Neutral Citation Number: [2021] EWCA Crim 954

Case No: 2020/01696/B5

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM LEICESTER CROWN COURT
MRS JUSTICE CARR
T.20187292

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/06/2021

Before:

LADY JUSTICE MACUR
MR JUSTICE JAY
and
MRS JUSTICE FOSTER

- -

Between:

REGINA	**Respondent**
- and -	
HANNAH COBLEY	**Applicant**

- -
- -

Mr J Hankin QC and Ms L Pitman (instructed by **CPS**) for the **Respondent**
Mr H A Godfrey QC and Mr H Laidlaw (instructed directly) for the **Applicant**

Hearing date: 19 May 2021

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Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand down is deemed to be 10am on Tuesday, 29 June 2021.

Macur LJ:

Introduction

1. On 6 June 2019, Hannah Cobley ("the applicant") was convicted of the murder of her newborn child. The female child was of approximately 32 weeks gestation and sustained several significant post-natal injuries which indicated a determined effort to kill her, as the jury found. The Registrar has referred the applicant's application for an extension of time in which to apply for leave to appeal against conviction and to adduce fresh evidence regarding her mental state at the relevant time, in the somewhat unusual circumstances that occurred at trial as we indicate in [20] – [22] below.

Background

2. The applicant gave birth to a baby girl in the early hours of 26 April 2017. She had concealed the pregnancy, which was the product of a consensual 'one-night-stand' with a stranger. The birth took place between about 2 and 2.45 a.m., into the bowl of an outside toilet at her parents' farm in Leicestershire. Although premature, post-mortem examination revealed that the baby was a normal healthy female child and had been born alive. There was no evidence to suggest that the labour had been obstructive or difficult.

3. In September 2010, the applicant had undergone a termination following her first, unplanned pregnancy. Her second pregnancy had also been unplanned and resulted in the birth of her daughter, E, on 25 March 2014. The applicant said that she did not know that she was pregnant with E until a late stage; she gave birth in the upstairs bathroom of the family home.

4. Initially, the health visitor was concerned about the applicant bonding with her baby, but by October 2014, there was observable positive interaction; E thrived.

5. In April 2017, the applicant was living with her parents, her cousin and E, in the farmhouse of her parents' working farm. The farm's outside toilet was used by anyone who might be out in the yard or in the kitchen; it was never locked.

6. On Saturday 29 April 2017, the applicant collapsed and was taken to hospital by ambulance. She told the paramedics that she had expelled a large mass from her vagina a few days earlier, she didn't know what. She had been bleeding heavily with large clots and had collapsed, she didn't know if she was pregnant or had miscarried. She received medical treatment to remove placental tissue, which was infected. It was weighed by the midwife who estimated an approximate baby birth weight of five pounds; the 'missing baby' policy was initiated. There was evidence of an acute infection and inflammation of the placenta, indicating the 'breaking of waters' three days earlier.

7. The applicant remained in hospital until 3 May 2017. She told nursing staff that on the previous Tuesday she had passed something into the toilet that was larger than a tennis ball, and which she had flushed away. The applicant said that she had not thought she was pregnant and that she had been passing a menstrual blood clot.

8. However, later that evening, she told her father that she had given birth, the baby had been stillborn and instead of flushing it down the toilet, she had put it in a bag in the

garden. He contacted the police. Police officers then searched the farm and found the body of the baby wrapped in several plastic bags in an enclosed area of overgrown waste-ground. A number of other bloodstained items were found at the farm and in the applicant's bedroom. Forensic analysis of bloodstaining from the storeroom floor indicated that all the components of the DNA profiles of the applicant and the baby were present.

9. The applicant was arrested, her mobile phone was seized, and she was interviewed. She told police that she hadn't known she was pregnant until she had given birth. She said that the baby wasn't breathing, hadn't moved, or made a sound and so she sure the child was dead; she panicked and hid the body so that no one would know what had happened. She was ashamed of her actions but denied that she had done anything to cause the baby harm. She said that she had no idea that she was pregnant.

10. The download of her mobile phone revealed internet searches in the early hours of 27 April including: "what happens if you drop a new-born baby" and "how long can a new-born baby last without milk and in the freezing cold".

11. A post-mortem examination was carried out on 1 May 2017. The baby had traumatic injuries to her brain, which were sustained when she was alive and she had survived for perhaps a few hours, but at least one. The baby was breathing and swallowing after birth and it was likely she made some sound including gasping, grunting, and crying. It was also likely that she was moving, and this would have been apparent. The umbilical cord appeared to have been cut with a pair of sharp scissors.

