CASE COMMENTARY

Assessment and Evaluation of Fetal Alcohol Spectrum Disorder (FASD) and its Potential Relevance for Sentencing: A Clarion Call from Western Australia

LCM v The State of Western Australia [2016] WASCA 164 per Martin CJ, Mazza JA and Beech J

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LCM was a child of 15 whose diagnosis of FASD was not made prior to his being sentenced for the senseless and brutal manslaughter of his infant son. The diagnosis arrived at by a multidisciplinary team shortly before his appeal to the Western Australian Court of Appeal in *LCM v The State of Western Australia* [2016] WASCA 164 resulted in a significant reduction in his sentence. It also prompted the Court to undertake a foundational and internationally informed analysis of the relevance of FASD to the sentencing process and to call for improved awareness of the need for early and accurate diagnosis of the disorder.

Introduction

On an appeal from the Children's Court of Western Australia, Australia's most extensive analysis of the relevance of Fetal Alcohol Spectrum Disorder (FASD) to the sentencing of criminal offenders was delivered by the Western Australian Court of Appeal on 22 September 2016 in *LCM v The State of Western Australia* [2016] WASCA 164. The case involved the tragic killing of a young baby by his 15-year-old Aboriginal father with FASD that was not identified until the period immediately prior to the proceedings before the Court of Appeal. This highlights systemic and resource deficits in relation to awareness of FASD. The decision also draws attention in an analytical way to its potential relevance to the assessment of moral culpability at sentencing, as well as to the difficulties likely to

be experienced by an offender with FASD consigned to penal detention, and to the measures necessary for reducing the risk posed by offenders with FASD.

This case commentary reviews the background to the offending by LCM, the expert evidence in the case, the failure to identify a condition plainly relevant to his sentencing, and the concerns expressed by the Western Australian Court of Appeal about what such a failure means for the integrity and fairness of the criminal justice system.

The Facts

LCM met C when she was 12 years of age. She was a few months older than LCM. After a short while, they formed an intimate relationship in which LCM was emotionally

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dependent upon C. In due course they cohabited at C's family home. C's pregnancy was not planned.

At the age of 15 years and 10 months, LCM violently assaulted his newborn son in a room at the Bunbury Regional Hospital with two blows to the right and left side of his head, fracturing his skull and causing severe injuries. The assault caused the baby's death. LCM asserted that what had happened was an accidental bump to the baby's head, but evidence from a pathologist and a neuropathologist was clear that a considerable application of force would have been required to cause the fatal injuries and that LCM's account could not be correct. LCM was charged with murder but was not prepared to plead guilty. However, shortly before to trial the State accepted a plea of guilty to manslaughter in satisfaction of the charge of murder.

Reports from a psychiatrist (Dr Gosia Wojnarowska) and a psychologist (Ms Kate Riordan) were prepared for the court. They identified LCM's highly dysfunctional background but did not refer to any mental impairment or brain injury.

LCM came from what Ms Riordan described as a 'large, fragmented family system which has been characterised by domestic abuse, neglect, abandonment, disrupted attachment relationships, parental substance misuse and involvement in the criminal justice system' (at [49]). In 2004, LCM and his siblings were placed into the care of the Department for Child Protection due to neglect. He returned to the care of his family in 2008, but shortly afterwards his father died in his presence. The death had a deep impact on LCM who was taken back into the care of the Department two years later as a result of further neglect, including being exposed to illicit drug use, transience, being left alone for long periods without adult care and a failure to be provided food. Even in the Department's care, though, LCM did not have stable accommodation in which to live or adequate supervision or care. He commenced using illicit substances at the age of

11 in the context of a family environment in which substance abuse was normalised. He became a regular user of cannabis and, on occasions, amphetamines, as well as alcohol.

LCM received only limited education. After he completed year 7 at school, he attended year 8 for a short period before dropping out altogether. As a result, his literacy skills were limited, as were his vocational skills.

He engaged in a variety of forms of criminal conduct prior to the manslaughter, including aggravated robbery (2011), aggravated burglary (2013) and acts or omissions causing bodily harm (2013), the latter involving his throwing a knife at C, which missed and injured an innocent bystander. At the time of the manslaughter, LCM was subject to a 9-month conditional release order.

