APPEAL COURT, HIGH COURT OF JUSTICIARY

[2026] HCJAC 34
HCA/2025/13/XM

Lord Justice Clerk
Lord Matthews
Lady Carmichael

OPINION OF THE COURT

delivered by LADY CARMICHAEL

in an

Appeal following a reference from the Scottish Criminal Cases Review Commission

by

JAMES GIBSON

Appellant

against

HIS MAJESTY'S ADVOCATE

Respondent

Appellant: Culross, G Reid; Faculty Services Limited (for Lawson Coull & Duncan, Dundee)
Respondent: Prentice KC, sol adv, AD; the Crown Agent

5 August 2026

Introduction and background

[1] This is an appeal against sentence, brought following a reference by the Scottish Criminal Cases Review Commission. The appellant seeks to establish that the imposition of a hospital order with a restriction on discharge constituted a miscarriage of justice. He contends that psychiatric evidence now available establishes that he did not suffer from a

particular mental disorder (paranoid delusional disorder, a mental illness) at the time when the order was imposed.

[2] On 3 March 1998 at the High Court of Justiciary in Glasgow the appellant pleaded guilty to the following charges:

> "(001) on 17 September 1997 in Argyll Street, near the Queens Hall, Dunoon, Argyle, he did conduct himself in a disorderly manner, seize hold of the door of a motor vehicle in which Elspeth Catherine Black and a child, aged 14 years, both care of Dunoon Police Office, were then seated, attempt to pull open said door, place the said Elspeth Catherine Black and the child in a state of fear and alarm and commit a breach of the peace.
>
> (003) on 13 November 1997 at the car park between Church Street and Moir Street, both Dunoon, Argyll, he did assault Elspeth Catherine Black, care of Dunoon Police Office, push her and pull her about, repeatedly punch her on the head and knock her to the ground, all to her severe injury; and he did commit this offence while on bail, having been granted bail on 13 November 1997 at Dunoon Sheriff Court."

[3] Some years earlier, the appellant had engaged a solicitor to act for him in a claim for medical negligence. He became unhappy with the way the solicitor was conducting the case. He was convicted of assaulting that solicitor in 1994. The appellant then instructed another solicitor, Ms Elspeth Black, to pursue a claim based on the negligence of the first solicitor. In October 1995 she indicated that she could no longer act for him. He was dissatisfied with her withdrawal from acting. He continued to try to contact her to persuade or force her to act for him. He attended at her office frequently and tried to approach her at her home. In 1996 he was convicted of three charges of breach of the peace, and one of breaching bail.

[4] On 17 September 1997, Ms Black and a child, aged 14, were in a car in Argyll Street, Dunoon when the appellant approached the car, tried to pull open the door and, by his behaviour, put Ms Black and the child in a state of fear and alarm. He only desisted when

another solicitor intervened. He was traced on 21 September 1997 and charged with breach of the peace.

[5] On 13 November 1997, he was granted bail at Dunoon Sheriff Court, having pleaded not guilty to the complaint. Immediately after leaving the Court, he saw Ms Black in the car park and seized her, pushed and pulled her about, repeatedly punched her on the head and knocked her to the ground, all to her severe injury. The number of punches was variously estimated by eyewitnesses as from five to eleven. There were at least three separate sites of injury, and her injuries included a fracture of the nose and whiplash injury to the neck, resulting from the force of the blows she received.

[6] The sentencing judge had before him reports from psychiatrists and heard oral evidence from Dr (now Professor) Lindsay Thomson (21 August 1998) and Dr Colin Gray (13 November 1998). Dr Gray considered that the appellant had a mental illness, namely paranoid delusional disorder, and that he also had abnormal personality traits. Professor Thomson also diagnosed a paranoid delusional disorder and noted that the appellant had longstanding abnormal personality traits. Reports for the defence were prepared by Dr John Baird and Dr M A E Smith. Dr Baird's conclusion was that the appellant had paranoid schizophrenia. Dr Smith's opinion was, on balance, that the appellant had borderline personality disorder (categorised as a mental illness). Unlike Drs Gray, Thomson, and Baird, Dr Smith did not recommend a restriction on discharge.

[7] The sentencing judge also had reports from five other psychiatrists. The earliest report was dated 24 November 1994 when Dr Sykes opined that the appellant had abnormalities of personality and that his mental state was such that there was a risk of his developing a psychiatric disorder in the future. In November 1997 Dr Jauhar noted features suggestive of a paranoid personality, and thought that the appellant may be developing a

paranoid illness. He was unable to reach a view because he was not able to carry out a comprehensive examination. Dr White, in December 1997, thought that it was possible that the appellant's beliefs were part of a relatively circumscribed paranoid delusional disorder, and that further assessment in hospital was needed. Dr McMahon's report has not been recovered. According to the report of the sentencing judge, Dr McMahon found it difficult to give a definite psychiatric diagnosis. The appellant presented as someone with a severe personality disorder and should receive a full psychiatric assessment in the State Hospital. In a report dated 19 March 1998, Dr Logan opined that the appellant had a mental illness, namely paranoid personality disorder.

[8] On 13 November 1998 the sentencing judge imposed a hospital order with an order restricting discharge.

[9] On 26 November 1998 the appellant sought leave to appeal against the disposal. At the time, he accepted that a hospital order was appropriate but challenged the restriction on discharge. Leave to appeal was refused at first and second sift. The appellant is currently detained in a psychiatric hospital. He was initially accommodated in the State Hospital but has been detained in a medium secure facility for the last 13 years. He is currently a patient in the Rohallion medium secure unit in Perth.

[10] On 9 September 2025 the Commission referred the appellant's case to this court in terms of section 194B(1) of the Criminal Procedure (Scotland) Act 1995 on the basis that they considered that a miscarriage of justice might have occurred, and that it was in the interests of justice that a reference be made. The appellant lodged a note of appeal on 28 October 2025.

The law

[11] Section 58 of the 1995 Act provided, at the time that the appellant was sentenced:

"58.— Order for hospital admission or guardianship.

(1) Where a person is convicted in the High Court or the sheriff court of an offence, other than an offence the sentence for which is fixed by law, punishable by that court with imprisonment, and the following conditions are satisfied, that is to say—

(a) the court is satisfied, on the written or oral evidence of two medical practitioners (complying with section 61 of this Act) that the grounds set out in—

(i) section 17(1); or, as the case may be

(ii) section 36(a),

of the Mental Health (Scotland) Act 1984 apply in relation to the offender;

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section

subject to subsection (2) below, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be, place him under the guardianship of such local authority or of such other person approved by a local authority as may be so specified.

(2) […]

(3) […]

(4) An order for the admission of a person to a hospital (in this Act, referred to as 'a hospital order') shall not be made under this section in respect of an offender or of a person to whom subsection (3) above applies unless the court is satisfied that that hospital, in the event of such an order being made by the court, is available for his admission thereto within 7 days of the making of such an order.