12. There were multiple injuries to her skull, her brain and brain stem, her neck and throat, and bruising and abrasions on her body which were unlikely to have been caused during a normal birth or from dropping into the toilet bowl. It was likely that the head injuries had been caused by violent shaking with multiple impacts or a significant and quite violent bang against a hard surface, more than once. There was quite marked bruising to the neck muscles and thyroid that must have occurred after birth and would not have occurred naturally. The most likely mechanism was something being placed into the baby's mouth with some force to obstruct her airway, together with manual pressure, gripping or squeezing to her neck. The very severe head injuries were more than enough to cause the death of the child, but the presence of the plastic bag and the degree of post injury survival meant it was not possible to determine the ultimate cause of death.

13. The prosecution case was that the applicant had deliberately and intentionally killed her baby. It was a cold-blooded killing intended to conceal the fact of her pregnancy and the existence of the birth. There was no question of the applicant experiencing mental illness, abnormality, or disturbance of mind at any stage. The applicant had been in control and was thinking rationally. There was evidence that she had forced something into the baby's throat to silence or gag her and had assaulted her, causing very severe head injuries. Despite recognizing that the baby might still be alive, she had then sealed the baby inside three plastic bags, one on top of the other and had abandoned her in an overgrown area of garden behind one of the farm buildings.

14. The applicant had known that she was pregnant and had deliberately concealed this. She knew she was in labour when she went outside on the night in question in order to give birth in secret. Before going outside, she had considered how she might harm her baby by dropping it.

15. She had acted in a rational and calculating way committing a sustained and repeated assault on the baby. There were multiple mechanisms for the injuries and the fact of the assaults, and their sequence proved that the baby was born alive, and the applicant knew this, otherwise why harm or silence her? The evidence had to be assessed in the context of a woman who was instinctively dishonest: faking her amnesia, her lack of recollection and faking her claims of panic and shame.

16. The Prosecution relied, amongst other things, on internet searches carried out by the applicant in the days and hours before the birth, indicating that she knew she was pregnant and then in labour and internet searches carried out by the applicant hours after the birth, indicating that she was thinking rationally and coherently and that she knew or at the very least suspected the baby was still alive after she had disposed of the body. In addition, the applicant's various accounts to the paramedics, her parents, medical staff, the police, and a social worker, including asking whether "they will be able to tell if the baby was breathing or not at the time that she was put in the bag".

17. The applicant gave evidence at trial. She said that she had an inkling that she might be pregnant from March 2017 and had just tried to bury her head in the sand. She was a 'closed' person. She agreed that she had made all the internet searches. She started bleeding and cramping at about 00:41. She denied that she thought about harming the baby, she was worried because the baby was early. The gap in the searches were when she had the baby, she hadn't taken her phone with her. She had gone downstairs to get milk for E. She used the outside toilet because it was easier. She was panicking and in pain and had delivered the baby in the toilet, it took about 10 minutes. She didn't think the baby had been born alive; the baby didn't cry at any time. She denied that she had tried to stop the baby making any noise.

18. She had cleaned the toilet and at that stage the baby was on the floor. She was cleaning for about 15 to 20 minutes and put the cleaning materials in a bag which had been in the toilet. She put the baby into a carrier bag because she was panicking, and the baby was just lying there lifeless. She used three carrier bags in total but didn't recall putting one of them around the baby's head and chest or putting a wad of tissues into the baby's mouth or throat. She could not remember causing any injury to the baby but agreed that she must have done so but it would not have been intentional, and she could not even remember doing it. She had not wanted to injure the baby. She put the carrier bag in the garden and returned to the house, she had been out for about 20-30 minutes. She didn't try and wake anyone up. She felt ashamed. She returned to her bedroom and got back into bed but couldn't get back to sleep, she felt empty and just lay there. She couldn't remember using her phone to make further searches. She felt ill over the next few days and was worried that the placenta had not come out. She had not initially told the paramedics or the hospital staff that she had been pregnant and had given birth because she was ashamed and scared. She hadn't known that the baby had been breathing when it was placed in the carrier bag. She was feeling scared when interviewed by the police. She couldn't remember everything that had happened. She denied that she had deliberately withheld information.

19. In cross-examination she accepted that she had been responsible for the baby's death. She agreed that she must have done something but said that she had no recollection of doing it and she never meant to do it. She did not accept that she had told any lies, she had simply told people what she could remember. Even after hearing all the evidence, she still had no recollection of harming the baby. She maintained that she had gone

downstairs to get milk for E and denied it was to conceal the birth or because she was planning to dispose of her unwanted baby. She did not intend that the baby should die. She denied pretending not to remember to escape responsibility; she wasn't a devious person.

20. Up until the conclusion of the applicant's evidence, the defence team had intended to call and rely upon the expert evidence of Dr Muzaffar, Consultant Psychiatrist. Dr Muzaffar had seen the applicant on two occasions prior to trial spending approximately two hours each time with her; he also spoke separately with her parents. He had been provided with a summary of the case, a transcript of police interviews and the applicant's proof of evidence and had access to the applicant's GP notes. On balance he considered that there was evidence of an acute stress reaction which had disturbed the balance of her mind and her ability to think logically. This was related to pregnancy and the birth. It would impact her ability to form a rational judgment and was a possible explanation for her actions and met the criteria for a defence of infanticide and/or diminished responsibility.

