IN THE COURT OF APPEAL

CRIMINAL DIVISION

CASE NO: 2021 04089/04090 B2
[2023] EWCA Crim 1103

Royal Courts of Justice
Strand
London
WC2A 2LL

Thursday 27 July 2023

Before:
THE VICE-PRESIDENT OF THE COURT OF APPEAL, CRIMINAL DIVISION
LORD JUSTICE HOLROYDE

MR JUSTICE GOOSE

SIR ROBIN SPENCER

REX
v
MARVIN SAMUELS

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Lower Ground, 18-22 Furnival Street, London EC4A 1JS
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MR TIM MOLONEY KC appeared on behalf of the Applicant
MR DUNCAN ATKINSON KC appeared on behalf of the Crown

J U D G M E N T
(Approved)

THE VICE PRESIDENT:

1. Almost a decade ago, in October 2013, this applicant was convicted of the murder of Sharlana Diedrick, the mother of his child. He had earlier pleaded guilty to raping and causing grievous bodily harm with intent to a woman to whom we shall refer as 'V'. He was sentenced to life imprisonment with a minimum term of 33 years less the time he had spent remanded in custody. He now applies for a long extension of time to apply for leave to appeal against conviction and sentence. That application is coupled with, and dependent upon, an application for leave to adduce fresh evidence pursuant to s.23 Criminal Appeal Act 1968. His applications have been referred to the full court by the single judge.
2. V is entitled to the life-long protection of the provisions of the Sexual Offences (Amendment) Act 1992. Accordingly, during her lifetime no matter may be included in any publication if it is likely to lead members of the public to identify her as the victim of the offences.
3. For present purposes, we can summarise the facts briefly. The applicant was aged 30 at the time of the offences, which were committed on 29 September 2012. At about 5 pm that day the applicant attacked V, who was not known to him, as she was walking her dog on a recreation ground. He raped her, strangled her, and beat her violently with a stick. V was found the following morning by concerned members of her family who were searching for her. She was naked, traumatised and severely injured. Semen recovered from vaginal swabs yielded a DNA profile matching that of the applicant.
4. After his attack on V the applicant changed his clothing. At around 11 pm that night he met up with Sharlana Diedrick. Their on/off relationship had been characterised by arguments, in particular over the applicant's contact with his son. When the applicant joined her in her car that night, he was armed with two knives. It seems they again argued about the arrangements for their son. The applicant stabbed Ms Diedrick repeatedly, wounding her fatally. She was heard screaming for help. Police quickly arrived, but the applicant had left the scene. He had placed into Ms Diedrick's hand the blood-stained knife which he had used to stab her. Ms Diedrick was pronounced dead a short time later.

5. The applicant, who had again changed his clothing, surrendered himself at a police station in the early hours of the following morning. He had cuts to his hand caused by a knife. He said that he and Ms Diedrick had argued and he had "lost it completely" and stabbed her. He said that he had felt "not in his right mind" that day.

6. When interviewed about the offences against V the applicant admitted that he had encountered V, spoken to her, and then pulled her into undergrowth and hit her. He had told her to remove her clothes and raped her. He had choked her with her own scarf and then hit her about the head with a bottle and with the branch of a tree. He said that he had been feeling abnormal at the time.

7. The applicant was charged on indictment with four offences:
   - rape of V (count 1);
   - attempted murder of V (count 2);
   - causing grievous bodily harm with intent to V (count 3, an alternative to count 2); and
   - murder of Ms Diedrick.

8. On 14 June 2013 at the Central Criminal Court the applicant pleaded guilty to counts 1 and 3. He stood trial on the remaining counts in October 2013 before His Honour Judge Pontius and a jury.

9. Before the trial the applicant was, for a period of about 3 months, transferred from prison to Broadmoor Hospital for assessment. It should be noted that around the time of that transfer, and whilst in hospital, the applicant committed three separate assaults: in the first he repeatedly slashed the face of a fellow prisoner with a blade; in the second he assaulted another patient in the hospital, striking him with a badminton racket; and in the third, on 31 July 2013, he punched a nurse. We shall return to that third incident (which we shall refer to as "the assault on the nurse") later in this judgment.

10. At trial there was little dispute about the facts, and much of the prosecution evidence was adduced in the form of statements which were read by agreement, and formal admissions of fact. The applicant's defence to count 2 was a denial of intention to kill. In relation to count 4 it was accepted on his behalf that he had killed Ms Diedrick with the requisite intention.