(5) A State hospital shall not be specified in a hospital order in respect of the detention of a person unless the court is satisfied, on the evidence of the medical practitioners which is taken into account under paragraph (a) of subsection (1) above, that the offender, on account of his dangerous, violent or criminal propensities, requires treatment under conditions of special security, and cannot suitably be cared for in a hospital other than a State hospital.

(6) […]

(7) A hospital order … shall specify the form of mental disorder, being mental illness or mental handicap or both, from which, upon the evidence taken into account under paragraph (a) of subsection (1) above, the offender is found by the court to be suffering; and no such order shall be made unless the offender is described by each of the practitioners, whose evidence is taken into account as aforesaid, as suffering from the same form of mental disorder, whether or not he is also described by either of them as suffering from the other form."

[12] Section 17(1) of the Mental Health (Scotland) Act 1984 provided:

"17.— Patients liable to be detained in hospital.

(1) A person may, in pursuance of an application for admission under section 18(1) of this Act, be admitted to a hospital and there detained on the grounds that—
(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
(i) in the case where the mental disorder from which he suffers is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct, such treatment is likely to alleviate or prevent a deterioration of his condition; or
(ii) in the case where the mental disorder from which he suffers is a mental handicap, the handicap comprises mental impairment (where such treatment is likely to alleviate or prevent a deterioration of his condition) or severe mental impairment; and
(b) it is necessary for the health or safety of that person or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this Part of this Act."

[13] Section 1 of the 1984 Act defined "mental disorder" as "mental illness or mental handicap however caused or manifested". The 1984 Act, at that time, did not use the expression "personality disorder" to denote a particular form of mental disorder distinct from mental illness or learning disability ("mental handicap" in the language of the 1984 Act). From 13 September 1999 – after the disposal in this case – section 1 of the 1984 defined "mental disorder" as "mental illness (including personality disorder) or mental handicap however caused or manifested". The statutory recognition of personality disorder as a category of disorder distinct from mental illness or learning disability was introduced in the Mental Health (Care and Treatment) (Scotland) Act 2003.

[14] Section 59 of the 1995 Act made provision for restrictions on discharge from hospital orders:

> "59.— Hospital orders: restrictions on discharge.
>
> (1) Where a hospital order is made in respect of a person, and it appears to the court—
> (a) having regard to the nature of the offence with which he is charged;
> (b) the antecedents of the person; and
> (c) the risk that as a result of his mental disorder he would commit offences if set at large.
> that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the person shall be subject to the special restrictions set out in section 62(1) of the Mental Health (Scotland) Act 1984, without limit of time.
>
> (2) An order under this section (in this Act referred to as 'a restriction order') shall not be made in the case of any person unless the medical practitioner approved by the Health Board for the purposes of section 20 or section 39 of the Mental Health (Scotland) Act 1984, whose evidence is taken into account by the court under section 58(1)(a) of this Act, has given evidence orally before the court.
>
> (3) […]"

[15] A hospital order with a restriction order has since 5 October 2005 been deemed to be a compulsion order with a restriction order ("CORO"): Mental Health (Care and Treatment) (Scotland) Act 2003 (Transitional and Savings Provisions) Order 2005, Article 20. An appeal against a compulsion order and/or a restriction order many be brought in the same manner as an appeal against sentence: 1995 Act, section 60.

[16] This court may interfere with a sentence if it satisfied that the sentence is a miscarriage of justice: 1995 Act, section 106(1)(b); *Kennedy* v *HM Advocate* [2024] HCJAC 50, 2025 JC 156, para [13].

[17] In *Johnstone* v *HM Advocate* [2013] HCJAC 92, 2013 SCCR 487 an appellant argued unsuccessfully that the sentencing court should not have made either a hospital order or a

restriction order. The court in that case considered the approach to be taken in appeals where issues of that sort arose, in the following passages.

(a) "The issue is not whether the disposal would have been different were the appellant to have been sentenced at the date of an appeal but whether, looking at the matter at the time of the sentence (albeit possibly taking into account fresh evidence or circumstances not before the sentencing court), a miscarriage of justice occurred." [55]

(b) "Where substantially the same evidence was available from one or more psychiatrists at the time of the trial diet, it cannot be said that its subsequent availability from one or more different psychiatrists renders it 'fresh'". [57]

(c) "The court cannot alter hospital orders retrospectively merely on the basis of changes in the practice of psychiatric assessment. The issue is whether the hospital and restriction orders were appropriate at the time when they were made, according to the practices then current, albeit perhaps analysed in light of circumstances which have occurred since sentencing." [60]

(d) "If the evidence is only that the diagnosis would be different if carried out today, but that it was one which was properly made at the time, it will seldom be possible to conclude that there had been a miscarriage of justice on the part of the sentencing court... The court has to have regard to the views then current in determining whether what happened at that time can be said to amount to a miscarriage of justice." [61]

(e) "It remains important to bear in mind that the decision on whether a person is mentally impaired and treatable is one for the court to make; albeit that it must be supported by the written or oral evidence of two medical practitioners, normally psychiatrists… the test of whether a miscarriage of justice has occurred is one to be applied as at the date of the decision under attack … albeit that circumstances not referred to at the diet and fresh evidence may enter that equation." [63]

(f) "The court notes the general concern that the appellant may be being held in a regime which is regarded by the medical profession as being, in a sense, surplus to his needs. It may well be that, in some ways, he would be better held within a prison regime… It is not, however, for the court to quash validly made hospital and restriction orders because psychiatric opinion has changed or because expectations have not been realised. If the orders were appropriate at the time they were made, in the sense that they proceeded upon expert opinion properly given, they must be allowed to stand." [70]

The evidence

[18] The appellant led evidence from Dr David Walsh and Professor John Crichton, and the respondent from Professor Lindsay Thomson. It was agreed each of these witnesses should be permitted to be present in court to hear the evidence of the others. All three witnesses had provided reports for the purposes of these proceedings. We will refer to Professor Thomson by that title, although her designation in 1998 was Dr Thomson.

Dr David Walsh

[19] Dr Walsh has been a consultant forensic psychiatrist since 2019. He is the appellant's registered medical officer overseeing his care on a day-to-day basis, since August 2022. He reviews the appellant on the ward when the appellant consents to meet him.

[20] When the appellant was admitted to the State Hospital in 1998, his diagnosis was of paranoid delusional disorder. That diagnosis changed in 2003. The disorder involved an individual's having a single delusional belief, or a small set of delusional beliefs, which affected his function within the "sphere" to which the beliefs related, but not in other aspects of his life. Dr Walsh's understanding was that the appellant was treated with antipsychotics for about a year after admission. There was then a break in the provision of that medication. In 2001 he received medication for less than a year. At the end of 2002 his psychiatrist decided that there should be a trial period of 6 months of treatment with an intramuscular antipsychotic. There did not appear to be a significant change in his presentation when he was on medication, and psychotic symptoms did not emerge when the antipsychotic medication was discontinued.

