Northern Ireland
Legal Quarterly
Summer Vol. 72 No. 2 (2021) 397–405
Commentaries and Notes: DOI: 10.53386/nilq.v72i2.880

R v Foy (Nicholas): voluntary intoxication, mental health and the case for diminished responsibility

Bethany Simpson

Northumbria University

Correspondence email: bethany.l.simpson@northumbria.ac.uk

ABSTRACT

In *R v Foy*, the appellant sought to adduce fresh evidence based on a difference in expert opinion. Dismissing the appeal, the Court of Appeal in England held that, where there is no solid basis for expert assertions, these appeals must fail. The case highlights the legal complexities intrinsic in diminished responsibility cases in the context of intoxication and mental health issues. This commentary addresses the legal ambiguities that arise under these circumstances.

Keywords: homicide; diminished responsibility; recognised medical condition; mental disorder; voluntary intoxication; fresh evidence; expert opinion.

INTRODUCTION

The appellant (F) sought leave to adduce fresh psychiatric evidence supporting a defence of diminished responsibility. Pre-trial, F's psychiatrist produced an adverse report to such a plea meaning the defence was not pursued. The case presents the opportunity to explore the views expressed by the Court of Appeal (CoA) in England when considering challenging cases in which diminished responsibility is not considered by the jury, but subsequent fresh evidence emerges in support of the plea. The appeal demonstrates the application of section 23 of the Criminal Appeal Act 1968 (CCA), alongside consideration of the vexed questions that can arise *vis-à-vis* killings in the context of voluntary intoxication and mental health issues.[1] The latter will be the focus of this commentary.

The reformed partial defence of diminished responsibility to a charge of murder is contained in section 2 of the Homicide Act 1957 (HA), as amended by section 52 of the Coroners and Justice Act 2009. Under

1 For an in-depth discussion of the application of s 23 of the CCA in the context of diminished responsibility and this case see Mark Thomas, '"Expert shopping": appeals adducing fresh evidence in diminished responsibility cases' (2020) 84(3) Journal of Criminal Law 249.

section 2 the defendant (D) must prove on the balance of probabilities that at the time of the killing:

> (1) D was suffering from an 'abnormality of mental functioning' which—
>
> (a) arose 'from a recognised medical condition',
>
> (b) substantially impaired D's *ability* to: understand the nature of his conduct; form a rational judgment; and/or exercise self-control;[2] and
>
> (c) provides an explanation for D's acts or omissions in doing or being party to the killing.[3]

It is worth noting that section 5 of the Criminal Justice Act (NI) 1966, as amended by section 53 of the Coroners and Justice Act 2009, is identical to section 2 HA (save for the requirement of a 'recognised *mental* condition'[4] as opposed to a 'recognised medical condition' in section 2(1)(a)).[5]

Additionally, where D causes the conditions of his own defence, the doctrine of 'prior fault' will negate a defence of diminished responsibility where D is proved to have formed the necessary *mens rea* of murder before the abnormality of mental functioning arose.[6] The doctrine follows that:

> D's behaviour when acting to directly cause death ... may be defensible in isolation, but when considered in light of h[is] prior fault at the earlier point ... [for example] when choosing to lose partial control or faculty through intoxication ... such exculpation is intuitively much less justifiable.[7]

Application of the 'prior fault' doctrine in light of F's voluntary intoxication will also be examined.

---

2 Homicide Act 1957 (as amended by s 52 of the Coroners and Justice Act 2009), s 1(1A). The criteria listed can be traced back to the judgment in *R v Byrne* [1960] 2 QB 396 under the old law.

3 Under s 2(1B) of the Homicide Act 1957, as amended by s 52 of the Coroners and Justice Act 2009, an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.

4 Criminal Justice Act (NI) 1966, as amended by s 53 of the Coroners and Justice Act 2009, s 5(1)(a) (emphasis added).

5 The distinction between the two appears to be immaterial. Indeed, practitioners and the judiciary use the term interchangeably: see *R v Foye* [2013] EWCA Crim 475 [43] and *R v Lindo* [2016] EWCA Crim 1940. Thus, the judgment in *Foy* provides persuasive value to the courts in Northern Ireland.