Expert Evidence at Sentence

Dr Wojnarowska, a consultant psychiatrist specialising in child and adolescent psychiatry, stated in a report prepared for the sentencing hearing that there was no evidence of a major, or even transient, psychiatric disorder that could explain LCM's violent behaviour towards his son but observed that LCM presented with antisocial behaviours which were consistent with the diagnosis of conduct disorder with childhood onset. She expressed the opinion that LCM's immediate risk to others was low but his long-term risk to the community was substantial and should be re-evaluated at the time of his release into the community. In her opinion, LCM did not require further psychiatric assessment and treatment, although she recommended psychological intervention.

Ms Riordan noted that LCM reported being the victim of extreme forms of violence across multiple settings which she said appeared to be indicative of the community and family context in which his growth and development had occurred. Ms Riordan expressed the view that the violence LCM had experienced had normalised his reliance

on ‘reactive and instrumental aggression’ as a response to perceived threat. In Ms Riordan’s opinion, LCM’s offending was opportunistic and impulsive. She found it difficult to make psychological recommendations for him, given the prospect he would receive a lengthy term of detention, but she expressed the view that he would benefit from long-term psychological intervention and suggested that, closer to his release, he should be given ‘carefully planned assistance to reintegrate to society as well as appropriate vocation and literary skills’ (at [55]).

The Sentence at First Instance

LCM was sentenced to 10 years’ detention with an order that he be eligible for supervised release after serving half of that term. The sentencing magistrate gave a 10% discount for LCM’s plea of guilty, noting that it had come very late in the proceedings. He concluded that LCM was only minimally remorseful for his conduct but acknowledged that his ability to express his remorse was limited by his youth, immaturity and the fact that he had been normalised to aggression and violence.

The Appeal

An appeal was lodged on behalf of LCM asserting only that the sentence imposed at first instance for the manslaughter of his son had been manifestly excessive. However, shortly before the appellate hearing, senior counsel for LCM was informed that he had been diagnosed by a research team from the Telethon Kids Institute (‘TKI’) with FASD. The appeal was adjourned to enable grounds relating to the FASD to be added and to enable the psychiatrist and psychologist who had assessed him for the sentencing hearing to comment on the diagnosis by the TKI. A further report from a consultant paediatrician, Associate Professor Raewyn Mutch (Dr Mutch), from the TKI team was also submitted to the Court of Appeal on LCM’s behalf,

as was a further report from the psychologist, Ms Kate Riordan, who had initially examined and written a report about LCM.

The New Evidence Before the Court of Appeal

Dr Mutch, a paediatrician who was part of the TKI assessment, explained that brain damage caused by prenatal alcohol exposure continues throughout life and gives rise to secondary consequences. Some with FASD exhibit physical characteristics but others do not. She observed that often those with the disorder are diagnosed only when it is noticed that their behaviours have become difficult. She contended that the best means of diagnosing the condition is by a multidisciplinary team, comprising a medical practitioner, usually a physician or a paediatrician, a psychologist, preferably a neuropsychologist, a speech and language pathologist and an occupational therapist. She expressed the view that, if there is proof of prenatal exposure to alcohol and if a child is found through standardised testing to be impaired in three or more domains by negative two standard deviations away from the mean, namely the subject of the assessment being in the lowest 2% in the population, a diagnosis of FASD may be made.

The TKI report was the product of a multidisciplinary assessment by a paediatrician, a speech pathologist, an occupational therapist and a psychologist with expertise in clinical neuropathology. It was confirmed that LCM’s mother consumed alcohol and engaged in varied recreational substance consumption throughout her pregnancy. LCM was assessed over eight domains, although it was acknowledged that norms did not exist for Aboriginal children:

- (1) Cognition;
- (2) Attention and activity levels and sensory processing;
- (3) Executive functions;
- (4) Memory and learning;
- (5) Language;

- (6) Adaptive functioning, social communication and social skills;
- (7) Academic functioning; and
- (8) Motor skills.

LCM was found to be impaired in cognition (1), executive functions (3), language (5), academic functioning (7) and motor skills (8). As to memory and learning (4), the overall assessment was that his memory for verbal and visual information was borderline impaired. With respect to adaptive functioning, social communication and social skills (6), the authors of the TKI report made no specific comment, except to observe that no concerns were raised by officers at the Detention Centre regarding his social communication and social skills. As to academic functioning (7), the assessment revealed that LCM had moderate to severe difficulties with sequencing and telling a story that was understandable to a listener. With respect to motor skills (8), LCM's particular deficits were in fine motor skills and body proprioception (the process by which the body can vary muscle contraction in immediate response to incoming information regarding external forces by utilising stretch receptors in the muscles to keep track of the joint position in the body).

