SUPPRESSION ORDERS EXIST IN RELATION TO ASPECTS OF THIS JUDGMENT PURSUANT TO S 205 CRIMINAL PROCEDURE ACT 2011: SEE PARAGRAPH [28].

IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CRI-2013-090-005451
[2014] NZHC 541

UNDER	Section 20 Criminal Procedure (Mentally Impaired Persons) Act 2003
BETWEEN	THE QUEEN Applicant
AND	MAX ALLEN McGOWAN Respondent

Hearing:	20 March 2014
Appearances:	W P Cathcart for Crown S E McCabe for Respondent
Judgment:	20 March 2014

ORAL JUDGMENT OF COURTNEY J

Introduction

[1] On the evening of 11 September 2013 the Police attended a call from an address in Titirangi. There they found two seriously injured people, both of whom had sustained stab wounds. A bloodied kitchen knife was found in the kitchen. June Gainsford McGowan died within a short time of the Police arriving. Her husband, Stephen Charles McGowan, was treated for a stab wound to his chest. When the Police arrived Stephen McGowan told the police officers attending that "my son, he lost it, he has gone crazy, he has done this".

[2] The son that Stephen McGowan was referring to was Max McGowan, who also lived at the address. Mr McGowan is now facing charges of murdering his mother and attempting to murder his father. He accepts that he inflicted the wounds that killed his mother and injured his father but he contends that at the time of the incident he was insane as that is defined in s 23 of the Crimes Act 1961. Having regard to the circumstances of the offending and the expert reports regarding Mr McGowan's psychiatric state, the Crown agrees that the only reasonable verdict will be one of not guilty on account of insanity under s 20(2)(b) of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

[3] The matter has come before me today to determine whether a finding should be made under s 20(2)(b) and, if so, to determine the most suitable method of dealing with Mr McGowan.

Finding of insanity under s 20(2)(b) of the Criminal Procedure (Mentally Impaired Persons) Act 2003

[4] The circumstances of the incident are clear from the accounts given both by Mr McGowan senior in his interview with the Police and by Max McGowan in his interviews with the two psychiatrists later engaged. Mr McGowan had felt unwell on 11 September 2013. Although he set off for work he returned and went to his room. He had feelings of being trapped and being controlled. He also had in his mind a longstanding belief about his father (which he now acknowledges to be false). When his father came to his room and told him to come to dinner Max McGowan went upstairs, took a knife from the kitchen and stabbed his father. His

mother tried to intervene. He then turned to stab his mother before resuming the attack on his father. His father fought him off.

[5] Mr McGowan returned to his room, collected some belongings and left the house. He was found near Titirangi Rd. He had blood splatters on his jeans. He asked whether his mother was alright. Mr McGowan was taken to the Henderson police station. The following morning he was examined by a forensic nurse at Waitakere District Court and remanded to the Mason Clinic for a psychiatric assessment.

[6] The charges that Mr McGowan faces reflect the intentional killing of his mother and the intentional assault on his father. As I have already noted, Mr McGowan accepts that he committed those acts. The Crimes Act presumes that a person is sane when they commit an act until it is proven otherwise. However, s 23 of the Crimes Act recognises that people who meet the definition of legal insanity are not to be held responsible for acts committed while in that state and provides that a person who meets that definition is not to be convicted of an act that would otherwise be an offence.

[7] It is for the defendant to show that he meets the definition in s 23. There is more than one limb in s 23. Mr McGowan has sought to satisfy the definition by showing that when he stabbed his parents he was labouring under a disease of the mind to such an extent that he was incapable of knowing that the acts were morally wrong, having regard to the commonly accepted standards of right and wrong. Essentially, there are two aspects. First, was Mr McGowan suffering from a disease of the mind? Secondly, was the effect of that disease to prevent him from thinking rationally so that he could not see that his actions were wrong by the everyday standards in our community?