21. However, after hearing the applicant give evidence Dr Muzaffar informed the defence team that he no longer believed that her mental functioning had been sufficiently disturbed as to explain her actions.

22. He prepared an addendum report, explaining that during the applicant's oral evidence "the birth appears less sudden and therefore less of a surprise than [he] had previously considered". He had heard the evidence of the questions which it was said the applicant had asked of the nurse attending her in hospital which indicated that she was aware that the child had lived post birth and there had been changes in her account. Taken together this put into doubt her account of amnesia of immediate post birth events. She was unable to give details of the flashbacks she had reported to him and had said that they did not happen often. The internet searches before and after the incident would not support a disturbance in logical thinking before or after the event. She had continued to wear a t-shirt that she was wearing at the time of the birth after the event which negated post-traumatic disorder. Her external emotional reaction now appeared more in line with a premorbid personality and less likely indicative of a new onset dissociative process. "Cumulatively all the above put a significant doubt in my mind about a mental disorder being a preferred explanation of her behaviour. Even if a diagnosis of acute stress reaction/disorder is made, I no longer hold the opinion that the disorder led to a disturbance of balance of her mind to a sufficient degree as to provide an explanation for the events."

23. The applicant was represented by very experienced leading and junior counsel. Obviously, they did not seek to call Dr Muzaffar, neither did they apply to discharge the jury to seek a second opinion. We presume they reached this decision after appropriate consultation with the applicant and, no doubt, other interested parties with her consent.

24. Consequently, the prosecution stood down Dr Kennedy, a Consultant Psychiatrist, who would have been called to give expert evidence in rebuttal. An agreed fact was drawn to reflect that: "In the opinions of Dr Kennedy and Dr Muzaffar, [the applicant] was not suffering from any kind of mental illness, abnormality of mental functioning or disturbance of mind before, during or after the birth of the unnamed baby."

25. Therefore, at the conclusion of the evidence, the defence case could only be lack of necessary intent. In his closing speech, leading counsel recognised the force of the medical evidence which indicated that the applicant had caused serious injury to the baby shortly after delivery, although she could not positively remember doing so. However, she had panicked and was scared and did not know what to do, so she hid the baby. This had not been a cold-blooded killing, but a more hurried and chaotic event, without careful decision-making.

26. The labour had occurred spontaneously and the internet searches pre-birth were at a time when the applicant was bleeding and cramping. The clean-up exercise in the outside toilet was not total and the cleaning articles had come from within the toilet. The post-birth internet searches were of little assistance on the applicant's intention at the time of the baby's death.

27. The jury should make reasonable allowances for the applicant's condition in hospital, she was upset and emotional and she was a private person. She had been scared and ashamed and her lies were not maintained for long. In her significant witness and police interviews, she had given detail in an unsophisticated manner. The applicant's criminal responsibility was more properly reflected in a verdict of manslaughter.

28. However, the applicant was convicted of murder as indicated above.

Appeal

29. Post-conviction, her parents sought advice on appeal from her present counsel, Mr Godfrey QC. He advised that a further psychiatric opinion be sought which led to a report being commissioned from Dr di Lustro, a consultant psychiatrist, with particular interest in female psychiatric disorders. She saw the applicant on 8 January 2020 and prepared a report dated 29 May 2020. In Dr di Lustro's opinion, at the time of the index offence the applicant was suffering from symptoms of a moderately severe depressive disorder with features of complex post-traumatic stress disorder. The disturbance in the balance of the applicant's mind constituted a mental illness and was recognised for the purpose of diminished responsibility. It would have significantly impaired the applicant's ability to form a rational judgment about her situation and significantly affected her ability to exercise self-control. Therefore, it presented a partial defence.

30. Mr Godfrey QC relies upon this fresh evidence to base the applications that, if successful, would lead to the quashing of the conviction for murder and directions for retrial. He also relies upon the report of Dr Rampling, a consultant psychiatrist, who in November 2020, was commissioned by the prosecution to provide a second opinion on the applicant's mental state at the time of the killing and to comment on the views expressed by Dr di Lustro. Subject to issues of the applicant's credibility in recounting her history and the circumstances of the trigger event, Dr Rampling supported Dr di Lustro's opinion and considered that the applicant was "likely to have been suffering with a recurrent depressive episode of moderate severity at the time of her daughter's death …that, on balance of probabilities, this depressive disorder was likely to have impaired her ability to form rational judgement at the time of the offence for which she has been convicted, and that this is likely to explain her involvement in the offence. The partial defence of diminished responsibility would, therefore, be eligible."