The authors of the TKI report made a number of recommendations, including that a full specific cognitive assessment be undertaken to determine if LCM met the criteria for intellectual disability. They noted that LCM had a number of strengths, including:

- Remembering verbal information, especially with context (e.g. short story);
- Ability to hold basic information in his mind while working with it (working memory);
- Category fluency: the ability to think of related things (e.g. animals);
- Finding things on a page (visual scanning);
- Switching between basic information;
- Age appropriate balance skills;

- Strengths with gross motor skills including ball skills: aiming and catching;
- Readability of handwriting, although he had difficulty writing at a good speed;
- Ability to understand and explain the meanings of the limited amount of words he knew;
- Ability to have a short informal conversation with another person, including interaction skills in listening and responding appropriately;
- Usage of some emotive and cognitive vocabulary ('hungry', 'sad', 'thinking about'); and
- Forming sentences using Aboriginal English.

However, they identified that LCM's areas of difficulty were:

- Executive functioning difficulties (abstract thinking, making connections, understanding relationships, looking at the bigger picture and mentally manipulating information);
- Reading and other academic functioning (sentence comprehension, spelling, math computation);
- Remembering visual information with context (e.g. picture);
- When information became more complex or had extra components that he had to process at the same time, he had difficulty inhibiting or remembering (e.g. picture) and therefore any tasks with an extra cognitive load resulted in a decrease in his ability;
- Impairment of fine motor coordination skills and difficulty with proprioception;
- Remembering information;
- Understanding information;
- A limited vocabulary so his language use was basic and not age appropriate;
- Inability to remember all key elements from a short story;
- Difficulties with literacy (errors in sentence grammar such as using conjunctions and more complex sentences);

- Manipulating information in his mind in order to figure out a task (sequences, spatial information and comparative information);
- Giving accounts containing key information and appropriate grammatical structure;
- Providing enough information to the listener; and
- Limited abstract thought ability to make inferences.

Dr Mutch noted that even in the domains which did not reach the level of a serious impairment, LCM had a measured degree of impairment which may have impacted adversely on his functioning. She expressed the view that his level of impairment fulfilled the criteria at the cut-off point for assignment of intellectual disability. She made the point that deficits in executive functions can affect self-control, the ability to resist temptation and impulsivity, working memory and cognitive flexibility, seeing things from different perspectives and adapting quickly and flexibly to changed circumstances. Her view was that LCM had a level of impairment in his executive function which along with other impairments ‘can and might have impacted on his reasoning, sequential thinking and capacity to verbalise for assistance on the day of the offence’ (at [99]).

Dr Mutch concluded that:

[T]he TKI research report contains well considered and reliable information that is relevant to understanding [LCM’s] thinking, actions and behaviours and therefore the TKI report is relevant for inclusion when sentencing [LCM].

The diagnosis of FASD and recognition of [LCM’s] vulnerabilities arising from his many domains of significant impairment should be considered by the courts.

Tragically, if a detailed nature of [LCM’s] impairments had been understood and provided with some intervention early in his life, some of his and his

loved ones’ lived trauma may have been prevented.

I recommend the TKI report to you as reliable, important and critical information to amplify and inform [the court’s] consideration of [LCM’s] sentencing (at [104]).

Ms Riordan’s view on reassessing LCM’s presentation, given that the IQ tests administered to LCM had not been normed to Aboriginal children, was that his scores represented an underestimate of his true intellectual ability. She accepted before the Court of Appeal that he exhibited difficulties commonly associated with FASD, including impulsivity, susceptibility to peer influence, difficulties with emotional regulation and executive functioning but said that it was not possible:

with any sort of scientific rigor or reliability to disaggregate the neurological deficits that are likely to have occurred as a direct cause of prenatal exposure to alcohol . . . apart from the impact of the cumulative impact of [LCM’s] experience of disrupted attachment, trauma, neglect and his own substance misuse. It is therefore my opinion that it is not possible to state with any degree of certainty how prenatal alcohol exposure and the hypothesised resultant deficits caused by his exposure has directly contributed to [LCM’s] involvement in the offending behaviour independent and distinct from the cumulative effect of his adverse childhood experiences. The cognitive and executive functioning deficits described in the research literature as being experienced by those who have been subjected to prenatal alcohol exposure are similar, and in some cases identical, to those who have experienced trauma, neglect, abandonment and disrupted attachment. [LCM’s] early childhood history was well known to the Children’s Court of Western Australia before sentencing and are available for consideration to the Supreme Court of Appeal (at [112]).