[8] The Criminal Procedure (Mentally Impaired Persons) Act provides a procedure by which the Court can make a finding that a person satisfies the definition in s 23 of the Crimes Act and should therefore not be convicted of the offence with which they are charged. This is the procedure that we have followed this morning. I have to hear expert evidence and decide on the basis of that evidence

whether Mr McGowan was insane within the meaning of s 23 when he stabbed his parents. If I am satisfied then I must record a finding that Mr McGowan is not guilty on the charges he faces by reason of insanity.

[9] I have carefully considered the evidence given by two psychiatrists, Professor Mellsop and Dr Chaplow. Professor Mellsop interviewed Mr McGown on 8 November 2013. He also reviewed the documentary material available whichincluded the initial report of the forensic nurse at Mr McGowan's first court ap September 2013, Police jobsheets, witness statements and records from the Mason Clinic.

[10] Professor Mellsop considered Mr McGowan's personal and mental health history. These included Mr McGowan's intermittent but longstanding beliefs about his father, his variable psychotic symptoms over the previous decade, intermittent psychiatric care and medication. He records Mr McGowan's description of events on 11 September 2013, his distracted mental state, his feeling of panic and needing to run away because he was being controlled by his parents, his attack on his parents. Professor Mellsop's conclusion is that, to a varying extent, Mr McGowan has suffered from schizophrenia for many years. This has been characterised by disordered thinking, depressed mood, affect laden delusional beliefs and auditory hallucinations. Although he has responded to some extent to anti-psychotic medication, that has not been persisted with.

[11] The result of the illness has been reduced social, occupational and intellectual functioning. Professor Mellsop considers further that Mr McGowan's disorder was probably at its most intense by September 2013 with the evidence consistent with significant auditory hallucinations and delusional beliefs relevant to his actions. He was likely to have been suffering from a level of thought process disorder which impaired his ability to think normally and logically.

[12] Professor Mellsop notes that schizophrenia is generally considered to be a disease of the mind as that term is used in s 23 of the Crimes Act. He considers that Mr McGowan knew the nature and quality of his actions on 11 September 2013 notwithstanding his schizophrenia. But he also considers, on the balance of

probabilities, that when Mr McGowan attacked his parents the intensity of his psychotic experiences was such that he did not know what he was doing was morally wrong, having regard to commonly accepted standards of moral judgment.

[13] Upon receipt of Professor Mellsop's report the Crown engaged Dr Chaplow. He interviewed Mr McGowan on 29 January 2014. Mr McGowan was still residing at the Mason Clinic and had had the benefit of several months' treatment. Dr Chaplow obtained from Mr McGowan a description of his early years and the onset of his mental illness. This included treatment in his early 20s for depression and in his mid-20s for psychosis. He particularly noted statements made by Mr McGowan to a police officer on the night of the incident and to observations of mental health staff who observed Mr McGowan that night, recorded by the police officer. This included an observation that Mr McGowan was suffering from paranoid delusions and was in a state of psychosis. Dr Chaplow also notes that in his police interview Stephen McGowan describes being suspicious in the period preceding the incident that his son's mental state was deteriorating.

[14] Dr Chaplow summarised Mr McGowan's history as being one of a 17 year history of mental illness characterised by poor socialisation, social maladaptation and classical symptoms of auditory hallucinations, paranoid delusions and both negative and positive signs of schizophrenia. When treated appropriately his illness was contained but he was often non-compliant and when not taking medication would relapse into psychotic illness. Dr Chaplow's conclusion was that the history that he obtained from Mr McGowan and from other sources of information accorded with a diagnosis of paranoid schizophrenia. He describes this illness as a psychotic illness characterised by the presence of "positive" signs such as auditory hallucinations and paranoid delusions and "negative" signs such as social withdrawal, difficulty concentrating and difficulty relating meaningfully to other people. It is also accompanied by a lack of insight into what is real and what is not. It appeared to Dr Chaplow that on the night in question Mr McGowan was psychotic and overwhelmed by feelings, particularly in relation to his father.

[15] Dr Chaplow was of the view that, although Mr McGowan clearly knew of his actions and could describe what he did, he lacked any understanding of the moral wrongfulness of those actions at the time.