[21] As the appellant's treating psychiatrists were no longer able to identify symptoms of psychotic delusions, the diagnosis was changed.

[22] The appellant had made very little progress during his time in hospital. He found the detention and restrictions of hospital life to be stressful. When he was stressed he had a low threshold for displaying anger. He would present as hostile to staff and might make threats of violence. He had done so on occasion over the preceding year or two. Dr Walsh had considered the appellant's difficulties, which included his low threshold for anger, his making threats of violence, his propensity to hold grievances for protracted periods, his failure to learn from adverse events that he had experienced in the past, and his struggles with changes in relationships. Dr Walsh's opinion was that all of those features were in keeping with a diagnosis of personality disorder not otherwise specified. He had not observed him presenting with any delusions.

[23] The appellant had been subject to particular stressors in about December 2021. A number of members of staff with whom he had key and positive relationships had moved on from their posts. The patient population on the ward had changed, with the introduction of patients whom the appellant was "not sure of". Covid measures limited his access to facilities. Those stressors had not caused delusional symptoms to emerge. In Dr Walsh's experience, in a patient with a diagnosis of a mental illness such as paranoid delusional disorder, stress could be a trigger for a relapse.

[24] The appellant had displayed difficult and hostile behaviour towards Dr Walsh. The appellant sometimes refused to meet him. The appellant was finding the prospect of discharge to the community (if his appeal were successful) stressful. He had a grievance against Dr Walsh. That was in relation to the conduct of a registrar formerly working under Dr Walsh's supervision, and in relation to the report that Dr Walsh prepared for the purposes of the two-yearly statutory review of his detention under the Mental Health (Care and Treatment) Scotland Act 2003 in 2024. He had made threats to harm Dr Walsh and

Dr Walsh's family. The threats had started when the former registrar returned to Rohallion as a consultant.

[25] Dr Walsh characterised the appellant's grievances against him as rational, in the sense that they had some basis in reality. Dr Walsh was the appellant's RMO. He had given evidence at mental health tribunal hearings and had reported to the Scottish Government that he continued to satisfy the statutory criteria for detention. The appellant believed that doctors and solicitors were privileged and came from a place of privilege. Although that was not the experience of individual doctors or solicitors, it was not an unreasonable belief. The appellant felt that such professionals could not understand his difficulties or the significance to him of his own reputation being harmed. He might think that Dr Walsh was protecting his own professional reputation in declining to differ from other medical professionals. It was necessary to consider certain adverse experiences to which the appellant had been exposed when he was a child. It was reasonable that he would form an idea that people in authority would not help him.

[26] When thinking was delusional, a thought could be held very firmly and pursued to extremes.

[27] Counsel referred Dr Walsh to an incident in 1990 when the appellant had been concerned about a skin condition. Dr Walsh understood that the appellant was seen by a psychiatrist in 1991 but not diagnosed with a mental illness. In 2007 a Dr Todd had prepared a report after completing a semi-structured interview with the appellant for personality disorder. The appellant told Dr Todd that his general practitioner had prescribed him medication for acne. The medication should have been left on the skin for fifteen minutes and then rinsed off, but the general practitioner had omitted to tell the appellant to wash it off. He had left it on overnight and as a result had experienced

reddened skin. He believed that his appearance had been affected and that that had contributed to the breakdown of a relationship. Dr Walsh said that the appellant did have a skin condition. He was very sensitive to that being cared for appropriately in Rohallion. He believed the condition was affected by the ambient temperature and accused staff of deliberately changing the temperature in his room with a view to aggravating his skin condition. While he might have some increased redness, it was not as bad as he thought. Again, childhood experiences of bullying about his physical appearance provided a relevant context for his sensitivity about the matter.

[28] The first time that a psychotic component was suggested in relation to the appellant's presentation was in 1990, when he reported concerns about the condition of his facial skin. Dr Walsh's opinion was that his reports at that time were in keeping with a pattern of thought and behaviour that had been consistent throughout his life. That pattern was more in keeping with a personality disorder than with paranoid delusional disorder. Dr Walsh believed that the outcome in 1991 was that the clinician at the time thought that the appellant did not have a mental illness. He had not, however, seen the contemporaneous report himself.

[29] The appellant's behaviour in the period leading to the index offence in 1997 was no different from the appellant's pattern of behaviour in the longer term. The solicitor-client relationship with Ms Black had come to an end. The appellant was resentful towards Ms Black and had a grievance against her, while at the same time looking to her for support. He believed that Ms Black had been subjected to pressure because the wife of his previous solicitor had been the teacher of Ms Black's daughter. He perceived that she had ceased to act for him as a result of that pressure. That scenario was similar to the appellant's grievance against Dr Maior (Dr Walsh's former registrar). He believed that she offered the

opinion that he presented a risk only because of pressure on her to do so from Dr Walsh. Similarly, he perceived Dr Walsh as unable to "stand up to" senior colleagues and offer opinions differing from theirs.

[30] The appellant had had a number of different RMOs over the years. Even on admission to the State Hospital there was a question about what diagnosis was most appropriate. From 2003 there had been a shift. At that time episodic psychosis, then in the past, had been noted. In 2007 his diagnosis was recorded as personality disorder, with no mention of a previous delusional disorder. With the passage of time, and stressful events, such as moving from New Craigs to Rohallion, and the disputes with Dr Maior and Dr Walsh, there would have been an increased risk of psychotic relapse if the appellant had had a delusional disorder in the first place.

[31] Delusional disorders tended not to resolve spontaneously. The individual might still have the delusion, but be less emotionally aroused, and have less impaired functioning, with the passage of time. Delusional disorders could be quite persistent. A small number resolved completely with antipsychotic medication, but more often there was a change in the intensity with which the patient's behaviour was affected by their beliefs. The appellant's beliefs about "the system" continued up to the present and had been present before the index offence.

[32] What was helpful in the appellant's case was getting the background history and examining his beliefs in the context of what it was reasonable for him to believe. It was important also that the appellant had not responded to medication and seemed to present with the same problems as he had at the time of the index offence.

[33] The appellant had formerly had escorted access to the community, since about 2021. At the beginning of 2026 he sought permission for unescorted suspension of detention. His

access to the community had been revoked. His behaviour deteriorated after a mental health tribunal hearing. He found such hearings, and care programme meetings, stressful, and he presented with dysregulated behaviour on the ward with increased frequency. During suspension of detention he had tried to engage Dr Maior in conversation.

[34] In cross-examination the advocate depute asked Dr Walsh about a 1995 article to which Professor Thomson had referred at page 8 of her most recent report, where she wrote:

> "Neuroleptic medication is the mainstay of treatment but evidence regarding the efficacy of pharmacological interventions is limited. In 1998 the newer (second generation) antipsychotic medications had not been studied for treatment of delusional disorders. One study (Munro and Mok, 1995) of 209 cases found 52.6% were said to have made a recovery defined as 'a return to full function, with total or near total remission of symptoms'; 28.2% had made a partial recovery; and 19.2% had shown no improvement. They noted that non-compliance was common in this disorder, adding further methodological problems. Psychotherapeutic treatment such as cognitive behavioural therapy is also used."