6 See *Attorney-General for Northern Ireland v Gallagher* [1963] AC 349.

7 John J Child, 'Prior fault: blocking defences or constructing crimes' in Alan Reed and Michael Bohlander (eds), *General Defences: Domestic and Comparative Perspectives* (Ashgate 2014) 38. See also Alan Reed and Nicola Wake, 'Potentiate liability and preventing fault attribution: the intoxicated "offender" and Anglo-American dépecage standardisations' (2013) 47 John Marshall Law Review 57.

A FRESH OPINION

In the present case, F ingested huge quantities of alcohol and cocaine before fatally stabbing a French tourist (V). F was experiencing a psychotic episode at the time of the attack. F was witnessed gouging at his foot with a knife attempting to remove what he believed was a bomb. F then ran towards V and stabbed him in the stomach. F was arrested and charged with murder.

F accepted he had stabbed V but advanced the defence of lack of necessary *mens rea*, owing to his acute intoxication. Counsel favoured denial of *mens rea* over running a partial defence of diminished responsibility. F suffered from depression, anxiety and paranoia, alongside a history of alcohol and cocaine abuse – albeit not to the extent that it satisfied the requirements for diminished responsibility.[8] On the premise that intoxicated intent is still intent, the jury convicted.

Pre-trial, the defence relied solely on the psychiatric report of 'a very experienced consultant psychiatrist', Dr Isaac.[9] Based on medical records and interviews with F, Dr Isaac ruled out diminished responsibility and insanity, reporting that, although F was suffering from an abnormality of mental functioning at the time of the killing (namely 'a [florid] psychotic episode') this was likely 'caused by a combination of cocaine and alcohol',[10] as opposed to a recognised medical condition. Upon reviewing additional material evidencing F's paranoid mental state, his original conclusion stood.

Post-trial, F's family secured funds to obtain a fresh opinion. An alternative psychiatric report was produced by Dr Joseph who had initially been approached by the defence pre-trial but was not instructed owing to a dispute over fees. In his report, he contested that F suffered from an 'abnormality of mental functioning caused by the recognised medical condition of an acute transient psychotic episode, *possibly exacerbated* by the abuse of cocaine'.[11] He further opined that the abnormality of mental functioning was 'extremely severe', enough to substantially impair F's ability even when discounting intoxication.[12] F appealed his conviction based on the new report.

NO VIABLE DEFENCE

The appeal raised two questions: should the fresh evidence be admitted at all? If so, would it render the conviction unsafe? Rejecting the appeal on both grounds, Davis LJ concluded that the fresh evidence was

8 *R v Foy (Nicholas)* [2020] EWCA Crim 270 [6].
9 Ibid [22].
10 Ibid [26].
11 Ibid [43] (emphasis added).
12 Ibid.

inadmissible; and, had it been admissible, it would not have provided a viable defence to render the conviction unsafe.[13]

An appeal is not a means of re-litigation in the hope that a different outcome is achieved, and the facts here did not amount to an exception to this approach. The evidence had been available at trial, carefully considered, and diminished responsibility rejected. Had there been any dissatisfaction with the initial report, funds should have been raised pre-trial to obtain another. Instead, the defence received Dr Isaac's evidence, disapproved of his conclusions and sought to introduce Dr Joseph's evidence to support their contentions post-trial; which Davis LJ referred to as 'bluntly, expert shopping'.[14] Consequently, the CoA determined that it was not '[necessary or expedient] in the interests of justice' to permit Dr Joseph's evidence to be adduced.[15]