[16] On the basis of this evidence there is no question in my mind that when Mr McGowan stabbed his parents on 11 September 2013 he was suffering from a disease of the mind, namely schizophrenia and that, as a result, he was incapable of knowing that what he was doing was morally wrong according to commonly accepted standards of right and wrong. I indicated to counsel this morning that this was my view and I now formally make a finding under s 20(2)(c) that Mr McGowan is not guilty of the murder of June McGowan and the attempted murder of Stephen McGowan on account of his insanity.

Next step

[17] Following my indication that I would make that finding under s 20 we moved to the next stage of the procedure which is an inquiry to determine the most suitable way of dealing with Mr McGowan. I am required to consider all the circumstances of the case and the evidence of the psychiatrists as to whether an order that Mr McGowan be detained as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is necessary. Both the Crown and defence submit that such an order is necessary and is the appropriate order to make. Such an order would mean that Mr McGowan would be detained indefinitely at a secure mental health facility until the Minister of Health, after receiving reports from medical practitioners, is satisfied that continued detention is no longer necessary to ensure the safety of the public.

[18] Professor Mellsop and Dr Chaplow were recalled to give evidence on this issue. Once again, they were consistent in their views about the way forward. Dr Chaplow, who saw Mr McGowan only two months ago, noted that the psychiatrist treating him at the Mason Clinic, Dr Seth, had advised that Mr McGowan is responding to anti-psychotic medication. On admission Mr McGowan had been disorganised in speech, hearing voices consistent with auditory hallucinations. But there has been a marked improvement since that point.

When Dr Chaplow interviewed Mr McGowan he considered that he was well stabilised, however, he is still showing residual negative signs of psychotic illness.

[19] Dr Chaplow gave evidence about the merits of detaining Mr McGowan as a special patient. His opinion was that Mr McGowan has a confirmed chronic illness and without adequate supervision and treatment could lapse into an acute state again. If his illness is not adequately managed there will be a significant risk to him and to others. For these reasons Dr Chaplow considered that Mr McGowan needs to be in a situation where there can be ongoing assessment and treatment. In particular, he identified Mr McGowan's needs as being to become stable, to adjust to the tragedy that has befallen the family, to accept his illness and manage his treatment.

[20] Dr Chaplow also talked about the importance of accountability in this process, meaning the shift from the hospital taking responsibility for Mr McGowan's treatment and behaviour to Mr McGowan himself being at a point where he can be accountable for that. This process could be a long one with a structured process for ending the status as a special patient. However, Dr Chaplow considered that the special patient status gave the greatest prospect of success in terms of treatment, accountability and managing the risk that Mr McGowan currently presents as a result of his illness.

[21] Professor Mellsop had a very similar view. He considered that the special patient order was both necessary and appropriate. He noted that Mr McGowan already has an intermittent psychiatric illness of some years' standing from which fact he inferred it was not an easy one to treat. Further, in the context of that illness Mr McGowan had committed very serious acts. Professor Mellsop considered that a special patient order would be to Mr McGowan's advantage in that it reduced the chance of anything adverse happening to him and gave a better time frame and more structured procedures within which to treat him.

[22] It is clear that Mr McGowan is seriously ill and that the illness is longstanding and that long term treatment is needed. I readily accept the evidence of Dr Chaplow and Professor Mellsop that there is risk both to Mr McGowan himself and to the public as a result of his illness. I am satisfied that the best prospects for

effective treatment lie in his detention as a special patient pursuant to an order under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and this is the order that I make. Mr McGowan is to be detained at the Mason Clinic pursuant to that order.

Publication of defendant's name

[23] I turn now to the issue of whether Mr McGowan's name ought to be published.[1] Counsel were agreed that, as a result of the order that he be held as a special patient, Mr McGowan is a vulnerable person as that is defined in s 11D of the Family Courts Act 1980. As a result[2], s 11B(3)(b) of the Family Courts Act 1980 precludes publication of his identifying details without the leave of the Court.

[24] Status as a special patient is the only relevant criteria for that protection in the circumstances of this case. There is no additional threshold such as hardship or harm resulting from publication. Section 11B(3)(b) recognises that the interests of those identified as vulnerable are, all things being equal, best served by not publishing their identifying details. Parliament has determined that for those who fall within the scope of s 11B(3) the principle of open justice will not necessarily prevail.