Dr Walsh said that he was not familiar with the study cited. He had attempted to find research about statistics in relation to response to treatment, because the figures quoted had surprised him in the context of what he had observed in practice. The difficulty was that delusional orders were rarer than schizophrenia or personality disorders. There were no randomised studies. There might be a publication bias, as there was a tendency to publish information about cases with a positive outcome. He had found an article from 2010 which related to 69 patients with a delusional disorder who received antipsychotic medication. The condition resolved in 5%, 85% experienced a reduction in symptoms, and the remainder did not respond to the treatment.

[35] Dr Walsh did not dispute that a person might have both a personality disorder and a delusional disorder. Professor Thompson's report indicated that between 27% and 42% of the State Hospital population had a secondary diagnosis of personality disorder; that was in keeping with his own patient group in a medium secure setting.

[36] As to whether the diagnosis of delusional disorder had been correct in 1998, some descriptions of the appellant's presentation, supposedly supportive of the diagnosis, had been in relation to the extremity of his behaviour. Dr Walsh did not regard that information as supportive. The appellant's behaviour at the present time was extreme as a result of the thoughts he had currently. The people incorporated into his grievances were those in authority and in his vicinity. At the time of the index offence it had been Ms Black, and it had subsequently been staff involved in his care.

[37] In re-examination Dr Walsh said that when someone had personality disorder, the way they thought, felt and behaved could be extreme. It was extreme to threaten, as the appellant had, to wipe out Dr Walsh's family as a result of a grievance about a report Dr Walsh had written in 2024. It was similarly extreme to shout and threaten violence against nurses when they delayed an IT session for the appellant because of staffing issues.

[38] In answer to questions from the bench, Dr Walsh explained that he would have some concerns if the appellant were to be released, so far as the protection of the public was concerned. He referred to the need for stable housing and support in the community. Dr Walsh had prepared Police Scotland and relevant local authorities for the possibility that the appellant might be released. He was not overly concerned for his own safety, as it was likely the appellant would be housed in a local authority area some distance from where Dr Walsh was located. The police were undertaking an investigation as a result of the threats made to Dr Walsh.

Professor John Crichton

[39] Professor Crichton is the medical executive director of the Mental Welfare Commission for Scotland. He prepared reports on the appellant in 2022 and 2024.

[40] He first encountered the appellant in 1999 when he was a clinical lecturer and working in the State Hospital. He was a senior trainee on placement with Dr Gray.

[41] He had forgotten his earlier involvement with the appellant until he was preparing his 2022 report. When he met the appellant, he thought it was likely their paths had coincided, but neither he nor the appellant could remember.

[42] The key feature of delusional disorder is the presence of delusions, false beliefs held with unwavering conviction, and which are out of keeping with the "social background". It involves psychotic symptoms. The disorder is different from paranoid schizophrenia; it does not feature auditory hallucinations. In the context of delusional disorder, the psychotic symptoms are the delusions. They involve disordered thought; the delusion is the key diagnostic feature. Without it one cannot make the diagnosis.

[43] In 1999 Professor Crichton attended regular team multidisciplinary meetings concerning the appellant. He probably met the appellant in person 30 or 40 times in a 6-month period. He met the appellant again in 2022 and carried out an assessment of him based on the meeting and the appellant's medical records. At that time, he did not have a full set of medical records. Subsequently the Commission obtained more records. That had permitted a more coherent longitudinal history, so that Professor Crichton could see how the appellant's presentation had been, not just during his detention but in the years preceding it.

[44] In considering the changes in the appellant's diagnosis since the index offence, Professor Crichton had encountered a "huge density" of clinical information. He had concentrated on the reports prepared for the Scottish Ministers, and also, after the commencement of the 2003 Act, when the appellant came to be deemed to be subject to a CORO, reports for mental health tribunal hearings. He had concentrated also on particular

periods, for example a period when the appellant was treated by respiridone, administered by injection. Another period of interest was when the appellant was the subject of a structured personality assessment by Dr Todd. Professor Crichton had also reviewed periods when the appellant was having difficulties with the people supporting him, or with his RMOs. There had been a period when he had strong feelings of antagonism towards Dr Campbell, after a relationship that had previously been good.

[45] It was not unusual for a diagnosis to be modified with the benefit of a longer history. In the appellant's case there was not just a modification, but a change of diagnostic category. Changes of that sort were thought through very carefully. The RMO would have to state in the two-yearly reports for the mental health tribunal what diagnostic category or categories applied. From 2003 personality disorder was a distinct statutory category of mental disorder.

[46] The appellant had a combination of abnormal personality traits. He believed that people were malign in their approach to him. He could project fear into others; that had an antisocial characteristic. Health anxiety involved an obsessional element, and some degree of emotional instability. The people that the appellant went on to threaten, or in relation to whom he had engaged in stalking-type behaviour, were people he had seen as being there to support him. He would then become very distressed at the thought of abandonment, either blaming the individual or a third party for disturbing the relationship.

[47] A trial of injectable medication had been carried out to try to clarify the diagnosis. Non-compliance with medication could be a problem; administration of it by injection got round that problem. When assessing the response to medication there would be good days and bad days, which might be attributable to the medication. The clinical team had used a structured approach in assessing the presence of psychotic features. They did not think

there was delusional disorder present at the time. Dr Bilcliffe had come to the same position as Professor Thompson: in the past there had been episodes of delusional disorder, but at the moment none was present.

[48] The Commission had asked Professor Crichton to prepare a report and had interviewed him. It was not unusual for him to have an initial meeting with the Commission for discussion as to whether he could provide a useful contribution.

[49] Professor Crichton did not believe that the appellant had ever had paranoid schizophrenia. That disorder involved not only delusions but also abnormalities of perception and a cluster of other symptoms. These included thought disorder; the grammar and syntax of speech might be muddled. There were also negative symptoms. The patient's ability to interact socially might be diminished.

[50] A person might have personality disorder with paranoid elements to it. They might concentrate on particular events. It could be very difficult to distinguish that from a true delusion. Sometimes only with the passage of time did clinicians arrive at an understanding of that. A positive response to medication could be helpful in making a diagnosis.

[51] Delusional disorder might occur and cause a real change in an individual's presentation. Although it had been suggested that both delusional disorder and personality disorder were in play in the appellant's case, the pattern of his presentation suggested that all of his presentation could be explained by the presence of the latter.