31. Mr Godfrey QC submits that it is necessary or expedient in the interests of justice that we should receive this fresh evidence having regard to the factors in section 23(2) (a) to (d) of the Criminal Appeal Act, 1968 namely, the evidence is capable of belief, may afford a ground of defence, would have been admissible in the trial and there is a reasonable explanation why it was not available at trial.

32. Mr Hankin QC, on behalf of the respondent prosecution, does not question the integrity of Dr di Lustro's or Dr Rampling's professional opinions but he does challenge the veracity of the facts upon which they rely. In summary, he argues that the applicant's account was disingenuous and devious to overcome and explain the issues which led Dr Kennedy and, ultimately, Dr Muzaffar to conclude that there was no medical defence. Dr Kennedy had been asked to revisit his previous opinion having regard to his professional colleagues' views. Even subject to the plausibility of the applicant's new account of her personal history and reasons why she had not disclosed some of these facts before, he remained firmly of the view that there was no medical defence, not least in the light of the indications of pre-meditation to kill as shown by the internet searches and her conversations in hospital after the event. The respondent relies also upon the addendum report (see [22] above) and further report of Dr Muzaffar and the report of Dr Acovski.

33. However, quite apart from the challenge made to the integrity of the provenance of the psychiatric evidence upon which the applicant seeks to rely, the respondent takes as a preliminary point that the applicant should not be allowed to advance a medical defence and evidence which could and should have been put before the jury who tried her. Mr Hankin QC relies upon R *v Erskine (Kenneth) [2009] 2 Cr.App.R. 29*. We summarise his argument to be that this is a prime example of 'expert shopping' which subverts the trial process. Examination of the evidence available and deployed at trial, including that of the applicant, and the circumstances in which the medical defence that was to be pursued on her behalf was abandoned means that it is not in the interests of justice and contrary to the public interest in finality that this court admits the proposed 'fresh' evidence. Dr di Lustro, in her oral evidence to this court, had confirmed that there was no psychiatric or cognitive impediment why the applicant could not reveal the facts upon which the new psychiatric opinions had been based. Her reluctance to do so was said to be the product of a psychological formulation but the decision to withhold and/or misrepresent her symptoms was both competent and voluntary. Therefore, there is no "reasonable and persuasive explanation" to account for the failure to do so.

34. We note that there is no suggestion that the applicant was unfit to stand trial in any of the psychiatric reports. Further, there is no proposed ground of appeal which suggests that the applicant was not fully engaged by her trial counsel in the decisions that were made as we reflect in [23] above. We pressed Mr Godfrey QC on this point, who has not sought to do so in his written or oral submissions and, in the absence of any criticism of her trial counsel or solicitor, the applicant has not been asked to waive privilege for the Registrar to seek their response to any suggestion that legal advice tendered was misinformed, her instructions were misinterpreted or ignored, or that her will was overridden in this respect. Nevertheless, we have examined the psychiatric reports and had regard to the oral evidence regarding the applicant's psychological characteristics which are said to account for her failure to make adequate disclosure to the psychiatrists previously instructed, we have explored any potential 'exceptional' reason that would

explain why she had not 'spoken out' at the appropriate time about the decisions made at trial.

35. In this regard, and for the purpose of this exercise, we bear in mind that Dr Rampling considered that "the applicant's longstanding feelings of inadequacy would lead to her feeling uncomfortable when challenged in formal settings such as police/psychiatric interviews and she would seek to resolve this discomfort through conflict avoidance, including her responding to questions in a manner she calculated would result in a least intimidating verbal exchange".

36. We cannot conceive of a situation in the circumstances of this case, nor is there asserted, any confrontational interaction between counsel and the applicant in conference following on from Dr Muzaffar's effective withdrawal from the case. The applicant had given her evidence of the events on the night in question and had obviously recalled more detail than had comprised the basis of the instruction to Dr Muzaffar. It would have been impossible for her counsel to 'test' whether her recollection under oath was reliable. It is unlikely that the applicant suggested that she had 'patched the events together' in interview and under cross-examination, as she told Dr di Lustro subsequently. In these circumstances we consider that there is no reasonable basis to doubt the reliability of her implicit decision not to instruct her counsel to seek discharge of the jury at that stage, nor in relation to her 'agreement' to the agreed fact. Ostensibly this would be sufficient to dispose of the application to adduce fresh evidence, but we have nevertheless considered the issue further and in the round, by virtue of what may be termed the 'practical necessity' thrust upon the applicant at trial to abandon a medical defence.