Additionally, Dr Joseph's new evidence could 'not in any event afford a viable defence of diminished responsibility which a jury, properly directed, could accept on the balance of probabilities'.[16] The court was satisfied that the abnormality of mental functioning that F was suffering from was the florid psychotic episode, however, it was not satisfied that the psychotic episode arose from a relevant recognised medical condition absent the intoxicants. Indeed, several possible conditions suggested by Dr Joseph were discharged as not being a recognised medical condition for the purpose of section 2. Reviewing the fresh evidence and excluding the voluntary consumption of intoxicants, there was 'no solid basis for asserting an abnormality of mental functioning arising from a recognised medical condition which *substantially* impaired [F's] ability in the relevant respects and which provided [a statutory] *explanation* ... for his acts'.[17]

Voluntary acute intoxication

The principal concern, *vis-à-vis* diminished responsibility, was the dispute between the psychiatric experts as to the role the combination of voluntary consumption of intoxicants and F's mental state played in the resultant death. Despite intoxicants featuring in the vast majority of homicide cases, the threshold for the disease of alcoholism to amount to a finding of diminished responsibility is 'almost unattainable'.[18]

The current legal position, which *Foy* confirms, is that a defendant who kills whilst in a state of voluntary acute intoxication (alcohol, drugs

13 Ibid [64]–[65].
14 Ibid [60].
15 Ibid [64]. In accordance with s 23(1) CAA 1968.
16 Ibid [65].
17 Ibid [95] (original emphasis).
18 Nuwan Galappathie and Krishma Jethwa, 'Diminished responsibility and alcohol' (2010) 16(3) Advances in Psychiatric Treatment 193.

or a combination), even if the intoxication triggers a psychotic episode, cannot found a defence of diminished responsibility; there is no recognised medical condition.[19] This is despite 'acute intoxication' being listed in the World Health Organization's international classification of diseases (ICD-10)[20] and scholarly commentary suggesting that 'states of acute intoxication *may* satisfy the "recognised medical condition" requirement'.[21] There may, however, be a recognised medical condition giving rise to an abnormality of mental functioning where D suffers from substance addiction and has consumed intoxicants as a result of that addiction.[22] In such cases, it is the addiction ('dependency syndrome') that gives rise to the abnormality rather than the intoxication.

The position differs slightly where there is an abnormality of mental functioning arising from a *combination* of voluntary intoxication and the existence of a recognised medical condition. In such circumstances, the abnormality of mental functioning need not be the sole cause of D's acts: even if D would not have killed had he not taken alcohol, 'the causative effect of the drink did not necessarily prevent an abnormality of mind from substantially impairing the mental responsibility for the fatal acts'.[23] As Wortley notes, ambiguity persists in the application of the law to cases in which an underlying medical condition *relates to* (ie is triggered by) the consumption of intoxicants.[24] This refers to the court's application of the 'prior fault' doctrine which permits a D, whose underlying medical condition is triggered by voluntary intoxication, to plead diminished responsibility, yet denies the defence to a D whose voluntary intoxication triggers a drug-induced psychosis where no pre-existing medical condition prevails. Incidentally, *Foy* fails to clarify this issue.

If the voluntary intoxication and underlying medical condition both substantially impaired D's responsibility, the defence may still

19 *R v Dowds* [2012] EWCA Crim 281; *R v Lindo* (n 5 above). See also, *R v Gittens* [1984] QB 698.

20 For further discussion see Natalie Wortley, 'New cases: evidence and procedure: appeal (fresh evidence): *R v Foy*' (2020) CLW 20/10/1. The court in *Dowds* further acknowledged that 'recognised medical condition' should be interpreted in the legal sense as opposed to psychiatric, [40]. See also *R v Wilcocks* [2016] EWCA Crim 2043 [45]

21 Nicola Wake, 'Recognising acute intoxication as diminished responsibility? A comparative analysis' (2012) 76 Journal of Criminal Law 71, 96 (original emphasis).

22 *Dowds* (n 19 above); *R v Stewart* [2009] EWCA Crim 593. Note that 'drink/drugs dependency syndrome' is most commonly cited.

23 *R v Dietschmann (Anthony)* [2003] UKHL 10; [2003] 1 AC 1209; *Stewart* (n 22 above).