He put forward the partial defence of diminished responsibility, contending on that basis that he was not guilty of murder but guilty of manslaughter.

11. The applicant himself did not give evidence. The judge in due course directed the jury that they should take the applicant's mental health history into account when deciding whether it would be fair and proper to hold against him that he did not give evidence.

12. Three consultant forensic psychiatrists gave expert evidence on the issue of diminished responsibility: Dr Richard Taylor and Dr Nadji Kahtan for the defence, and Dr Philip Joseph for the Crown. Each of them had interviewed the applicant at least once and had reviewed previous medical records, details of the applicant's previous convictions and other relevant material.

13. Dr Kahtan's opinion was that it was likely that the applicant suffered from a mental illness, most appropriately diagnosed as some form of paranoid psychosis and probably paranoid schizophrenia, in addition to "his previous long-standing mental health problems". His evidence was that at the time of the killing the applicant was suffering from an abnormality of mental functioning arising from that recognised medical condition, and that as a result there was substantial impairment of both his ability to form a rational judgment and his ability to exercise self-control.

14. Dr Taylor's opinion was that the applicant clearly fulfilled the criteria for a personality disorder. That disorder appeared to be "predominantly antisocial by evidence of his substance misuse and his repeated pattern of offending, but there is also some evidence of paranoid personality traits". In addition, the applicant's account of auditory hallucinations, persecutory delusions and delusions of reference were suggestive of a psychotic illness in addition to his established personality disorder. Dr Taylor's opinion was that the applicant was suffering from abnormality of mental functioning, namely acute psychotic symptoms, including persecutory delusions and auditory hallucinations, in the context of schizophrenia. This, he said, was against a background of well-established personality disorder with predominantly antisocial and also paranoid features. In Dr Taylor's opinion, this abnormality of mental functioning substantially impaired the applicant's ability to form a

rational judgment and provided an explanation for his actions at the material time. Thus, the two expert witnesses on whom the defence relied were not in full agreement as to which of the applicant's capabilities had been impaired.

15. The judge, when summing up, later summarised the evidence of those two defence witnesses as follows:

> "Dr Taylor and Dr Kahtan accept the existence over many years, and certainly since early adolescence, of an antisocial personality disorder in the defendant but, in their opinion, his symptoms go beyond that pre-existing disorder. They give, therefore, a dual diagnosis of paranoid personality disorder, not in law a mental illness, plus a more recently developing psychotic illness, probably schizophrenia, which is, for these purposes, a mental illness. Both said that, in their opinion, that mental illness is highly unlikely to have arisen only after the defendant's arrest but was an existing condition on 29 September."

16. Dr Joseph took a different view. He noted the history of conduct disorder during the applicant's childhood and felt it likely that in adulthood the applicant had developed features of antisocial personality disorder. Dr Joseph further noted that the applicant's own account of psychiatric symptoms was not supported by any medical record prior to the offences. Moreover, although the applicant had since his remand in custody described a number of symptoms suggestive of mental illness, his presentation had been inconsistent. Dr Joseph thought it possible but not probable that the applicant was experiencing psychotic symptoms at the time of the killing of Ms Diedrick. Dr Joseph went on to opine that if the applicant was suffering from a recognised mental condition at the material time, the most likely diagnosis was an antisocial personality disorder; but that condition did not substantially impair the applicant's ability to understand the nature of his conduct, form a rational judgment or exercise self-control. He therefore concluded that even if the applicant was suffering from that condition, it did not substantially impair his mental responsibility for the killing.

17. The judge in his summing-up gave impeccable directions of law, about which no complaint is or could be made. In particular, he directed the jury clearly about their approach to the partial defence of diminished responsibility, explaining that the burden was on the defendant

to show on the balance of probabilities that at the time of killing Ms Diedrick he was suffering from an abnormality of mental functioning which arose from a recognised medical condition and which substantially impaired his ability to understand the nature of what he was doing and/or to form a rational judgment and/or to exercise self-control; and that the abnormality of mental functioning which caused that substantial impairment caused the applicant to kill Ms Diedrick or at least was a significant contributory factor in causing him to do so. It should be noted that the judge directed the jury that the general term "a recognised medical condition" was not confined to mental illness and "... will obviously include an antisocial personality disorder, which there is no doubt amongst the three psychiatrists is a condition which has afflicted the defendant for many years. So you may have little difficulty in reaching the conclusion that he was afflicted at least by that medical condition – a personality disorder – in September of 2012, whether or not he was also suffering from a psychotic illness".