37. We are satisfied that Dr di Lustro's opinion that the applicant suffered also from a complex post-traumatic stress disorder, which is not supported by any other psychiatrist, is not established to the orthodox prescribed standard, as she conceded in cross-examination; however, it is not a necessary makeweight. The possible partial defence of diminished responsibility is dependent upon Dr di Lustro and Dr Rampling's assessment that the applicant was suffering from a moderately severe recurrent depressive disorder at the time of the killing and assumed dissociative behaviour during the fatal insults. This is based upon the applicant's account of her personal history to them, which contradicted the information that she had first provided to Dr Muzaffar, Dr Kennedy, and Dr Acovski, and her assertion that she is amnesic as to the events surrounding the birth.

38. We heard the evidence of Dr di Lustro and Dr Kennedy, *de bene esse*. Mr Godfrey QC and Mr Hankin QC had agreed with the Registrar that only they were required to give live evidence if we agreed to receive it. We regard this to be a pragmatic solution and a sensible use of court time. We have otherwise had regard to the reports of Dr Rampling and Dr Muzaffar.

39. In her comprehensive report Dr di Lustro was satisfied that the applicant had "understanding that any appeal against her sentence and conviction could depend upon the outcome of the assessment." The applicant had revealed to her that she had been subjected to verbal bullying at school and consequently had had a 'miserable time for years'. She had been involved in an emotionally abusive relationship with one partner and described her initial indifference to her daughter E which had caused her considerable shame and distress. She felt a failure. Dr di Lustro noted that the

applicant's inability to bond with E and emotional detachment had been reported and documented by the health visitor, but that there did not appear to have been any consideration of whether she was suffering from post-natal depression at the time.

40. The applicant told Dr di Lustro that she had seen Dr Acovski, after arrest and then Dr Muzaffar and Dr Kennedy before trial, who saw her for 'half an hour'. She had felt uncomfortable and judged by the male psychiatrists and had not been open with them. In Dr di Lustro's opinion: "consistent themes during her early life of experiencing a sense of failure …, being abused when perceived as inadequate or failing and a consistently low estimation of one's self-worth, these would have been factors in maintaining [the applicant's] silence". She considered the applicant's explanation for the lack of disclosure to the psychiatrists who had assessed her previously was credible.

41. Dr Rampling met with the applicant on 25 November 2020 and interviewed her for just short of two hours. The applicant gave a similar account to Dr Rampling, a male psychiatrist, as she had provided to Dr di Lustro regarding the bullying and symptoms suggestive of post-natal depression. Dr Rampling considered that the applicant described herself in terms that were strongly shaped by a position of longstanding low self-esteem and feeling constantly judged by other people. When asked about her interviews with Dr Muzaffar and Dr Kennedy, she said "I thought mental health was irrelevant, because I didn't think I'd done what they said I'd done… This was a new situation for me, I'd never been in trouble like this before. I didn't think it was relevant, and I didn't want E to know this was how I felt". She said she was now able to speak more openly about her feelings since she had spoken to a prison doctor and mental health worker in prison who had prescribed medication to help her sleep and to lessen her 'flashbacks'.

42. Dr Rampling noted that on 22 August 2017 there is record of an Edinburgh Postnatal Depression Scale (EPDS) being completed at which the applicant scored 13/30. The EPDS scoring guidelines state that "mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention". On this scale she marked highly on feelings of self-blame, anxious, scared/ panicky, letting things get on top of her but gave a low score on feelings of sadness. Her answers to direct interview questions contradicted some of the responses to the EPDS but Dr Rampling found that she provided convincing evidence of a post-natal depression after the birth of E, which occurred against a backdrop of longstanding low self-esteem. In his opinion these depressive thoughts escalated as the reality of her 2017 pregnancy became harder to ignore, thereby generating a fear of new motherhood which influenced the killing. At the time of the death of her daughter, the applicant described to him low mood, loss of enjoyment, disturbed sleep, poor concentration, low self-confidence, and a fear of the future which are symptoms of a depressive disorder of moderate severity. Dr Muzaffar's description of symptoms which could indicate an acute stress reaction, could equally be considered symptoms of a depressive episode.

43. Dr Rampling thought the symptoms of depression she presented were plausible, although they had not been corroborated by objective assessment at the time. However, there is a plausible formulation to explain why the applicant kept her symptoms hidden from professionals, therefore compromising their ability to make the diagnosis.

44. Dr Rampling also thought that it was plausible that the applicant withheld information from Drs Muzaffar and Kennedy for fear of her inadequacies being exposed. That they

were men in positions of influence may have had significance 'but it is difficult to hold this position with any certainty' and other possible explanations would include that the applicant was "elaborating her symptoms to serve the interests of her appeal."

45. Dr Muzaffar, who saw the applicant on two occasions, once in June 2018 and once in March 2019, was requested by the respondent to respond to the assertion that the applicant had been unable to communicate with him effectively about bullying, a previous emotionally abusive relationship which made her feel worthless, and symptoms of possible post-natal depression after E's birth because she was made to feel like they (he and Dr Kennedy) were 'judging me'.