24 Wortley (n 20 above). See also Karl Laird, 'Diminished responsibility: *R v Foy (Nicholas John)*' [2020] 9 Criminal Law Review 840, 842 for discussion of the prior fault doctrine.

be relied upon, but the jury must be directed to disregard the effects of intoxication when considering whether the requirements of section 2 are met.[25] Although the decision in *Foy* confirms this approach, the case illustrates how identifying the existence of such a condition to the requisite legal standard remains problematic amongst medical practitioners; reiterating the concerns of many scholars.[26]

An un-'recognised' medical condition

Under section 2, F was accepted to be suffering from an abnormality of mental functioning at the time of the killing; the 'florid psychotic episode'.[27] The remaining requirements were not as explicit.

The second requirement was to ascertain from what recognised medical condition the psychotic episode arose. Dr Isaac opined that F's abnormality of mind arose from voluntary intoxication as opposed to a recognised medical condition; F's account was consistent with a 'substance-induced psychotic disorder'.[28] Ruling out schizophreniform disorder as an alternative, Dr Isaac stressed that 'paranoid thoughts are not necessarily psychotic'.[29] Similarly, Dr Blackwood (for the Crown on appeal) diagnosed F as suffering from a paranoid personality disorder, capable of being classified as a recognised medical condition, but found it not to have any sufficient material contribution to the psychotic episode. On this basis, 'no recognised medical condition [gave] rise to the psychotic episode'.[30]

Paradoxically, Dr Joseph reported that F suffered transient psychotic episodes when not intoxicated resultant of his 'abnormal personality structure'; this diagnosis, however, was deemed not to be a 'recognised medical condition' in the legal sense.[31] Nonetheless, Dr Joseph maintained '[F] was suffering from an abnormality of mental functioning caused by the recognised medical condition of an acute transient psychotic episode';[32] an apparent conflation between what *was* the abnormality of mental functioning (the 'acute psychotic episode') and what *caused* it (later described by the court as 'an "acute transient psychosis"').[33] Dr Joseph conceded that it was 'almost tautological' and accepted the court's understanding of his argument

25 *Dietschmann (Anthony)* (n 23 above); *R v Kay; Joyce* [2018] 1 All ER 881.
26 See Wake (n 21 above).
27 *Foy* (n 8 above) [79]. Consistent with the approach in *Lindo* (n 5 above) and *Kay; Joyce* (n 25 above).
28 Dr Isaac also referred to this as 'cocaine psychosis': *Foy* (n 8 above) [35].
29 Ibid [25]–[26] and [35].
30 Ibid [81].
31 Ibid.
32 Ibid [43].
33 Ibid [88].

for the presence of 'acute transient psychosis', yet this suggestion was deemed not to be a 'recognised medical condition'.[34]

The decision highlights the complex legal position regarding voluntary intoxication and psychiatric issues and further emphasises the friction between the legal and medical nature of section 2 as it presents itself to psychiatric experts, with Dr Joseph suggesting that the distinction between the requirement for both an abnormality of mental functioning and a recognised medical condition is 'slightly artificial'.[35]

Supporting assertions

The third requirement of section 2 was to determine if the psychotic episode (absent intoxication) 'substantially' impaired F's mental ability. In *Golds*, 'substantial' required the jury to be satisfied that D's impairment was 'significant or appreciable'.[36] The meaning was further clarified in the context of diminished responsibility; 'substantial' ought to mean 'important or weighty' as opposed to being 'anything more than merely trivial'.[37] In *Foy*, Davis LJ reiterated that determining

> ... whether the impairment was sufficiently substantial remained a matter of fact and degree for the jury ... it was to be left to the jury to decide whether in any given case the impairment was of sufficient substance or importance to meet the statutory test.[38]

Dr Isaac maintained that even if F's abnormality of mind arose from a paranoid psychosis, it would not have met statutory requirements: 'without the [intoxicants] ... I cannot see that in itself it would have *substantially* impaired his responsibility'.[39] Dr Joseph, however, was confident that F's abilities were substantially impaired. The CoA previously acknowledged that, despite considerable advancements in psychiatry and scientific understanding of how the mind functions, 'it is impossible to provide any accurate scientific measurement of the extent to which a particular person ... could understand or control his physical impulses on a particular occasion'.[40] Since there is no simple scientific test to determine substantial impairment, the jury is to rely on the evidence presented by experts. In this case, there was simply no evidence to support Dr Joseph's assertion that F's responsibility was substantially impaired.