18. The jury returned a verdict of not guilty on count 2 but a verdict of guilty on count 4. After a short adjournment, the judge sentenced the applicant to life imprisonment on each of counts 1, 3 and 4, specifying minimum terms of 7 years, 6 years and 33 years respectively.
19. In February 2014 the applicant, who had been in prison, was transferred back to Broadmoor Hospital, where he remains.
20. The ground of appeal against conviction is that the conviction for murder is unsafe because fresh evidence is now available which shows that the applicant cannot have been suffering from a personality disorder at the time of the offence. His ground of appeal against sentence is that if his appeal against the murder conviction is successful, the sentences imposed for the offences of rape and/or of causing grievous bodily harm with intent are wrong in principle and/or manifestly excessive.
21. The applicant asks the court to receive as fresh evidence the expert evidence of Dr Kevin Murray, a consultant forensic psychiatrist. Between December 2014 and September 2017 the applicant was under Dr Murray's care at Broadmoor Hospital.
22. The respondent opposes the admission of Dr Murray's evidence. If it is received by this

court, the respondent seeks in response to rely on fresh evidence from another consultant forensic psychiatrist, Dr Nigel Blackwood. Each of those prospective witnesses prepared reports for the assistance of the court.

23. The appeal was listed for hearing on 18 May 2023. On that day, however, the court was informed that in 2014 Dr Blackwood had been instructed by the solicitors acting for the applicant in relation to the assault on the nurse. He had been asked to prepare a report addressing the applicant's fitness to plead to that charge and whether a defence of insanity was available to him. He had also been asked to comment on a suggestion by the solicitors that there may have been a misdiagnosis of the applicant's condition at his trial for murder. This unexpected development led to the hearing being adjourned and directions given as to the further evidence. Those directions have been complied with and so the matter comes before the court today. We have heard *de bene esse* oral evidence from both Dr Murray and Dr Blackwood.

24. Dr Murray recorded in his report that the applicant spoke to him of "a history of abnormal mental experiences since early adolescence, including hearing voices in his head". He notes that in recounting the circumstances of his attack on V, the applicant said that when he was raping her, "he had thoughts of having to kill her, thoughts that were going into his head", but that the idea had then come into his mind that "he had to leave her and instead to find and kill a friend of his, someone named DB". The applicant went on to tell Dr Murray that when he later met Ms Diedrick, she drove him to a place where he thought he might find DB. DB was not there, so he got back into the car and thereafter, he said, he heard the devil's voice repeatedly telling him to kill Ms Diedrick.

25. Dr Murray considered the expert evidence given at trial, and the reports and records of the applicant's care at Broadmoor Hospital since his conviction. He refers to recent reports of the applicant's intellectual limitation which had not previously been noted by the witnesses at trial. He notes that each of the four consultant forensic psychiatrists, including himself, who has had the care of the applicant during the period since 2014, has diagnosed the applicant as suffering from paranoid schizophrenia, complicated by the evidence of

intellectual impairment. It is Dr Murray's opinion that the applicant's paranoid schizophrenia significantly predated the offences. It is further his opinion, taking into account neuropsychological testing and the applicant's behaviour since conviction, that it is no longer possible to assert that the applicant has a paranoid and antisocial personality disorder. He concludes that at the time of killing Ms Diedrick the applicant was suffering from an abnormality of mental functioning which arose from a recognised medical condition, namely paranoid schizophrenia, and which substantially impaired his ability to form a rational judgment and to exercise self-control in response to overwhelming auditory command hallucinations. On the issue of impairment, therefore, Dr Murray holds the same opinion as was expressed at trial by Dr Kahtan.

26. In his oral evidence, Dr Murray placed emphasis on the comparative speed with which a particular antipsychotic drug had improved the applicant's mental condition after his return to Broadmoor Hospital in 2014. He stated that those suffering from an antisocial personality disorder do not suddenly improve with medication. Even in the most careful and structured environments they continue to exhibit impulsiveness and aggression for many years. Dr Murray did not regard the differing accounts of his symptoms which the applicant has given at different times as detracting from a broadly consistent account. He stated that psychotic illness does not totally remove rational thought and that accordingly his opinion and assessment were not affected by what could be regarded as features of rational behaviour by the applicant at the time of the offences.