Dr Mutch disagreed with the view that it was not possible to disaggregate the neurological deficits caused by prenatal exposure to

alcohol. In her view, the key point was that LCM had FASD:

that is, he started his ex utero life with a brain that 'could not work normally', and was already impaired. On top of this, she said the appellant had undergone traumatic life events, each of which could be considered 'a noxious insult' to the brain. In the appellant's case, he has had many such insults, but his ability to 'make sense of and repair' such events was impaired because of the organic brain damage he had suffered prenatally. Thus, the appellant's capacity to cope with each lived traumatic event he experienced was less than someone without FASD. Further, the appellant's lived trauma compounds and exacerbates the likely consequences of the appellant's brain injury (at [113]).

The Judgment of Mazza JA and Beech J

The judgment of Mazza JA and Beech J accepted that FASD involves disorders on a spectrum from minor to severe, meaning that FASD has the potential to lead to a 'varying number of deficits of varying intensity' (at [123]). They concluded that 'blanket propositions about how a diagnosis of FASD bears on the sentencing process should be avoided. Rather, attention should be directed to the details of the particular diagnosis of FASD, including the nature and extent of the specific disabilities and deficits, and how they bear upon the considerations relevant to sentence' (at [123]). They identified the decisions of the Victorian Court of Appeal in *R v Verdins* [2007] VSCA 102; (2007) 16 VR 269 and of the Western Australian Court of Appeal in *Krijestorac v The State of Western Australia* [2010] WASCA 35 to be highly relevant to the sentencing process of someone such as LCM with a FASD.

They found that although it was known when LCM was sentenced that 'his behaviour had been shaped by dysfunction and trauma, what was completely unknown was that prenatally he had suffered permanent brain damage which left him with significant and

lifelong deficits, most relevantly in his cognitive, linguistic and executive functioning' (at [126]). While acknowledging that the tests administered to LCM to measure his intellectual ability and adaptive behaviours were not normed or standardised for indigenous persons and that some further testing was required, they found that the evidence clearly established that LCM's powers of reasoning, logical thought and self-control were all compromised, as was his ability to deal with traumatic events. They commented that 'This is all in addition to the effects of his lived trauma, which itself compounded the effects of his FASD' (at [126]).

They accepted Dr Mutch's opinion that LCM's FASD, as well as his lived trauma, contributed to why he behaved as he did towards his infant son: 'In other words, we are satisfied that the appellant's FASD was a significant cause (but not the sole cause) of his offending behaviour' (at [127]).

Importantly, they concluded that the FASD of LCM impacted in at least six areas:

- (1) it diminished his moral culpability for the offence;
- (2) it moderated the weight to be given to personal and general deterrence;
- (3) it diminished the adverse impact of the primary judge's findings that the appellant acted 'deliberately' and 'violently';
- (4) it bore on whether and to what extent LCM was to be seen as lacking remorse, and the weight to be given to that;
- (5) it bore on the significance of LCM's failure to call for treatment immediately after the offence, a matter on which the primary judge made an adverse finding; and
- (6) LCM's impaired language skills may well explain his persistent adherence to the position that his actions were an 'accident', a position which the primary judge regarded negatively (at [128]).

This was particularly to the point, they found, because LCM's offending was impulsive and unexpected:

[He] was, at the time, faced with the responsibility, at 15, of taking home and rearing a

newborn baby. For any young person of that age, that would be a daunting and stressful prospect. For a young person with the appellant's background and impairment, it would have been an extremely traumatic prospect. The appellant's irrational behaviour was in part a reflection of the impairments which the appellant has and which are attributable to FASD (at [129]).

They determined that, while the sentencing judge accepted the submission on behalf of LCM that his capacity to exercise judgment was affected by his background of lived trauma, that generalised proposition could not be equated with the expert opinions placed before the Court of Appeal that he had the various deficits caused by FASD. This led them to conclude that his FASD was a significantly mitigating factor which was not known when he was sentenced and thus to the decision that he should be resentenced. They emphasised that LCM's FASD and his traumatic life did not deprive him of the capacity to know that what he did was wrong but there was significant mitigation to his conduct, having regard to his FASD, dysfunctional upbringing and his youth. They found him to have some relative strengths and, with appropriate mentoring and care, to have some capacity for learning and positive change. They resentenced him to seven years' imprisonment and to be eligible to supervised release after serving one half of that term.

