CASE COMMENTARY

Huntington's Disease and Fitness to Stand Trial

The State of Western Australia v Lowick [2016] WASC 339, Fiannaca J

Ian Freckelton QC

Barrister, Crockett Chambers, Melbourne, Australia; Professorial Fellow in Law and Psychiatry, University of Melbourne, Australia

There is an extensive jurisprudence on fitness to stand trial and a substantial clinical literature on Huntington's disease. However, few commentators have given consideration to the circumstances in which the symptomatology of Huntington's disease may result in an accused person being determined unfit to participate in the criminal process. This paper scrutinises the reasoning of the Western Australian Supreme Court in *State of Western Australia v Lowick* [2016] WASC 339 where such a determination was made and reflects upon the potential for those with Huntington's disease to satisfy the criteria for unfitness, as well as the difficulties which arise in relation to the humane disposition of such persons subsequent to a finding of unfitness. It argues for reform to the law so that such persons can be detained subject to conditions set by a criminal court judge.

Key words: detention; fitness to stand trial; Huntington's disease; mental illness; treatment.

Introduction

It has been observed that neurodegenerative conditions such as Huntington's disease ('HD') have a significant potential to affect both criminal responsibility and criminal culpability.¹ However, there is relatively little scholarly analysis of the issue or case law on the subject.

Until 2016, there were only a few reported cases involving HD and the criminal law. In one of the best known, *R v Norman*,² the Court of Appeal of England and Wales

concluded in the context of a 50-year-old man with HD who had been charged with child abduction, and who spoke about his conduct to fellow prisoners, that evidence the accused wished to adduce about HD, and therefore about the potential explanations for what he had said against his interests, should have been permitted. The jury verdict against him was quashed.

In *R v Baird*,³ the Court of Appeal also reduced the sentence of a man who contended that his action in causing death by dangerous

Correspondence: Dr Ian Freckelton QC, c/o Barristers' Clerk Howells, Owen Dixon Chambers West, 525 Lonsdale St, Melbourne, 3000, Victoria, Australia. Email: I.Freckelton@vicbar.com.au

¹See P Jensen and others, 'Crime in Huntington's Disease: A Study of Registered Offences Among Patients, Relatives and Controls' (1998) 65 J Neurol Neurosurg Psychiatry 467; I Freckelton, 'Huntington's Disease and the Law' (2010) 18 Journal of Law and Medicine 7.

²[2008] EWCA Crim 1810; [2009] Crim LR 346.

³[2002] EWCA 737.

driving was the product of loss of concentration caused by depression at the prospect of being diagnosed with HD.⁴

In *R v Larmour*,⁵ a person sentenced to two terms of life imprisonment for murders committed in the company of a loyalist gang associated with the Ulster Freedom Fighters had a one year tariff set after it became apparent that he had developed HD. In addition, in *R v Jans*,⁶ Grove J of the New South Wales Supreme Court took the unusual step of imposing only a four-year good behaviour bond on a man who pleaded guilty to the manslaughter of his wife and who had suffered from severe paranoia as a result of having HD.

An important 2016 decision from the Supreme Court of Western Australia in relation to fitness to stand trial, *State of Western Australia v Lowick*⁷ has added to the limited international jurisprudence on the subject and broken new ground in determining a woman with advanced HD to be unable to participate in the criminal trial process and therefore to be unfit to stand trial.

Huntington's Disease

Huntington's disease (HD) is an autosomal dominant neurodegenerative disease passed through the family line.⁸ It is named after the United States physician, George Huntington, who described the condition in 1872 in his article 'On Chorea'.⁹ It is not evident at birth, and its symptoms tend to appear when people

are between 35 and 55 years of age.¹⁰ Occasionally symptoms commence earlier in the form of juvenile HD.¹¹

HD can be identified by genetic testing.¹² It is caused by a defective gene on chromosome 4 that causes a build-up of the huntingtin protein which damages nerve cells in the brain, in turn adversely affecting neurological function. The disease occurs when there is an increased number of DNA trinucleotide repeats in the huntingtin gene (HTT): when the number of cytosine-adenine-guanine (CAG) repeats on at least one copy of this locus is more than 35, a person will develop HD. The gene, which was discovered in 1993, is dominant, so if a person inherits it, they will develop Huntington's disease at some time in their life. Each person with an HD-positive parent has a one in two chance of inheriting the gene. A 2017 study suggests that CAG repeat length in HTT is a relatively consistent and significant factor for the progression of HD, especially in motor, cognitive and other neurological symptom deterioration.¹³ A higher number of CAG repeats is associated with shorter survival, faster institutionalisation and earlier percutaneous endoscopic gastrostomy.