46. Dr Muzaffar accepts it is possible and not very uncommon for patients to form different levels of engagement with different professionals and therefore have some variation in the amount of information they provide. The level of engagement can change as the mental state changes. The settings in which the interactions take place, and the individual styles of various professionals are relevant. The context and implications of the interviews are also important and relevant. Some patients find it easier to engage with a particular gender. He thought it is possible that the applicant felt judged during their meetings and was unable to speak about certain aspects of her past, although that was not apparent during his interviews with her. He did not record any extreme discomfort in her interactions with him and did not think that she was guarded but he noted that she did not appear to "accept her general level of distress." However, he noted that the applicant had given a similar account to the one she had given to him in the first interview to Dr Acovski, a female psychiatrist, who saw the applicant on 1 September 2017.

47. Dr Kennedy had been instructed by the prosecution prior to trial to report upon the applicant's mental state. He saw the applicant on two occasions, once in March and once in April 2019. He was also asked to comment on the different history that the applicant had provided to Dr di Lustro, as compared with what she had told him and Dr Muzaffar, and her stated reason for so doing. In his oral evidence before us, he immediately made clear that he had seen the applicant for substantially longer than the half hour she claimed, and that she had not raised any objection to seeing him or said that she would prefer to see a female psychiatrist. However, he had interviewed the applicant again by video link on 14 January 2021 and the applicant said that she had told things to Dr di Lustro that she had not told him because she felt 'judged' and had just 'closed myself up'. He too referred to the fact that Dr Acovski, who had seen the applicant post-partum, is female.

48. He did not see any indication in the clinical records that the applicant had been low in mood, irritable, anxious, or tearful but did note the Health Visitor's account "mother not seen to interact well with baby, possibly due to unknown pregnancy and limited bonding time" and professional concerns recorded following further visits to similar effect until she saw the applicant and E together on 18 October and noted that all was well. Throughout, the applicant had denied feeling down, depressed, or hopeless and said that she was fine but there was a record that "I [the health visitor] have not reached the point with [the applicant] where I felt she was completely emotionally open with me". In 2016 the health visitor described the applicant as "very closed and difficult to form a relationship with … having met with her multiple times over all the contacts she always presented the same way, and I came to the conclusion that this was her personality".

49. He found nothing to suggest that the applicant was unaware of how she had felt that she was unaware of any bullying that she might have experienced and, nothing to suggest that she was unaware of her fear of feeling unable to bond with the baby. It was these experiences which formed the basis for any psychiatric defence. There was no psychotic or cognitive process preventing her from making these disclosures. He would have made clear to the applicant that her symptoms and functioning prior to the killing was of crucial legal importance. The material which she failed to disclose to him, or Dr Muzaffar was not, objectively, particularly sensitive except for failing to bond with E.

50. There was no account in any of the pre-trial reports or statements of any deterioration in her social and occupational functioning prior to the birth. ICD-10 states "An individual with a moderately severe depressive episode will usually have considerable difficulty in continuing with social, work or domestic activities". There is no account of poor performance at work, of her being impaired in concentration when she drove to Skegness or of her appearing anything other than her normal self. There was no evidence other than her more recent self-report and the nature of the killing itself, to suggest that her functioning was substantially impaired. In his opinion on the balance of probability, any depressive episode was no more than mild.

51. We have cautioned ourselves of the difficulties which arise from retrospective medical assessments, particularly based upon self-report, or the revised recollections of close family members post-conviction of the applicant's apparent emotional state. We are satisfied that Dr Muzaffar and Dr Kennedy explained the nature of their role to the applicant and that the information that she provided would be important to their opinion and to any possible medical defence. We have no doubt that she understood her precarious legal position at the time of their interviews, regardless of what she said to Dr Rampling. We agree with Dr Kennedy that it is difficult to understand her reluctance to refer to the verbal bullying she experienced at school. We observe that she extricated herself from what appears to have been a controlling relationship. We are, however, prepared to give the applicant the benefit of the doubt that she was shy to describe what may be regarded as personal failures. In any event, we find that there is independent evidence identified by Dr di Lustro and Dr Rampling upon which a jury could conclude that the applicant did suffer from post-natal depression after E's birth. However, we are not persuaded that this persisted beyond the autumn of 2016 and note that the applicant's account to Dr Rampling to the effect that she had never regained her equilibrium after the birth of E nor really formed a maternal relationship with her, amplifies the details that she provided to Dr di Lustro, to whom she described a resolving and improved emotional state and her closeness to E. This last aspect being apparent from contemporaneous report and, it seemed to us, the applicant's reaction to reference to her daughter throughout.