The Judgment of Martin CJ

The Chief Justice of Western Australia, Martin CJ, agreed with the reasoning and outcome in the judgment of Mazza JA and Beech J but took the opportunity to review relevant case law and principles relating to FASD and the sentencing of defendants with FASD in criminal cases in Australia and Canada. He particularly emphasised the history of defendants not being assessed for FASD, noting that two years before, in *AH v The State of Western Australia* [2014] WASCA 228, the Western Australian Court of Appeal

had identified the inadequacy of facilities for assessing offenders for FASD. He observed that LCM had been taken into the care and protection of the State in his early childhood because of a recorded history of alcohol and substance abuse by his mother, as well as continuing 'prolific substance abuse' by members of his family. Given the intellectual deficits which LCM manifested, he commented that 'it is remarkable that those responsible for his care and protection did not initiate an assessment of whether or not he was affected by FASD. ... [I]f the extent of LCM's neurological deficits had been understood and addressed by appropriate management intervention early in his life, the trauma which he subsequently experienced and caused to others may have been averted' (at [4]). He went further and was critical of the fact that neither experienced defence counsel who represented LCM at first instance nor the authors of the psychiatric and psychological reports, or the court itself, identified what he described as 'the fairly obvious prospect that LCM might be affected by FASD, or initiated an assessment to ascertain whether or not he was, in fact, suffering from that condition' (at [5]).

Martin CJ lamented that the inadequacy of the arrangements for the assessment of FASD in Western Australia made it impossible to make any meaningful assessment of the extent to which the condition was suffered by offenders in that State. He observed that:

Unless those arrangements are improved, not only will injustice be suffered by those who commit crime at least in part because of a condition which they suffer through no fault of their own, but also the opportunity to reduce the risk to the community by appropriately managing such offenders will be lost. I can only hope that the observations made by the court in this case will have greater effect than the observations we made in *AH* (at [7]).

Martin CJ joined with Mazza JA and Beech J in emphasising the variability of the

severity of FASD symptoms and referred to the useful analysis by Heather Douglas¹:

The cognitive, social and behavioural problems associated with FASD often bring sufferers to the attention of the criminal justice system. It has been estimated that approximately 60% of adolescents with FASD have been in trouble with the law. Impulsive behaviour may lead to stealing things for immediate consumption or use, unplanned offending and offending behaviour precipitated by fright or noise. As a result of their suggestibility, FASD sufferers may engage in secondary participation with more sophisticated offenders. Lack of memory or in not understanding cause and effect may lead to breach of court orders, further enmeshing FASD sufferers in the justice system. Impaired adaptive behaviour that results from brain damage is translated into practical problems such as trouble handling money and difficulties with day to day living skills. It may be difficult for FASD sufferers to understand or perceive social cues and to tolerate frustration. Inappropriate sexual behaviour is also common amongst FASD sufferers; in one study, about 50% of FASD sufferers had displayed inappropriate sexual behaviours. Canadian research has found that FASD is over-represented in prison populations of sex offenders.

... Pre-natal alcohol exposure increases up to threefold the likelihood of alcohol abuse in adolescence. Researchers have noted that about 30% of FASD sufferers develop substance abuse problems. Such problems also increase the likelihood of involvement with criminal justice interventions, especially in Indigenous communities in Australia where alcohol use is often prohibited (at [10]).

He identified that until 2016, little detailed consideration had been given to the relevance of FASD to sentencing, save by the Queensland Court of Appeal decision of *R v MBQ; ex parte A-G (Qld)* [2012] QCA 202 where McMurdo P observed (at [9]) that: 'Those with FAS typically are impulsive and have difficulty foreseeing the consequences of their actions. They may have a poor sense of personal boundaries, lack judgment and be susceptible to peer pressure'.