There are three categories of Huntington's disease symptoms – physical, cognitive and emotional. The best-known and most recognisable symptom of HD is chorea – uncontrollable dance-like or jerking movements that begin as twitches and become more pronounced over time. As the disease progresses, walking becomes more difficult,

⁴See, too, *DPP v McDowall* [2014] VCC 891, where Judge Mullally took into account the likelihood that an offender had HD in formulating the sentence he imposed.

⁵[2004] NICC 4.

⁶[2000] NSWSC 525.

⁷[2016] WASC 339.

⁸See DM Lawrence, *Huntington's Disease* (Chelsea House Publishers, NY 2009); S Sulaiman, *Learning to Live with Huntington's Disease: One Family's Story* (Jessica Kingsley, London 2007).

⁹See JB Martin and JF Gusella, 'Huntington's Disease: Pathogenesis and Management' (1986) 315 *New England Journal of Medicine* 1267.

¹⁰See Huntingtons Queensland, 'What is Huntington's Disease?' <<http://huntingtonsqld.org.au/huntingtons-disease/what-is-hd/>>

¹¹See Mayo Clinic, 'Huntington's Disease' <<http://www.mayoclinic.org/diseases-conditions/huntingtons-disease/basics/definition/con-20030685>>

¹²See Brain Foundation, 'Huntington's Disease' <<http://brainfoundation.org.au/disorders/huntingtons-disease>>

¹³TK Chao, J Hu and T Pringsheim, 'Risk Factors for the Onset and Progression of Huntington Disease' (2017) *Neurotoxicology* (epub ahead of print).

and people become more awkward and tend to lose their balance and bump into things or other people. In addition, they tend to develop difficulty with swallowing and speaking. Choking can be a life-threatening risk. While HD is a progressive disease, its duration varies considerably – from 10 to 30 years.

Persons with HD tend to develop executive deterioration in the sense of difficulties in focusing, planning, recalling and making rational decisions. Some have little insight into what is taking place with their cognitive abilities. Short-term memory may be affected and judgment can become impaired. A small percentage of those with HD develop obsessive behaviours.¹⁴

Those developing HD may become more irritable and moody than previously, and depression and anxiety are common amongst those with HD, including in its early stages.¹⁵ A percentage of those with HD develop personality changes. They can become more impulsive and lack empathy.¹⁶ There are significant similarities between HD symptoms and cortical dementia.¹⁷

There is no cure or even treatment for HD, although medication administered by a multidisciplinary team can assist with alleviation of some of the symptoms, including those that are emotional or causing problems with movement. Research continues into the

characteristics of the disease and into ways to halt its progression, repair damage done by it¹⁸ and enhance the quality of life of those with the disease.¹⁹

Facts of the Case

Sherry Louise Lowick was a woman of 35 with three children aged 18, 14 and 4. She lived in a unit in Esperance with her 18-year-old son. While he was in his bedroom, she set fire to her bed, with the fire taking hold and spreading quickly. She left without alerting her son to the fire. He opened his bedroom door and smelled smoke. He saw that the door to his mother's bedroom was turning black, forced it open and was met with smoke and heat. On running out to safety, he found his mother outside.

In the course of an interview by the police, Ms Lowick stated that she had wanted to kill herself and that she was intoxicated at the time by alcohol, cannabis and amphetamines. She was charged with one count of causing criminal damage by fire – arson – and one count of unlawfully performing an act through which the life, health or safety of another person was likely to be endangered.

Ms Lowick was given bail in respect of the charges but then was hospitalised as an involuntary patient under the Mental Health Act 2014 (WA), initially at the Kalgoorlie Hospital Mental Health Ward and then at Graylands Hospital, where she was treated in a secure ward. Questions arose as to her fitness for trial, and psychiatric reports were commissioned to deal with the issue.

¹⁴National Health Service, 'Huntington's Disease – Symptoms' <<http://www.nhs.uk/Conditions/Huntingtons-disease/Pages/Symptoms.aspx>>

¹⁵See EA Epping and JS Paulsen, 'Depression in the Early Stages of Huntington's Disease' (2005) 17(4) *J Neuropsychiatry Clin Neurosci* 496; JS Paulsen and others, 'Depression and Stages of Huntington's Disease' (2005) 17(4) *J Neuropsychiatry Clin Neurosci* 496.

¹⁶Health Direct, 'Huntington's Disease' <<https://www.healthdirect.gov.au/huntingtons-disease>>

¹⁷See M Butters and others, 'Neuropsychological Similarities and Differences Among Huntington's Disease, Multiple Sclerosis and Cortical Dementia' (1998) 13(8) *Archives of Clinical Neuropsychology* 721; GM Peavy and others, 'Cognitive and Functional Decline in Huntington's Disease: Dementia Criteria Revisited' (2010) 25(9) *Mov Disord* 1163.