27. Dr Blackwood referred in his report to the applicant's troubled childhood and the clear evidence of conduct disorder from a young age, together with substance misuse from a young age, and to the applicant's previous convictions both as a child and as an adult. In Dr Blackwood's opinion, that childhood conduct disorder evolved in adulthood into an antisocial personality disorder, characterised by impulsivity, irritability, aggressiveness, reckless disregard for the safety of others, and irresponsibility. Dr Blackwood notes that the applicant had not been in contact with adult mental health services before the present offences and that his account of his mental state and the circumstances of the offences have

changed across time. Dr Blackwood stated in his report:

> "While Dr Murray's confident working diagnoses of paranoid schizophrenia and some degree of cognitive impairment may be reasonable ones, any potential psychotic symptoms at the time of the index offences operated in the context of an established antisocial personality disorder (characterised by elevated aggressivity, irritability and impulsivity), voluntary skunk cannabis misuse (which may have caused or amplified any emergent psychotic symptoms) and an argument in the context of a highly volatile relationship which had previously been characterised by violence. I do not consider that Dr Murray's attempted exclusion of important other diagnostic constructs (antisocial personality disorder and significant voluntary skunk cannabis misuse) is merited. The cluster of mental state abnormalities which Mr Samuels has described with varying degrees of consistency as operating at the material time (paranoia; potential auditory hallucinations) did not in my view substantially impair his ability to form a rational judgement and to exercise self-control at the time of the murder, and I do not accept that the partial defence of diminished responsibility should have obtained at the time of the 2013 trial."

28. In his oral evidence, Dr Blackwood said that when first instructed in this matter he had no recollection of having previously provided a report on the applicant. He explained that when reporting in 2014 and 2015 he had been provided with only limited information directly relevant to the assault on the nurse. He did not have any of the details of the murder trial or any earlier materials. He accepted that in his correspondence with the defence solicitors at that time, he had expressed the opinion that the applicant was then suffering from paranoid psychosis. He also accepted Mr Moloney KC's suggestion that the applicant's initial wish to be kept in prison, and unwillingness to engage in any medical treatment, are counterintuitive if this was a case of malingering. However, having reflected on the matter in the light of the more extensive information now available to him, Dr Blackwood maintains the diagnosis and assessment set out in his report in these proceedings. In his opinion, the diagnosis of antisocial personality disorder was clearly established at the time of the offences and cannot now be ruled out in the way Dr Murray suggests. He attaches significance to the fact that after a period at Broadmoor Hospital before the trial, the applicant was then returned to prison until 2014. Dr Blackwood observes that the treating clinicians must therefore not have been of the view that the

applicant was suffering from paranoid psychosis, as if they had been they would have wished to keep him at the hospital for treatment.

29. Mr Moloney submits on behalf of the applicant that the necessary long extension of time should be granted to enable the applicant to pursue an appeal. He points to the practical difficulties which the applicant in hospital faced in communicating through his advocate a wish that his solicitors should pursue an appeal. He suggests that if an appeal had been commenced several years ago the applicant would have been vulnerable to the criticism that nothing had really changed since the time of the trial, whereas now Dr Murray can point to observations of the applicant in Broadmoor Hospital over a period of nearly 10 years.

30. Mr Moloney goes on to submit that the evidence of Dr Murray meets the criteria in s.23 Criminal Appeal Act 1968 and should be received in evidence. He relies on this evidence in support both of his application for an extension of time and of his application for leave to appeal against conviction. He submits that it is the passage of time which has enabled Dr Murray positively to exclude the suggestion that the applicant was suffering from a personality disorder and that the evidence has only now become available. The exclusion of such a disorder, it is submitted, would have been critical to the jury's assessment of whether psychosis at the time of the killing was possible or probable, and leads to the conclusion that the applicant's responsibility for the killing was substantially diminished by an abnormality of mental functioning arising from paranoid schizophrenia. In support of these submissions Mr Moloney points to the fact that the jury during their deliberations sent a note asking the judge for assistance on whether a personality disorder was an abnormality of mental functioning and whether it was a recognised medical condition.

31. Mr Moloney accordingly submits that the conviction of murder should be quashed and a conviction of manslaughter on the ground of diminished responsibility should be substituted. If he succeeds in that submission, it follows that the applicant would no longer be liable to a mandatory sentence of life imprisonment, and Mr Moloney would also wish to argue that the sentences for the other offences should be varied.