[52] It was important to examine the history in detail, because errors of understanding could occur. An error in an annual report might be repeated in later reports. In the appellant's case there were extensive records, including the views of many RMOs, some of whom were very senior. That was extraordinarily helpful. There was not just the pattern of idealising individuals and then being thoroughly unpleasant to them. It was significant that

none of the RMOs from the early 2000s identified psychotic symptoms. They were satisfied that his challenging presentations could be explained by personality disorder.

[53] The incident from 1990 involving the appellant's skin condition was suggestive of the abnormal thinking involved in paranoid personality disorder. The appellant had a problem with his skin and obtained cream, but, instead of applying for a short period, left it on overnight. His concern caused him to present as a psychiatric emergency at the Royal Edinburgh Hospital. He was not found to have skin abnormalities. On balance Dr Laing, who saw him at the time, did not think there was a "psychiatric diagnosis". Professor Crichton was not, however, surprised to see that the potential of a mono-symptomatic delusion had been raised.

[54] Counsel noted that about a week after the commission of the offence, there was a conclusion that the appellant might have been developing a paranoid illness. Professor Crichton responded that there was no question that the appellant interpreted events in a paranoid manner. The question was as to the diagnostic significance of that. The appellant had been admitted to hospital for assessment; in those days the time available was quite short. The appellant was trialled with antipsychotic medication for only about a month. A clinician would wish a trial of at least six weeks of compliance with the medication. A longer period, perhaps six months, would have allowed for more nuance on "diagnostic certainty".

[55] The appellant's compliance with medication had been variable. Professor Crichton did not recollect that there had been any improvement while the appellant was taking medication (olanzapine). On 3 December 1998 the appellant was noted to be smiling more, and less brittle, but still holding to the belief that "blue statements" had been fabricated.

[56] In August 1998 Professor Thomson had reported that the appellant was more able to answer questions directly since commencing medication. In Professor Crichton's view, that did not necessarily mean that the medication was working. Matters were more complex. The appellant was at that point receiving chlorpromazine, which acted as a tranquiliser, as did olanzepine. He may have been less distressed, but that did not provide an indication that he had stopped having the preoccupations that had been part of his presentation. Professor Thomson's diagnosis was not unreasonable, based on the information at the time; she had subsequently modified her view to thinking that it was likely that a personality disorder had been present at the same time. Professor Thomson had noted the following in 1998:

> "In 1991 there does appear to have been frankly psychotic symptoms with his insistence that there was something markedly wrong with his face which his GP had failed to deal with adequately, although assessing clinicians could see nothing wrong."

Professor Crichton agreed that those symptoms were significant and needed to be taken into account. They might be categorised as dysmorphophobia, which could be either delusional or non-delusional.

[57] Following a review in December 2002, while the appellant was under the care of Dr Natasha Billcliff, a trial was undertaken of respiridal (respiridone administered by intramuscular injection). Data from the psychotic inpatient profile ("PIP") showed a decrease in paranoid projection, but an increase in depression. After 6 months the medication was stopped, and the appellant's presentation was monitored using the PIP. The diagnosis following that process was one of personality disorder. The medication had not made a material difference to the underlying psychopathology, as opposed to offering symptomatic relief.

[58] In 2007 Dr Linda Todd had prepared a psychology assessment, which included a structured personality assessment. The examination disclosed that the appellant met the diagnostic criteria for personality disorder unspecified. It provided a thorough and detailed understanding of the appellant's personality disorder and characterised the different aspects of the disorder that were present. As time went on, the idea that there was comorbidity, in which there had been both mental illness and personality disorder, changed. The reports of the RMOs indicated that they thought the correct diagnosis was one of personality disorder. If someone had episodic delusional disorder, it would be typical for them to relapse at times of stress. That had not happened in the appellant's case. Where the appellant's presentation deteriorated, that was in the context of his personality disorder, rather than being an episode of psychosis.

[59] The appellant's behaviours were similar to behaviours seen before the index offence. He felt let down and abandoned and had engaged in stalking behaviour. He had subsequently become very unpleasant to Dr Campbell and Dr Walsh, having felt let down by each of them. In some psychological and psychotherapeutic contexts, an individual would go from idealising a carer to denigrating them when they were perceived to have let the individual down. It was a phenomenon also seen in interpersonal relationships and was a feature of certain personality disorders. An episode that stood out in the appellant's case was when he had become fixated on a member of nursing staff in Inverness. That had led to his accommodation in medium secure conditions in Perth. Professor Crichton's impression was that the appellant was currently in the middle of a similar episode so far as Dr Walsh was concerned.

[60] The index offence was part of that pattern of behaviour, although it had involved both physical violence and a degree of intoxication. The offending fitted well with the sort

of personality disorder just described. If it had been part of a paranoid delusional disorder, Professor Crichton would have expected the psychiatrists over the years to have revised their diagnostic understanding and have commenced the use of antipsychotic medication.

[61] The longitudinal history available by reference to records from 1981 to 2024 was important new evidence that would have been pivotal had it been known (although it could not have been) to those providing reports at the time of sentencing. It was common to revisit diagnosis in the light of a longer history. Dr Crichton did not believe the episode relating to the appellant's skin condition was delusional. The appellant had preoccupations which were part of his anxious approach to physical health. The assessing doctor at the time would have considered a delusional disorder. A longitudinal history assisted; the appellant still had anxiety about his health.

[62] Professor Crichton's opinion is that the correct diagnosis in 1998 was one of personality disorder. In 1997 the appellant had reached a crisis in the form of a manifestation of his conspiratorial view of the world and his preoccupation about people wishing to do him harm. He felt badly let down and that explained his conduct at the time. The diagnosis of paranoid delusional disorder had been reasonable at the time, but more was now known. The fact that the appellant engaged in extreme and outrageous behaviour was not a good indicator of paranoid delusional disorder. Life-taking violence might be associated with personality disorder. The appellant had an extraordinary ability to create fear and distress in other people in the absence of interpersonal violence, although the index offence had involved violence, and the appellant had been destructive of property as well in the past.

[63] Asked about the 1995 article cited in Professor Thomson's report,

Professor Crichton's view was that response to medication for paranoid delusional disorder

was a difficult area to study. The study in question had involved both oral and injected medication. There had been an issue with compliance with medication. It was difficult to define complete remission as opposed to a substantial improvement in clinical presentation. The article would not change his understanding of the appellant's case.

[64] For a delusional disorder, Professor Crichton would be looking for a false belief held with complete conviction. It was difficult to tell paranoid personality disorder from paranoid delusional disorder.

[65] As to whether the appellant's beliefs were false, Professor Crichton spoke about the issue regarding the appellant's skin. There had been a real event, and something had happened for which there had been some objective evidence. What then occurred was paranoid elaboration and preoccupation, which led to the appellant's coming back, repetitively, to the same theme. That was different from what one might see in a delusional disorder where there might not be any clear antecedents to the belief. There might be a fully formed false belief not based on any real-life occurrence, held with complete conviction and not amenable to reason.