52. Nevertheless, this aspect of her pathology does not resolve the issue for the purpose of the applications before us. Assuming, in the applicant's favour, that the jury would have found that, on the balance of probabilities, there was at the time of the killing an abnormality of mental functioning which arose from a recognised medical condition, the issue of whether the defendant had a substantial impairment of ability to understand/form rational judgment/exercise control and whether it is a cause or explanation for the killing is not so readily resolved. This, we consider, would necessarily be adjudged against the empirical evidence of the time, and not the

applicant's retrospective reports upon which Dr di Lustro and Dr Rampling's opinions are based.

53. The applicant gave a clear account to Dr Acovski of being able to remember the birth, of thinking the baby was born dead, of being surprised and panicking and placing the body in a corner of the garden behind a tree where nobody visits. She stated that she did not know that she was pregnant until she gave birth in the toilet and reported no history of depression or of depressive symptoms.

54. The applicant told Dr di Lustro that she could not recall in detail the events of the night when the child was born including the internet searches since it 'was all a blur'. The only thing she could remember was the baby lying on the floor in the toilet and did not recall whether alive or dead at that time. She had 'patched events together' during the police interviews and trial. In Dr di Lustro's opinion, the "overwhelming fear of a similar experience of failure and inadequacy as a mother would have resulted in an overwhelming drive to ensure that this did not recur. Therefore, in the moment, when faced with the living child, [she] may have been, compelled to act in order to ensure that there was not a repetition of these circumstances and traumatic experiences … It is likely that she was acting in a dissociated state at the time after the birth of her daughter and this would have influenced her ability to recall events around that time …".

55. The applicant's account of the trigger event told to Dr Rampling was that, when her waters had broken on 23 April, she recognised this meant "I was going into labour, but I didn't want it to, so I just didn't think about it". She was woken by labour pains but said that she did not remember leaving her bedroom or going to the toilet. She had no recollection of the birth and said that she next recalled seeing the body of her daughter lying on the floor "not breathing or anything". This memory was vivid for her because it subsequently returned to her in flashbacks. She said that the detailed account of her thought processes during this time and her efforts in clearing up which she related in interview and at trial were false and influenced by the line of questioning. Her next memory was of placing the child in the garden but was lacking in detail with no recollection of her thought processes or emotions at the time.

56. She had given a similar account to Dr Muzaffar although she provided him with additional detail of the birth: that the baby was born very quickly, the placenta was not present, the cord was attached to the baby, who was not breathing and 'not fully formed' and 'really small'. In hospital once events had been discovered she was able to give an account of where the baby was. Dr Muzaffar's initial opinion had been that it was probable that the incident was traumatic, and she did not have any recollection of the events. If that assumption was correct, it is likely that she filled in gaps in her memory by confabulation. It was likely that psychological denial continued after the birth and it was plausible that her lack of detailed memory was a result and integral part of her 'acute stress reaction', as indicated by dissociative symptoms during the traumatic event and for some time thereafter, including a lack of emotional response and a state of reduced awareness and interaction with her surroundings.

57. In the first interview, the applicant told Dr Kennedy that she didn't know she was pregnant until the child was born. She felt she needed to use the toilet and gave birth in the toilet but did not feel any labour pains. She 'jumped up' when she had the baby; the baby was not breathing. She panicked. She did not know why she had put the baby in the bag or why she had not told her parents. She carried on as normal after the event,

'for E's sake', and had driven to Skegness with a relative. She denied any nightmares or vivid dreams but said she was experiencing flashbacks for a couple of weeks post birth when she could remember what was happening vividly.

58. During her second interview she said that she had suspected that she was pregnant although she did not conduct any tests to confirm this. She said she did not remember the details of giving birth, how she felt or what happened immediately afterwards. She vaguely remembered putting the bag in the garden but did not remember what she was thinking. She went back to bed and did not think she got a lot of sleep. She had been trying to block it out since. When referred to the internet searches she said she was 'leaking' for three days and could not remember all the searches she had made. In the post-trial interview, she had said regarding the trigger event that she had woken up in pain and then could not remember and all she had was "an image of her lying there on the toilet floor, not moving, not doing anything". She said that she could not remember the internet searches she had made and specifically denied that she had ever thought about killing the baby. She said she lied to the paramedics in panic.

59. Dr Kennedy had listened to the recording of the 999-call made to summon the ambulance for the applicant. He could hear the applicant and there was no sign that she was confused. She appeared fully aware that she had given birth and he noted the applicant's description of events to Dr Acovski.

60. In his view, the short space of time between the delivery and the killing, the sudden onset of acute illness resulting from the retention of the placenta and haemorrhage, the subsequent investigation and the applicant's separation from E were all highly traumatic events which could themselves have produced an acute stress reaction as perceived by Dr Muzaffar, but because she has given no explanation for the killing he did not consider this was attributable to the birth or could, on the balance of probabilities, be said to be an explanation for the killing. There are no events other than the killing itself which suggest impairment of ability to make rational judgements or to exercise self-control.