[25] Mr Cathcart sought leave to have Mr McGowan's name published on the ground that publication was in the public interest and that the name was already in the public arena. He referred me to Collins J's decision in *R v Tampin* in which the name of a defendant found not guilty of murder on account of insanity was allowed to be published, notwithstanding ss 11B and D of the Family Courts Act.[3] In that case, as in the present, there had already been publication of the defendant's name and the medical evidence was that publication was unlikely to have an adverse effect on his treatment.

[26] In my view these two factors raise very different issues. The first is the relevance of the effect of publication on the defendant's treatment. As I have noted,

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1 I reserved the right to edit this part of my judgment following discussion with counsel. This section therefore differs from my oral judgment, though the result is the same.

2 Presumably on the basis of s 25 of the Mental Health (Compulsory Assessment and Treatment) Act 1992

3 *R v Tampin* [2013] NZHC 2571

the only relevant criterion for suppression under s 11B(3)(b) is status as a special patient. Whilst the lack of any adverse effect on the defendant's treatment could be relevant to the decision whether to grant leave to publish, it is not a matter that the defendant must establish. Nor, in my view, is it necessarily the factor that should determine whether leave is granted.

[27] The reasons are self-evident when the circumstances of the present case are considered; Mr McGowan is suffering from a long-term serious illness that has resulted in tragedy for both himself and his family. He now appreciates the enormity of his actions and has some insight into them. Doctor Chaplow has described the feelings of shame and embarrassment he feels. Whilst it is in the public interest to know how such cases are resolved, I do not necessarily see that it is in the public interest to know the identity of the very ill person at the centre of it.

[28] The second issue is the effect on s 11B of previous publication. At a call-over in September 2013 Brewer J declined ongoing name suppression. I accept that because Mr McGowan's name has already been published it is not feasible to now refuse leave under s 11B(5) to publish his name and leave is granted to do so. However, it seems to me that there is a difficult issue facing judges and counsel at the pre-trial stage in cases such as this. There appears to be a risk that the protection provided by s 11B may be rendered nugatory in relation to defendants whose status under the Criminal Procedure (Mentally Impaired Persons) Act is yet to be determined; unless they can meet the high threshold under the s 200 of the Criminal Procedure Act publication will not be suppressed and (as here) by the time the order is made that the person be detained as a special patient the fact of previous publication will likely dictate the outcome of an application under s 11B(5) for leave to publish.

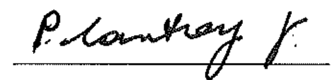
Publication of matters affecting Mr McGowan senior

[29] There is a different issue arising in relation to Mr McGowan senior. There are matters regarding the beliefs and delusions that Mr McGowan junior had about his father which featured in the evidence given in court today. The Crown, supported by Ms McCabe, seeks an order under s 205 of the Criminal Procedure Act

2011 forbidding the publication of that evidence on the ground that it would cause undue hardship to a victim of the offence.

[30] Mr Cathcart has outlined the circumstances of Mr McGowan senior that are relied on in support of this application. There are two particular concerns. The first is that notwithstanding the obviously false belief that Mr McGowan junior held at the time and which he now acknowledges was false, there is nevertheless the risk that readers of a report of the evidence may not fully grasp the correct position and form an entirely unfair view of Mr McGowan senior. So the damage to his reputation is a significant worry to him. The second concern is that Mr McGowan senior conducts a consultancy business both here and overseas. He has a presence on-line. He is very concerned that the material in question may adversely affect his business interests.

[31] I am satisfied that both of these concerns are legitimate and well founded. Further, Mr McGowan senior has suffered a dreadful tragedy. He has lost his wife in terrible circumstances. His son is suffering serious and long term illness which has seen him detained as a special patient, and he himself suffered serious injuries on the night in question. In all of these circumstances, it is completely appropriate to make an order under s 205 suppressing the evidence about Mr McGowan junior's delusional beliefs regarding his father. So those matters are suppressed.



P Courtney J