called for as to whether the defendant was insane.

WINKELMANN CJ:

It's plain from the scheme of section 20 that it's not the Crown who puts forward insanity because the only capacity for the Crown to act in this is section 20(2)(b): "Before or at a trial, the Judge must do the things specified in subsection (1) if": (a) the defendant indicates an intention to raise the defence; (b) the prosecution agrees the only reasonable verdict is a finding of proven but not criminally responsible; (c) the Judge is satisfied, on the basis of expert evidence, that the defendant was insane. So it's not –

MR HARRISON KC:

That's where an express role is given to the prosecution but it must be the case that, for example, under subsection (5) the Crown can say to the Judge: "You should ask the jury for a finding. Your Honour, it does appear from the evidence and therefore I invite you, your Honour, to proceed under subsection (5)." The Crown must be able to do that. My only point is that the *Green* ruling pre-dates this section and can't possibly be seen as occupying the whole territory, particularly not at the pre-trial voir dire stage when the trial judge has been called upon to make the classification.

So my submission is that the interpretation I am urging is justified there as the application of a reverse burden of proof as per section 23(1) on a defendant who wants to run an automatism defence is an unjustified burden and consequently the Court should shy away from imposing that burden by reading down "disease of the mind" to the extent that I have argued. So that's the Bill of Rights issue.

One small point at page 28, 95, common law rules, I'm not sure that really that is, with respect, is helpful. This is an issue of interpreting –

WINKELMANN CJ:

What paragraph, sorry?

MR HARRISON KC:

Paragraph 95. There's a small section on common law rules and the Bill of Rights. The issue is more that we rely on section 21 as preserving the common law and that is in play when we come to interpret section 23. It's not a question of just saying: "Here's a common law rule and give effect to it under the Bill of Rights," not the argument.

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The miscarriage of justice point, as I said in opening at the outset, it appears to be accepted that if I'm right in my first line of argument that *Cameron* was wrong then plainly there's a misdirection and a miscarriage of justice. The argument here is directed to my second aspect and the argument at 102 is, first, there is no requirement for the experts to opine on whether the condition in question is a disease of the mind, given it's multifactorial. That submission appears to be contradicted by paragraph 36 earlier where the Crown rightly submit that as observed in *Cameron*, the application of the "disease of the mind" test has each case turning on its fact and the expert evidence before the Court.

So in my submission, if the evidence was not before the Court, the expert evidence directed to whether the condition in question is a "disease of the mind", then that has resulted in a miscarriage of justice. The existence of that evidence could well have made a difference to the classification outcome in any event.

That completes my reply submissions unless I can be of any further assistance.

WINKELMANN CJ:

Thank you, Mr Harrison. I would like to thank counsel for their helpful submissions. We will reserve our decision.

COURT ADJOURNS: 4.12 PM