32. On behalf of the respondent, Mr Atkinson KC submits that Dr Murray's evidence does no

more than revisit the information which was known at the time of the trial, albeit with different emphasis. He argues that if Dr Murray's evidence had been available at trial the issues for the jury would have been the same, and if Dr Blackwood's evidence had also been available the only difference would be that there would be three witnesses supporting a finding of diminished responsibility and two against, instead of two witnesses and one witness, as before. He submits that Dr Murray's evidence therefore should not be admitted as fresh evidence. He further submits that in any event it cannot be assumed that a new witness with a longer and more recent period of observation of the applicant is necessarily correct in his diagnosis; and even if he is, it does not follow that the jury's verdict would have been different, because the jury would have been entitled to accept the diagnosis of paranoid schizophrenia but nonetheless conclude that the applicant's responsibility for his actions was not substantially diminished. In support of that argument Mr Atkinson points to a number of features of the applicant's conduct before and at the time of the killing, including his conduct towards V, and emphasises that Dr Murray's opinion is dependent on the applicant's own account of his mental state at the time of the offences, an account which Mr Atkinson submits has differed over time in material respects.

33. In summary, Mr Atkinson submits that the fresh evidence on which the applicant wishes to rely is not in fact new; it relies on the account given by the applicant, who is unreliable; and it fails to address features of the applicant's history, including his drug and alcohol misuse and his volatile relationship with Ms Diedrick, which are consistent with the diagnosis of antisocial personality disorder which was recognised at the time.

34. We are grateful to counsel for their submissions. We have summarised those submissions and the expert evidence very briefly, but we have considered all the evidence and all the points made on each side.

35. As will be apparent, we have considered the proposed fresh evidence of both Dr Murray and Dr Blackwood *de bene esse*. As will also be apparent, the issues of extension of time, fresh evidence and leave to appeal are all closely intertwined.

36. We must first consider the application for an extension of time. We are sympathetic to the

practical difficulties which we recognise the applicant faced in deciding whether to give instructions to pursue an appeal, and we recognise the delays which can arise when commissioning further expert reports. We are, however, troubled by the fact that as long ago as 2014 to 2015 the applicant's solicitors were considering the issue of whether his mental condition had been misdiagnosed at trial, and by the fact that Dr Murray was actively involved in treating the applicant from 2014 to 2017 and would therefore have been able to provide his supportive evidence. In fairness to the applicant however, we would not wish to determine this case solely with reference to the late commencement of the appeal. We therefore turn to consider the merits of the ground of appeal.

37. We begin by reminding ourselves of two relevant statutory provisions.

- Section 2 of the Homicide Act 1957, as amended, provides, so far as is material for present purposes:

> "(1) A person ('D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—
>
> (a) arose from a recognised medical condition
> (b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and
> (c)provides an explanation for D's acts and omissions in doing or being a party to the killing.
>
> (1A) Those things are—
>
> (a) to understand the nature of D's conduct;
> (b) to form a rational judgment;
> (c) to exercise self-control.
>
> (1B) For the purposes of subsection (1)(c), 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.
>
> (2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section not liable to be convicted of murder.
>
> (3) A person who but for this section would be liable, whether as principal or as accessory, to be convicted of murder shall be liable instead to be convicted of manslaughter."

- Again so far as is material for present purposes, s.23 of the 1968 Act provides:

> "(1) For the purposes of an appeal ... under this Part of this Act the Court of Appeal may, if they think it necessary or expedient in the interests of justice—
>
> ...
>
> (a) receive any evidence which was not adduced in the proceedings from which the appeal lies.
>
> ...
>
> (2) The Court of Appeal shall, in considering whether to receive any evidence, have regard in particular to—
>
> (a) whether the evidence appears to the Court to be capable of belief;
> (b) whether it appears to the Court that the evidence may afford any ground for allowing the appeal;
> (c) whether the evidence would have been admissible in the proceedings from which the appeal lies on an issue which is the subject of the appeal; and
> (d) whether there is a reasonable explanation for the failure to adduce the evidence in those proceedings."

38. In **R v Kai-Whitewind** [2005] EWCA Crim 1092 at [97] the court said:

> "Where expert evidence has been given and apparently rejected by the jury, it could only be in the rarest of circumstances that the court would permit a repetition, or near repetition of evidence of the same effect by some other expert to provide the basis for a successful appeal. If it were otherwise the trial process would represent no more, or not very much more than what we shall colloquially describe as a 'dry run' for one or more of the experts on the basis that, if the evidence failed to attract the jury at trial, an application could be made for the issue to be revisited in this court. That is not the purpose of the court's jurisdiction to receive evidence on appeal."