By contrast, the issue has been traversed for some years in Canada where:

In 2013, the Canadian Bar Association published a resolution which noted the significance of an offender being diagnosed with FASD and which encouraged federal, provincial and territorial governments to develop and implement policies designed to assist and enhance the lives of those with FASD, and to prevent persistent over-representation of FASD affected individuals in the criminal justice system. The resolution recommended amendment of the law in various respects, including to specify that FASD should be regarded as a mitigating factor at the point of sentence. Also in 2013, an extensive consensus statement on the subject of legal actions associated with FASD prepared by a panel of distinguished citizens and experts led by the Hon Ian Binnie CC QC was published (at [17], excluding references).

He noted in particular the concern expressed a decade before by Fowler J in *R v Obed* [2006] NLTD 18 at [68], where he observed that: 'This case is like the canary in the coal mines. It's a warning that we will be incarcerating more and more people in our society for criminal matters, serious criminal matters unless immediate steps are taken to study this issue more carefully and to develop programs that have a meaningful way of dealing with them'. He also summarised the leading Canadian decisions of *R v Harper* [2009] YKTC 18, *R v Ramsay* [2012] ABCA 257 and *R v FD* [2016] ABPC 40, in the latter of which Judge Andrew observed (at [7]–[8]) that:

Research into FASD indicates that out of youth court cases reported, including Aboriginal young persons, 89% of aboriginal young persons were suffering from FASD. Further, studies indicate compelling evidence that a young accused person who is suffering from FASD is likely to have diminished capacity to foresee consequences, make reasoned choices or to learn from their mistakes. People with FASD are primarily compromised in the following areas: intellectual functioning, reasoning and judgment, verbal learning and memory, impulse

control and inhibition and perceiving social cues. Young accused persons with FASD lack the normal ability to process information and therefore their ability to plan, perceive and appreciate situations is distorted. Persons suffering from FASD do not have normal capacity to learn from experience and to retain learning. This includes an inability to appreciate consequences and to choose right from wrong. FASD accused have difficulty understanding how their behavior causes a certain outcome such as how they can get burned by a hot stove or how they may be sent to jail for committing a crime; therefore, they are unable to learn from their mistakes or to control their impulsive behavior. They are also unlikely to show true remorse or to take responsibility for their actions. These actions of FASD young persons are likely to clash with assumptions that judges have about human behavior at almost every stage of the justice system. The neurodevelopmental deficits associated with FASD challenge the basic principles of sentencing, which assume that the offenders are capable of making choices, understanding the consequences of their actions, and learning from their mistakes so as not to repeat. General deterrence – meaning that the punishment given to one person for breaking the law will operate to deter other persons, presupposes the ability of an FASD sufferer to process and translate information as well as to remember it. ... [T]here is no pharmaceutical solution, no successful talk therapy, no amount of jail time, and no probation order that will regrow brain cells of an FASD accused. In light of this, one could conclude that treating FASD offenders as other accused sets them up for failure because they will be required to act beyond their level of ability and will most likely fail to comply.

Chief Justice Martin concluded that LCM's case illustrated the significance which a diagnosis of FASD may have upon the application of established principles of sentencing and commented (at [25]) that:

It also illustrates that levels of awareness with respect to the possibility that an offender might be suffering FASD, and the arrangements which pertain to an assessment of that prospect and for the

management of an offender found to be suffering that condition are inadequate, especially when compared to the awareness of and attention given to this issue in another comparable jurisdiction – namely Canada.

Lessons from the LCM Decision

The decision by the Western Australian Court of Appeal in *LCM v The State of Western Australia* [2016] WASCA 164 should be regarded as highly significant from an international perspective. It is also very troubling. How a child with such problematic symptomatology and with the maternal drug and alcohol background that LCM was known to have had could have escaped close assessment for FASD in the lead-up to his being sentenced for the manslaughter of his baby son is difficult to understand, given the level of publicity that FASD has attracted latterly in Australia.² It appears that the multiple aspects of his dysfunctional background distracted all responsible from the serious potential that a partial explanation for his conduct may well have been FASD. Amongst other things, the case highlights the need for further education of both the forensic mental health and legal professions about the disorder and its forensic relevance.