[66] Professor Crichton had not seen any evidence that the appellant's condition was treatable by management other than the sorts of psychological approaches that could be provided in a prison setting. Colleagues in criminal justice dealt with the management of antisocial personality disorder every day.

[67] Had the only diagnosis in 1998 been one of personality disorder, it would have fallen within the category of a persistent mental disorder manifested only by abnormally aggressive or seriously irresponsible conduct. The "treatability" test in section 17(1) of the 1984 Act would have been important. At the material time it had not been the practice to detain patients with a primary diagnosis of personality disorder in the State Hospital.

[68] In cross-examination, Professor Crichton confirmed that there was no respect in which the process that led to the 1998 diagnosis was defective. The diagnosis itself had been a reasonable one. It had been properly made. Had the decades of experience and observation now available been available at the time, that would have influenced the recommendations made to the court.

[69] Professor Crichton accepted that delusional disorder could fade over time but said that that was true of any mental health presentation other than dementia or a condition that by its nature would not "wax and wane". He had no doubt that Professor Thomson had represented accurately the content of the study that she had cited. Professor Crichton agreed that a patient could have paranoid delusional disorder and a personality disorder at the same time. It was theoretically possible that that had been the case so far as the appellant was concerned, but not very likely.

Professor Lindsay Thomson

[70] Professor Thomson is the professor of forensic psychiatry at the University of Edinburgh. She has been medical director of the State Hospital and director of the Forensic Mental Health Services Managed Care Network since 2007. In 1998 she was senior lecturer in forensic psychiatry at the University of Edinburgh, and an honorary consultant forensic psychiatrist at the State Hospital. She wrote the chapter on paranoid disorder and related syndromes in the Companion to Psychiatric Studies 6th Edition (1998).

[71] Professor Thomson provided reports in March and August 1998. Her role was to provide a second, independent, report on the appellant. In March 1998 she recommended an interim hospital order. At that time her opinion was that the appellant had paranoid delusional disorder. She noted that it was a complex case that had been subject to

considerable thought by several psychiatrists. The number of people allegedly involved in the conspiracy against him, who included neighbours and lawyers, the deterioration in his functioning and the appellant's increasing conflict with the criminal justice system were indicative to her of the development of a mental illness. She had also noted longstanding abnormal personality traits.

[72] Professor Thomson saw the appellant in Barlinnie in March 1998. She met with him again on 2 July and in early August 1998. She consulted with the RMO in charge of his care, and with the clinical team. In August 1998 she confirmed the diagnosis she had reached in March 1998. There had been a serious incident in the State Hospital on 8 July 1998 when he had smashed the contents of his room, damaged the walls and barricaded himself in his room. He was subsequently commenced on chlorpromazine. When she saw the appellant in August 1998, he was warmer, and more able to consider events and answer questions. That was suggestive of an early response to medication. Her recommendation to the court had been of a hospital order with restrictions on discharge. The purpose of the hospital order was care and treatment. The restriction on discharge was concerned with public safety, what had happened in the past, and the risk, based on his mental disorder, of his causing serious harm. Professor Thomson had not seen the appellant since August 1998.

[73] She had read with care the reports by Dr Walsh and Professor Crichton. She had given the matter a great deal of thought. Professor Thomson stood by the diagnosis of paranoid delusional disorder and emphasised the importance of her contemporaneous account from 1998, and of her having seen a patient when he was unwell and had delusional intensity. Accounts "on paper" of behaviour sometimes did not convey the feeling of the condition having stepped over a line into delusion. She thought that having seen the

appellant when he was like that was important. Professor Thomson had considered the longitudinal account but had not changed her opinion.

[74] Symptoms of a delusional disorder need not be fixed for ever. When Professor Thomson saw the appellant in 1998 it was her opinion that he held his views with delusional intensity. There were 2 to 3 years of treatment. After about 5 years, the diagnosis was of intermittent episodes of paranoid delusional disorder, with personality disorder. The diagnosis subsequently became one of personality disorder. There had been a shift, but over a long period of time. That was perfectly possible.

[75] Professor Thomson's report for these proceedings included references from the chapter that she wrote in 1997, shortly before her involvement in the appellant's case. Those references included the one to the 1995 article which related that just over 52% of patients treated with antipsychotic medication had experienced a return to full function with total or near total remission of symptoms.

[76] She had subsequently found four other studies of interest. Professor Thomson spoke about these in her oral evidence, and the court was supplied with citations in writing for six chapters or articles. Dealing with those about which Professor Thomson spoke in her oral evidence, the Cochrane Review for Delusional Disorders (2012) had collated information from other papers and had noted a dearth of information as well as the fact that there was evidence for the use of cognitive behavioural therapy ("CBT"). A Cambridge University Press publication from 2018, Advances in Psychiatric Treatment, stated in a chapter entitled "Recent developments in the management of delusional disorders" that delusional disorder was likely to respond well to treatment with standard antipsychotics and CBT.

[77] There were no recent follow up studies. An older one from 1988 had used Nordic databases. It followed 71 patients over 30 years. Of those, 37 had recovered, and 32 had some symptoms either moderate (10) or severe (22).

[78] Professor Thomson had looked seriously for reasons to change her diagnosis but remained of the view that in 1998 the appellant had a delusional disorder.

[79] In cross-examination Professor Thomson said that when preparing her report she did not look in detail at all of the appellant's history *de novo*. She accepted the history recounted in Professor Crichton's reports. She accepted also that the primary diagnosis at present was likely to be personality disorder. She had read Dr Todd's assessment from 2007 when personality disorder was formally assessed.

[80] The intensity with which the appellant presented his beliefs in 1998 was significant. Over the past 28 years the appellant had been in controlled environments. It was true that there was a pattern of personality issues. There had been aggression to Ms Black, and in the State Hospital. What Professor Thomson saw in 1998 was delusional. The intensity was extreme. Although his subsequent behaviour was deeply unpleasant in terms of the threats, there had not since 1998 been violence towards people or property. When Professor Thomson saw the appellant in 1998, he held his beliefs with delusional intensity. The idea that delusional disorder could fade was borne out by the literature. The appellant believed that there was a conspiracy, involving more than one lawyer, to damage his reputation.

[81] The appellant had been known to mental health services since 1981, initially with depression, and then other disorders, including a personality disorder. He was noted to be chronically dissatisfied with life. When one reached the 1990s, the issue with the appellant's skin came to be of importance. The records of the Royal Edinburgh Hospital disclosed that

he thought that he had pus coming from his face and that he looked highly abnormal. That was why a colleague had queried monosymptomatic delusional disorder. There was a difference between some redness resulting from the wrong treatment, and the appellant's saying that he had pus coming out of his face when other people could not see it. By the mid-1990s a number of professionals had queried whether the appellant had personality disorder or psychosis. There was a pattern of the appellant's condition coming and going. Professor Thomson did not dispute that it was a complex case.