¹⁸See, eg, Edith Cowan University, 'Halting Huntington's Disease' (4 February 2015) <<http://www.mayoclinic.org/diseases-conditions/huntingtons-disease/basics/definition/con-20030685>>; see, too, C Tuckfield, 'First Use of Creatine Hydrochloride in Premanifest Huntington Disease' (2015) 202(7) *MJA* 378.

¹⁹See, eg, M van Bruggen-Rufi and others, 'Music Therapy in Huntington's Disease: A Protocol for a Multi-centered Randomized Control Trial' (2016) 4(1) *BMC Psychol* 38.

The Law as to Fitness to Stand Trial

The fitness hearing took place before Fian-naca J pursuant to section 9 of the Criminal Law (Mentally Impaired Accused) Act 1996 (WA) ('the Act') which prescribes that an accused person is not mentally fit to stand trial for an offence if, because of mental impairment, the person is:

- (a) unable to understand the nature of the charge;
- (b) unable to understand the requirement to plead to the charge or the effect of a plea;
- (c) unable to understand the purpose of a trial;
- (d) unable to understand or exercise the right to challenge jurors;
- (e) unable to follow the course of the trial;
- (f) unable to understand the substantial effect of evidence presented by the prosecution in the trial; or
- (g) unable to properly defend the charge.

'Mental impairment' is defined by section 8 to mean 'intellectual disability, mental illness, brain damage or senility,' and 'mental illness' is defined to mean: '[A]n underlying pathological infirmity of the mind, whether of short or long duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli'. By virtue of section 12(1), the question of whether an accused person is not mentally fit to stand trial must be decided by the presiding judicial officer on the balance of probabilities after inquiring into the question and informing himself or herself in any way the judicial officer thinks fit.²⁰

Section 10(2) of the Act provides that an accused found to be not mentally fit to stand trial is presumed to remain not mentally fit until the contrary is found. Pursuant to section 19(1) of the Act, if the judge who decides that

an accused is not mentally fit to stand trial is satisfied that the accused will not become mentally fit to stand trial within six months after that finding, the judge must make an order under s 19(4), quashing the indictment and either releasing the accused or making a custody order, subject to s 19(5) which provides, relevantly, that a custody order must not be made unless the judge is satisfied that such an order is appropriate, having regard to:

- (a) the strength of the evidence against the accused;
- (b) the nature of the alleged offence and the alleged circumstances of its commission;
- (c) the accused's character, antecedents, age, health and mental condition; and
- (d) the public interest.

The term 'public interest' is not defined.

The Evidence and Decision as to Fitness

Ms Lowick acknowledged to both psychiatrists who examined her that she had lit the fire, that she discovered her son was in the house and that both left the house. It was therefore apparent that she had some memory of what had occurred and that she was able to articulate what she recalled. Justice Fiannaca noted (at [28]) that she was also:

able to explain her motivation, in effect, that she wanted to die because she could not cope with the continuing deterioration of her condition. It seems that she also was able to appreciate the seriousness of her conduct and that the allegations include the risk of harm to her son, explaining that she did not intend to harm him or anyone else.

The State conceded that:

- (a) the accused suffered from a mental impairment;
- (b) because of that mental impairment, the accused was not mentally fit to stand trial; and

²⁰For a useful exegesis of the law on the issue, see *R v Dunne* [2001] WASC 263.

- (c) the accused would not become mentally fit to stand trial within the next six months.

The State made the concessions on the basis that Ms Lowick suffered from significant symptoms of Huntington's disease. Justice Fiannaca observed (at [19]) that:

The disease causes progressive impairment in the sufferer's physical and mental health in different ways: movement problems (including uncontrollable twitching, with eventual swallowing difficulties); cognitive problems (memory, attention and concentration, learning, speech); and emotional problems (aggression, apathy and psychiatric problems such as depression).

Psychological testing on Ms Lowick confirmed significant frontal lobe impairment with deficits across a broad range of cognitive domains. Dr Pascu, a psychiatrist who was head of Clinical Services at Graylands Hospital, concluded that:

Ms Lowick's very low score confirmed the significant frontal lobe damage due to the dementing process secondary to the Huntington's Disease. There was evidence suggestive of particular deficits in memory encoding and recall and in executive function (tasks that involve the coordination of a number of different cognitive abilities) (at [22]).

Dr Claassen, a psychiatrist at the Frankland Centre in the State Forensic Mental Health Services, described Ms Lowick's condition as a 'moderate neurocognitive disorder with behavioural disturbance, as a consequence of Huntington's Disease' (at [23]), affecting her capacity for complex attention, learning and memory, language and speech, executive function (planning, sequencing, organizing of tasks), motorperceptual functioning and social cognition.