39. As is well established, this court's discretion to receive fresh evidence on appeal is a wide one, to be exercised in the interests of justice. The decision of this court in **R v Petrolini** [2012] EWCA Crim 2055, on which Mr Moloney relies, shows that expert evidence may be admitted on the basis that the passage of time since the applicant's conviction has enabled medical practitioners to make a clearer assessment not only of his current mental state but also of his likely mental state at the time of the offending. It should be noted that the facts in **Petrolini** were very different from those in the present case.

40. Here, we readily accept that the evidence of Dr Murray is capable of belief and would have been admissible if available at trial. Since Dr Murray's opinion is based on assessments of

the applicant over many years, we also accept that it is at least strongly arguable that there is a reasonable explanation for the failure to adduce his evidence at trial. We must, however, consider the remaining matter specifically mentioned in s.23(2) of the 1968 Act, namely whether Dr Murray's evidence may afford a ground for allowing the appeal.

41. As we have noted, Mr Moloney submits that a particularly important feature of Dr Murray's evidence is that it excludes the previous diagnosis of personality disorder and so would support a conclusion that it was probable rather than merely possible that the applicant was suffering from a psychosis at the time of the killing. Mr Moloney suggests that was the critical area of dispute between the expert witnesses at trial. He goes on to submit that evidence which could show that the applicant probably was psychotic at the material time would also support a conclusion that the other necessary elements of the partial defence were established on the balance of probabilities.

42. Although the argument was presented by Mr Moloney with typical skill, it faces a number of difficulties.

- First, as will be apparent even from our brief summary of the expert evidence at trial, all three witnesses addressed each of the possible diagnoses of personality disorder and paranoid schizophrenia. All three considered each of those diagnoses, albeit that they expressed differing opinions about them. They did so with the benefit of the same information about the applicant's childhood, alcohol and drug misuse and criminal convictions as was available to Dr Murray, and they too considered the significance of the applicant's report of auditory hallucinations. If the proposed fresh evidence of Dr Murray does no more than add a fourth opinion on the same issue, it would not normally be in the interests of justice to receive it for the reasons explained in **Kai-Whitewind**. One of the factors which this court must take into account in deciding whether the interests of justice make it necessary or expedient to receive fresh evidence is the strong public interest in the finality of proceedings.
- Secondly, we accept of course that Dr Murray is able to point to assessments and observations over a period of years which were not available to the expert witnesses at

trial. However, that aspect of his evidence has to be seen in the context of the closely controlled environment in which the applicant has lived and been cared for during that period; in the context of the applicant's account of the killing and of the circumstances of his attack on V having changed in material respects; and in the context of all three expert witnesses at trial agreeing that the applicant suffered from a personality disorder. In relation to the last of those three features, we see much force in Mr Atkinson's submission that Dr Murray's analysis does not account for the evidence which caused the three witnesses to make that diagnosis. We are not persuaded that Dr Murray, looking back years later and necessarily relying to a significant degree on the self-report of the applicant, is able to reject as incorrect an assessment made by three professional colleagues who interviewed the applicant within a few months of the killing. We cannot accept the assertion, implicit in the ground of appeal, that if Dr Murray's evidence is received it would not be open to a jury to find that the applicant was suffering from a personality disorder at the time of the offence. Even if we could accept that proposition, it would not in any event be determinative in the applicant's favour, because of the third matter to which we now turn.

- Thirdly, it must be remembered that a jury considering whether a defendant has discharged the burden of proving the partial defence of diminished responsibility must consider not only the expert evidence but also all the other evidence in the case. Key features of that evidence, as it seems to us, included the nature of the applicant's attack on V; the fact that, after that attack, he both changed his clothes and armed himself with knives before going to meet Ms Diedrick; and the nature of his conduct during and immediately after his fatal attack upon Ms Diedrick. We would add that if Dr Murray's evidence were received, the evidence as to the circumstances of the attack on V would include the account now given by the applicant that he had thoughts of killing her but broke off his attack in order to find and kill someone else.

43. There was, in our view, compelling evidence before the jury to support their conclusion that, whatever the state of the applicant's mental health might have been at the time of his

trial, any abnormality of mental functioning from which he may have been suffering at the time of the killing was not such as substantially to impair his ability to understand what he was doing when he stabbed Ms Diedrick to death, his ability to form a rational judgment about his acts or his ability to exercise self-control. We are not persuaded that the evidence of Dr Murray could undermine that conclusion or cast any doubt on the safety of the murder conviction.

44. For those reasons we decline to receive the proposed fresh evidence and we refuse the application for an extension of time. It follows that the application for leave to appeal against conviction is also refused and the application for leave to appeal against sentence falls away.