61. In Dr Kennedy's opinion the applicant's different account of her personal history given to him in January 2021, which mirrored what she had described to Dr di Lustro, even if accepted in its entirety, would not have substantially affected her ability to exercise a rational judgement or to exercise self-control particularly if the act consisted of considerable violence. He did not agree with Dr di Lustro's formulation that "in the moment, when faced with the living child, [the applicant] may have been compelled to act…".

Analysis

62. We agree with Dr Rampling that we should beware that the applicant's inconsistencies in her different accounts may be explained by the wilful provision of false evidence to meet the agenda of her legal case, which "warrants some scrutiny". Accepting Dr Rampling's opinion that the applicant could have suffered from dissociative amnesia which may be immediate or delayed and her recollection of events to be fragmented or entirely absent, we also accept his evidence, and that of Dr Kennedy, that her recall is unlikely to fluctuate. Therefore, we find it improbable that the applicant would regain

a memory lost to a dissociative phenomenon during cross-examination and subsequently lose it again as the applicant now claims.

63. We find that Dr di Lustro as an experienced forensic psychiatrist is, as she said in cross-examination, well aware of the possibility of artifice and able to identify the same, but we do not consider that she did sufficiently consider the possibility of a pre-meditated act within her postulation of events nor that the evidence that the applicant gave at trial could have been reliable. Certainly, as Dr Rampling makes clear, the internet searches relating to the act of harming a newborn child prior to the calculated time of the child's birth, was problematic within the wording of Dr Di Lustro's report as "in the moment". However, we note that he says that this does not exclude the scenario in which the applicant's "motivating fear escalated to a point that she was driven to harm her child at a time when she could deny the pregnancy no longer and the birth was imminent." Nevertheless, whilst Dr Rampling is satisfied that on balance her actions will have been motivated by her depressive thought processes, he found it unlikely that these processes would have led her to act in ways that were entirely out of her control. In this respect, we agree with Mr Hankin QC that the formulation does not fully address the elements of a viable defence of diminished responsibility.

64. Dr Kennedy considered the nature, timing, and chronology of the internet searches to be significant. They suggested that the killing was premeditated, and that the applicant was fully aware of what she was doing both before and after the birth. The internet searches would suggest that she was conscious of what was happening and looking for advice in 'managing the situation'. In this respect we note, with interest, that when challenged by Dr Kennedy in the post-trial interview about the internet searches, the applicant gave new and additional information to the effect that she had been 'leaking for three days' which tells against the suggested amnesia with which she suffers, and which led her to describe this factor as 'a blur' to Dr di Lustro and Dr Rampling.

65. In Dr Kennedy's opinion, on the balance of probability, if her account of her symptoms prior to the killing is accurate, any depressive episode was no more than mild. There was no evidence other than her more recent self-report and the nature of the killing itself, to suggest that her functioning was substantially impaired. He had given anxious thought to the possibility of the rare post-partum psychoses that were reported in the scientific literature bearing in mind the apparent savagery of the attack but could find no basis to diagnose any such derangement on the circumstances revealed by the evidence, including the various accounts of the applicant.

66. We accept Dr Kennedy's evidence that: (i) the psychiatric evidence at the time of the trial was correctly reflected in the agreed fact drawn and referred to in [24] above; (ii) even accepting that the applicant had low self-esteem, a fear of being judged and had suffered from post-natal depression following the birth of E, there is no independent and contemporaneous evidence to support the diagnosis of a moderately severe recurrent depression at the time of the fatal act nor necessarily to suggest irrational thought process or lack of self-control; (iii) the applicant's professed amnesia is unusual in that it is regressive and unpersuasive in her apparently selective recall, most likely reflecting an awareness that her contemporaneous accounts and evidence given at trial undermined the prospective medical defence that was to be advanced; and (iv) the internet searches and the applicant's contemporaneous accounts and conversations do not support the proposition that she was delusional or that the fatal event was

spontaneous. It appears to us that Dr di Lustro conceded these last two points, as does Dr Rampling in his report.

67. There is no reasonable basis to doubt the detail of the evidence given by the applicant at trial and which led Dr Muzaffar to revisit his initial opinion, for the reasons that he gave. This is not a case where the contemporaneous empirical evidence reveals there to be a robust case for the defence of diminished responsibility beyond the nature of the assaults upon the child. We are satisfied that Dr Kennedy has given anxious consideration to this possibility and has ruled it out. In our judgment, Dr di Lustro and Dr Rampling's opinion is based upon the applicant's self-reporting and disregards concomitant events and her evidence at trial.

68. Consequently, we do not consider that it is necessary or expedient in the interests of justice to admit this fresh evidence for the conviction is not undermined by this prospective evidence. The applications for permission to admit fresh evidence and to appeal and for an extension of time are dismissed.