---

34 Laird (n 24 above) 842.
35 *Foy* (n 8 above) [47].
36 *R v Golds (Mark Richard)* [2014] EWCA Crim 748 [70].
37 *R v Golds (Mark Richard)* [2016] UKSC 61; [2016] WLR 5231 [28].
38 *Foy* (n 8 above) [77].
39 Ibid [35] (Dr Isaac's own emphasis).
40 *R v Khan* [2009] EWCA Crim 1569 [18].

Dr Blackwood concluded that the psychotic state 'informed [F's] actions ... but which did not endure'.[41] To the contrary, Dr Joseph maintained that the psychotic episode (discounting the effects of intoxication) provided an explanation for F's acts; described by Davis LJ as a simple assertion.[42] Although the issue of causal link was not raised, it is worth noting that Dr Blackwood stressed the impossibility of 'separat[ing] a psychotic disorder emerging independently from substance misuse from one arising in the context of substance misuse when substance misuse clearly occurred at the material time'.[43] This contention only seeks to raise further concern over the requirement of lay people to separate mental health issues from voluntary intoxication in jury trials.

CONCLUSION

The CoA in *Foy* has once again sought to ensure that, as a ground of appeal, successfully raising the issue of diminished responsibility remains exceptional; one cannot simply employ 'expert shopping' to reattempt litigation. This is especially the case where the new expert testimony falls short of giving rise to a viable defence.

Although the circumstances of *Foy* are distinguishing in nature, albeit not 'unusual' enough to justify admitting the fresh evidence,[44] the case highlights the ongoing potential for experts' opinions to differ based on the same material. The case evidences numerous problematic legal questions within the reformed section 2 defence – specifically, surrounding the role of voluntary intoxication and its relationship to psychiatric conditions/mental health – and fails to clarify the 'levels of gradation of voluntary intoxication that may or may not constitute a "mental abnormality" when a defendant kills while under the influence of alcohol [and/]or narcotics' on which the statutory defence remains silent.[45] The revised plea of diminished responsibility is heavily medicalised, thereby inviting greater input from psychiatric experts who are increasingly likely to hold differing opinions.

The enmeshing of medicine, psychiatrics and law within the complex arena of diminished responsibility allows for the arrival at divergent albeit equally weighted conclusions, but the ultimate decision must

41 *Foy* (n 8 above) [46].
42 Ibid [95].
43 Ibid [46].
44 Ibid [58]–[61]; Thomas (n 1) 254; *R v Challen* [2019] EWCA Crim 916.
45 Wake (n 21), citing A Reed and N Wake, 'Anglo-American perspectives on partial defences: something old, something borrowed and something new' in M Bohlander and A Reed (eds), *Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives* (Routledge 2011) 191.

reside with the jury; in this case Dr Joseph's initial opinions should have been presented at trial. Furthermore, experts should be mindful of presenting any overlap between the required elements of section 2, ensuring they explicitly identify relevant recognised medical conditions within the ambit of the law, devoid of vague assertions. Consideration of the onerous task of differentiating between the separate effects of alcohol, drugs and inherent causes would have been a welcome direction from the court.[46]

Finally, it is unfortunate that, despite raising several points of incoherence and ambiguity, the judgment failed to clarify the application of the law in cases in which voluntary consumption of intoxicants triggers drug-induced mental disorders.[47] Re-evaluation of the merits or coherence of the application of the 'prior fault' doctrine remains eagerly anticipated.

46 Galappathie and Jethwa (n 18 above).
47 Laird (n 24 above) 842.