[82] Counsel asked about the following passage in Professor Thomson's most recent report, which referred to her report of 17 March 1998:

> "… he described a series of events since the early to mid-1990s when he alleges that various people have been against him, neighbours and two lawyers, and he links these events in a way that is typical of a delusional system."

Professor Thomson explained that the reference to a delusional system was to a situation in which a person had a belief and extended that belief to other people. The previous lawyer was involved, then the current lawyer, the wife of the first lawyer was involved, and the child of the second lawyer was involved. That was more systematic than a one-off belief. The root of the belief was dissatisfaction with a general practitioner.

[83] One identified delusions by considering whether the belief was unshakeable. The nature of delusions was that they were bizarre and often had grounds in reality. The appellant believed that his neighbour had deliberately put rabbits on his lawn. Professor Thomson accepted that that belief was grounded in reality to the extent that there probably had been rabbits in the appellant's garden. There could be an overlap with symptoms of paranoid personality disorder, but she came back to considering the intensity of the delusions and how they affected the appellant. They had been all-consuming.

[84] The first time that the primary diagnosis for the appellant was personality disorder was in 2005. A year before that the diagnosis had been of episodic delusional disorder with personality disorder. It was not uncommon to treat psychosis and be left with a personality disorder. She accepted the assessment by colleagues that the primary problem was personality disorder. Professor Thomson accepted also that delusional disorder could recur at times of stress, but that might not occur.

[85] The legal framework had changed since 1998, and one of the results was that up to a year was potentially available for detention on an interim compulsion order, which allowed for a longer period of assessment. The 6 months of interim detention in the appellant's case had been lengthy by the standards of the time. Another change related to personality disorder. When Professor Thomson was trained, doctors were very circumspect about the diagnosis, as it could lead to a rejection from services. There was also a risk that the diagnosis could lead to longer punitive outcomes in the context of criminal justice. The appellant was assessed formally for personality disorder only in 2007. The tools for assessment were not generally available in 1998; the international personality disorder examination had been published only in 1997. The literature supported an understanding that delusional disorder could resolve and move on.

Further material provided by the appellant

[86] After Professor Thomson had given oral evidence, the appellant submitted further written material from Professor Crichton. That material included criticism by Professor Crichton of Professor Thomson's use of the phrase "delusional intensity". He wrote that it was not a recognised diagnostic construct in either the International

Classification of Diseases ("ICD") or Diagnostic and Statistical Manual ("DSM") classification systems. It was simply a phrase used descriptively by clinicians.

[87] The major classificatory systems distinguished delusional beliefs primarily by features such as fixity, conviction, resistance to counterargument, degree of insight, and associated psychotic phenomena, rather than by emotional intensity in itself. Individuals with personality disorder might present with extremely intense, emotionally charged, rigid and threatening grievance-based beliefs without these necessarily being psychotic in nature. Despite the intensity of presentation in post-conviction episodes, psychiatrists had not regarded those episodes as representing a psychotic or delusional disorder, but as manifestations of a personality disorder.

Further material provided by the respondent

[88] Similarly, after the evidence but before submissions, the respondent submitted further written material from Professor Thomson relating to the possibility of the remission of delusional disorder. The respondent relied in particular on the following matters.

[89] The 1988 study to which Professor Thomson referred in evidence was one by S. Opjordsmoen, entitled "Long-term course and outcome in delusional disorder" (Acta Psychiatr Scand 1988:78:576-586). It consisted of 301 patients with psychosis of whom 71 had a delusional disorder. In preparing the report, of the original 301 patients, 180 subjects were interviewed personally, 90 had died and 31 patients refused, had moved abroad or were untraceable. Over an observation period of between 22 to 39 years, the researchers recorded out of the remaining 41 delusional disorder cases: 37% made a complete recovery, 32% were found to have a mild defect or personality dysfunction, 10% a

moderate impairment because of psychotic illness, and 22% found to have severe impairment.

[90] The current International Classification of Disease 11 (ICD-11) manual categorised delusional disorder under four categories:

(a) 6A24.0 Delusional Disorder, currently symptomatic,

(b) 6A24.1 Delusional Disorder, partial remission,

(c) 6A24.2 Delusional Disorder, full remission, and

(d) 6A24.Z Delusional Disorder, unspecified

Submissions

Appellant

[91] The appellant submitted that the longitudinal history evidence – that is the evidence about the presentation of the appellant from before the index offence up to the present day – was fresh evidence which demonstrated, with the benefit of hindsight, that the diagnosis in 1998 was incorrect. The appellant's pattern over a long period was consistent, and consistent with a personality disorder. He had not experienced delusional symptoms at stressful times when detained, as might be expected in delusional disorder. His grievances had a basis in reality and were not irrational. Extreme behaviour was not an indicator of delusional disorder.

[92] A key feature of delusional disorder was false beliefs, held with unwavering conviction despite evidence to the contrary. That feature was absent. The appellant had not responded to medication, and his condition had not deteriorated when medication was stopped. A longer period of assessment before sentence would have resulted in better

testing of medication and a more in-depth consideration of personality disorder. Recovery from delusional disorder was unlikely.

[93] Professor Crichton's evidence should be afforded particular weight because he had significant involvement clinically with the appellant in 1999. None of the features upon which Professor Thomson based her conclusions in 1998 was specific to delusional disorder. She had not subsequently considered the longitudinal history. The intensity of the appellant's beliefs was irrelevant, because the beliefs were not false.

[94] A compatibility issue arose by reference to Article 5 of the European Convention on Human Rights. The question whether the appellant was of unsound mind for the purposes of Article 5 fell to be answered as at the time at which he was deprived of his liberty. Domestic courts must subject expert evidence to strict scrutiny and reach their own decisions on whether the person suffered from a mental disorder: *MB* v *Spain*, application 38239/22, 6 February 2025.

[95] The case of *Reid* v *HM Advocate* [2012] HCJAC 150, 2013 SCCR 70, in which the appellant established that he should not have been detained in a psychiatric hospital, was not easy to distinguish from the present one.

Respondent

[96] The respondent relied on the passage already quoted from *Johnstone* para [70]; it was not for the court to quash a validly made order because psychiatric opinion had changed. The orders had been appropriate at the time they were made. They had proceeded on expert opinion properly given and must be allowed to stand.

[97] Neither Professor Crichton nor Dr Walsh had been able to exclude the correctness of the diagnosis of paranoid personality disorder. Professor Crichton had conceded that it was

possible for a delusional disorder to fade over time, and for a person to have both a delusional disorder and a personality disorder.

[98] The court should accord weight to the evidence of Professor Thomson, as she had the benefit of examining the appellant in 1998.

Analysis and decision

[99] There is no suggestion in this case that the diagnosis made by Professor Thomson and Dr Gray in 1998 was one that was not reasonable for them to make on the information available at the time. The appellant contends that this case is one of the sort contemplated by the court in *Johnstone* at paragraph 55, in which fresh evidence is available which supports the argument that a miscarriage of justice occurred by virtue of the disposal in 1998. Developments after conviction can be important in allowing psychiatrists and the court to reach a sound conclusion on a person's earlier mental state: *Mackison* v *Bernard* [2025] HCJAC 45, 2026 JC 47, paras [27] to [29].