FASD poses a number of challenges for the criminal justice system. The Centers for Disease Control and Prevention observe that:

A person with an FASD might have:

- (1) Abnormal facial features, such as a smooth ridge between the nose and upper lip (this ridge is called the philtrum)
- (2) Small head size
- (3) Shorter-than-average height
- (4) Low body weight
- (5) Poor coordination
- (6) Hyperactive behavior
- (7) Difficulty with attention
- (8) Poor memory
- (9) Difficulty in school (especially with math)

- (10) Learning disabilities
- (11) Speech and language delays
- (12) Intellectual disability or low IQ
- (13) Poor reasoning and judgment skills
- (14) Sleep and sucking problems as a baby
- (15) Vision or hearing problems
- (16) Problems with the heart, kidneys, or bones

However, this is not invariable. When those with the condition do not have obvious physical symptomatology,³ it is easy for it to escape diagnosis – it can be overlooked in a context of symptoms thought to be attributable to intellectual disability, ADHD or an actual or incipient personality disorder. Authoritative diagnosis is challenging⁴ too because, at least optimally, it requires the involvement of a multidisciplinary team whose resources are frequently not available in the real world of a criminal justice system whose capacity to identify and respond sensitively to a condition such as FASD is limited and strained.

The Western Australian Court of Appeal in *Churnside v The State of Western Australia* [2016] WASCA 147⁵ has emphasised the need for courts, and all involved in the representation of persons who may have FASD, to be proactive in their efforts to arm a sentencing court with the information that is needed to incorporate evaluation of the potential relevance of FASD to the sentencing process, and realistic means by which the community can be protected in future against persons with FASD.

It is quite apparent that the spectrum on which a given individual's FASD symptoms exist can be highly variable.⁶ As the judgments in the LCM decision identify, this is important for sentencing. Thus, the Court of Appeal concluded that LCM was not so impaired as to be unable to understand that his homicidal conduct toward his defenceless son was wrong. However, his ability to think through the consequences of his conduct and to appreciate fully its seriousness may well

have been impaired by his condition. The key issue in this regard is the damage done by prenatal alcohol consumption to the offspring's executive faculties.

A focus upon the distressing nature of LCM's conduct and his apparent lack of remorse for what he had done prompted understandable pessimism at first instance about his prospects for rehabilitation and raised concern about the risk that he would pose upon release in spite of his youth. Some measure of optimism replaced this on appeal with the unequivocal diagnosis of FASD. Had LCM's condition been recognised prior to his offending, concerted and focused efforts could have been made to reduce the risk that he posed.

The LCM decision is a clarion call for the provision of necessary resources so that young persons with FASD are identified before they have engaged in criminal conduct and so that, if they do engage in such conduct, they are diagnosed with the disorder, and there can be an informed assessment of its potential connection to their offending, its consequences if they are imprisoned and how it may impact upon their rehabilitation. There was a good reason for the frustration expressed by Martin CJ. FASD assessments and interventions are not cheap, but if the kind of tragedy that gave rise to the case of LCM is not to be repeated on multiple occasions, it is imperative that adequate diagnostic and treatment resources are directed as a matter of urgency to dealing with persons with FASD.

Notes

1. H Douglas, 'The Sentencing Response to Defendants with Foetal Alcohol Spectrum Disorder' (2010) 34(4) Criminal Law Journal 221, 223–25.
2. See e.g. Northern Territory Legislative Assembly Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *The Preventable Disability* (2015) https://parliament.nt.gov.au/_data/assets/pdf_file/0005/363254/Final_FASD_Report.pdf; Western

Australian Legislative Assembly Education and Health Standing Committee, *Foetal Alcohol Spectrum Disorder: The Hidden Disability* (Report No 15) (2012) [http://www.parliament.wa.gov.au/Parliament/commit.nsf/%28Report+Lookup+by+Com+ID%29/1740F63B37A1314A48257A7F000766DD/\\$file/Final+FASD+Report+with+signature.pdf](http://www.parliament.wa.gov.au/Parliament/commit.nsf/%28Report+Lookup+by+Com+ID%29/1740F63B37A1314A48257A7F000766DD/$file/Final+FASD+Report+with+signature.pdf); *The Lilliwan Collaboration: Inquiry into Fetal Alcohol Spectrum Disorders (FASD): Submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs* (2012) https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwiI-oG1ueDUAhXKGZQKHlrATcQFggwMAI&url=http%3A%2F%2Fwww.aph.gov.au%2Fparliamentary_business%2Fcommittees%2Fhouse_of_representatives_committees%3Furl%3Dsplas%2Ffasd%2Fsubs%2Fsub%2520022.pdf&usg=AFQjCNEhSiPHRBB3dPZxIIKa9re2bhcpbQ; House of Representatives Standing Committee on Policy and Legal Affairs,

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