[100] There was evidence before the sentencing court that the appellant had a personality disorder. That was the opinion of Dr Smith, who like the other psychiatrists, recommended a hospital order. It cannot, be said that that evidence is substantially the same as that now available. Dr Walsh's and Professor Crichton's evidence was that it could now be said with certainty that the diagnosis in 1998 was wrong. The principal basis for the appeal was that much more information was available about the appellant's presentation over time. It showed that his behaviour at the time of the index offence was of a piece with his behaviour over a long period of time, and currently. It was behaviour consistent with his current diagnosis, which was one of personality disorder.

[101] We are satisfied that we need to evaluate that new evidence, along with that of Professor Thomson, with a view to determining whether a miscarriage of justice has occurred.

[102] In her most recent report, by reference to the book chapter that she authored in 1997, Professor Thomson wrote:

> "In ICD 10 the term 'persistent delusional disorders' is used. The essence of the delusional disorder is the presence of non-bizarre delusions or delusional system. The delusions are non-bizarre in that they have some understandable foothold in reality and are in keeping with cultural norms–for example, being poisoned by avaricious relatives, deceived by a partner's unfaithfulness or believing oneself to be loved by a famous person. The nature of the delusions is a key factor in distinguishing the disorder from schizophrenia. There must be no evidence of an organic mental disorder or of inducement by drugs or alcohol, and the criteria for schizophrenia must not be fulfilled. Where depressive symptoms are present these are intermittent and the delusional beliefs persist in their absence. Hallucinations may occur but again are usually intermittent and related to the delusional belief. Social functioning and behaviour are not markedly abnormal other than that arising directly from the delusions. Often patients may appear entirely normal until the subject of the delusional beliefs is raised. Sometimes the impact of the delusional beliefs may be such that the individual is disabled for example, being unable to leave home for fear of kidnap or assaults."

[103] Both Dr Walsh and Professor Crichton emphasised that delusions must be false beliefs. Dr Walsh disputed to some extent that delusions might have an understandable foothold in reality. He suggested that it was wrong to characterise as delusional the appellant's (false) beliefs that various persons in responsible positions or positions of authority had acted maliciously towards him. That was because it was understandable, in the context of his life history, that he might have formed such a view. There is no requirement in ICD 10 or ICD 11 that delusions be without a foothold in reality. The notion that delusions should have no foothold in reality is at odds with the description of delusional disorders in Professor Thomson's most recent report, which refers to the chapter she contributed to the 1998 edition of the Companion to Psychiatric Studies. We do not

accept Dr Walsh's evidence that the appellant's beliefs were or are rational simply because they may seem subjectively rational to the appellant in the light of (genuine) adverse life experiences. We do not accept that the beliefs he expressed in 1998 were not delusions because they had developed in the context of something that had, objectively, happened (eg Ms Black's having withdrawn from acting).

[104] We have considered Professor Thomson's evidence about the appellant's presentation in 1998 by reference to Professor Crichton's terminology, namely fixity, conviction, resistance to counterargument, degree of insight, and associated psychotic phenomena, and Dr Walsh's description of delusions as thoughts that could be held very firmly and pursued to extremes. The language used by Professor Crichton and Dr Walsh is consistent with the description that Professor Thomson gave of the "delusional intensity" with which the appellant presented his beliefs in 1998. The appellant at the time held, with fixity and conviction, false beliefs about a complex conspiracy involving more than one solicitor and other people associated with them. He pursued those beliefs to extremes in 1997 by assaulting Ms Black. Professor Thomson noted that the appellant had not, since 1998, used violence towards persons or property.

[105] We accept that more extreme behaviour of itself does not necessarily indicate that an individual has a delusional disorder rather than a personality disorder. It may, however, be legitimate to infer that behaviour of that more extreme nature at or close to the time of diagnosis, against a background of still troubling, but less extreme behaviour over a longer period, is consistent with the presence of a delusional disorder in an individual who also has a personality disorder.

[106] We turn to the question of whether symptoms of delusional disorder may resolve. Professor Thomson's view was that the appellant's delusional disorder had remitted, leaving

a presentation reflecting his personality disorder. All of the clinicians agreed that delusional disorder and personality disorder could co-exist. Dr Walsh and Professor Crichton agreed that it was possible that a delusional disorder might have resolved but thought it unlikely that that had happened in this case. They expressed a degree of caution as to the reliability of statistics in the literature regarding resolution of such disorders. We accept that there may well be limitations to the studies mentioned in evidence, in, for example, the relatively small numbers of subjects involved and uncertainties as to compliance with medication and as to the accuracy of diagnoses. The studies cited by Professor Thomson do, however, support the proposition that in a proportion of cases, delusional disorder does resolve partially or fully. We attach considerable weight to the fact that ICD 11 includes diagnostic categories of delusional disorder which include full and partial remission.

[107] The fact that a longer period of interim detention would be available now than in 1998 is irrelevant. It would have made no difference to the sentencing of the appellant. It was only in 2005 that his primary diagnosis became one of personality disorder. There is no real prospect that, had interim detention lasted a year rather than 6 months, the appellant would have been diagnosed as having a personality disorder.

[108] All three witnesses were eminently well-qualified to give evidence about the diagnosis of psychiatric disorders. We do, however, accord significant weight to Professor Thomson's evidence because she was in a position to observe the presentation of the appellant in March and August 1998. Her August 1998 report followed shortly after an episode in hospital in which the appellant had damaged his room and barricaded himself in it. She was in a position to observe some alteration in his presentation as between March and August 1998. She observed that it was difficult to convey on paper the clinical impression that a patient's presentation might create at a particular time. We consider that

she was uniquely well placed among the witnesses to assess the fixity (or intensity) of the appellant's false beliefs at the material time. While we understand the logical basis on which the opinions of Dr Walsh and Professor Crichton proceeded, we prefer the evidence of Professor Thomson.

[109] Although counsel placed some emphasis in submissions on Professor Crichton's involvement with the appellant in the State Hospital in 1999, the same cannot be said for Professor Crichton himself. His evidence was concerned with a detailed review of the medical records and the long-term history of the appellant's presentation, and he did not found on any personal recollection of the appellant's presentation when reporting or in giving evidence.

[110] The appellant has not demonstrated, on the evidence, that the diagnosis of a mental illness, namely paranoid personality disorder, on the basis of which the sentencing judge imposed a hospital order with a restriction on discharge, was incorrect. On the contrary, we accept Professor Thomson's evidence that the diagnosis she made in 1998 was correct, and the appellant's delusional personality disorder remitted so that the disorder which has remained is a personality disorder. It follows that we refuse the appeal.