Justice Fiannaca formed the view that Ms Lowick's condition satisfied the criteria for being a 'mental impairment' under the Act, first, because her intellectual functioning was

impaired to an extent that she could be said to have an intellectual disability and, secondly, because her condition had reached the point of meeting the requirements to be considered a mental illness in that 'there is an underlying pathology, namely a neurodegenerative disorder that has caused frontal lobe impairment, resulting in an infirmity of the accused's mind, in that her mental faculties and functioning are impaired' (at [25]).

Dr Pascu expressed the view that Ms Lowick's condition was such that she had 'no appreciation whatsoever' of the nature of the charges, 'no understanding whatsoever of the differences between the guilty and not guilty pleas' and 'no understanding at all of the process of a trial'. However, because Dr Pascu did not elaborate on the means by which she sought to ascertain such matters, other than 'psychological testing' and clinical interviews, Justice Fiannaca commented that 'it is difficult to evaluate the basis upon which she arrived at those conclusions'. He experienced the same difficulty in respect of the reasoning processes of Dr Claassen and noted that more information about both practitioners' methodology would have assisted him:

It is not readily apparent, for instance, to what extent the impression of a lack of understanding is due to an inability by the accused to articulate adequate responses, or whether any attempt was made to explain the various concepts or processes to the accused with the view to ascertaining if she could acquire and retain understanding that she is currently lacking (at [27]).

Justice Fiannaca's comments in this regard are one of many examples of judicial officers lamenting the propensity of some experts to engage in the *ipse dixit* – an assertion without a clear explication of their basis for their having formed their professional opinions.²¹

²¹ See further I Freckelton and H Selby, *Expert Evidence: Law, Practice, Procedure and Advocacy* (6th edn, Thomson Reuters, Sydney 2017).

Justice Fiannaca formed the view that whether or not Ms Lowick's understanding of matters such as the nature of the charges, the entering of a plea, the plea options and the purpose of a trial could be facilitated by instruction, the outcome would remain the same, as:

[A]ny improvement in her understanding would likely be temporary and, in any event, she would not be able to follow the course of a trial or defend the charges properly. In particular, it is likely that she would not be able to properly understand the evidence or its implications, or to give instructions. Her cognitive deficits in terms of attention, concentration and memory encoding, together with her speech impairment, are of particular significance in that regard (at [30]).

This meant that she was not fit to stand trial and would not become so within the next six months. Accordingly, he ordered the indictment to be quashed.

The Consequential Order

It therefore became necessary for Justice Fiannaca to decide which of the available orders he should make. He commented that this was difficult, requiring him to balance the public interest on Ms Lowick receiving treatment for her devastating illness in circumstances that would enhance her quality of life against the public interest in protecting her and the community against the risk that she would engage in further dangerous conduct if she were released unconditionally. In Western Australia, the legislative options do not include release of a person found unfit to stand trial on conditions. Chief Justice Martin had previously been critical of this lack of flexibility in *The State of Western Australia v Tax* [2010] WASC 208 at [18] where he observed that a court is precluded from releasing a mentally unfit accused 'in terms which would enable the court to fashion conditions which would enhance the protection

and safety of the community and perhaps enhance the treatment program that a mentally unfit accused person might need in order to be properly cared for'.

Justice Fiannaca expressed a similar frustration. He noted that Ms Lowick knew what she was doing when she set fire to her unit and that her conduct was 'purposeful'. She had a criminal record but it was largely for traffic offences, including drink driving, but also for breaches of orders, a violence restraining order and theft. Her mother had died of Huntington's disease earlier in the year. She had a history of childhood trauma and had been the victim of domestic violence as an adult. She had received psychiatric treatment for mood-related issues, namely depression and a panic disorder, but her engagement with mental health services and support agencies had been inconsistent (at [54]). Her first contact with psychiatric services had been in 2013, shortly before she was diagnosed with Huntington's disease. In July 2014, she was found disoriented in Perth and required admission to the intensive care unit of the Royal Perth Hospital. She was then admitted to the mental health unit of the hospital and discharged to receive psychiatric care in the community.

Ms Lowick's HD continued to deteriorate and she felt she had nothing to live for. She was advised that her life expectancy was between 6 and 12 months. By the time she was tested for forensic purposes, she was exhibiting apathy, emotional detachment and lack of insight into her cognitive difficulties. In short, her HD was becoming significantly more symptomatic. She was disorganised in her thinking and described as being vulnerable to exploitation from others. She engaged in multiple acts of self-harm and aggressive behaviour consisting of throwing and damaging furniture and assaulting staff.

After being granted bail, she was readmitted as an involuntary patient under the Mental Health Act 2014 (WA) because of expressing suicidal ideation after being evicted from her ex-partner's house and making an attempt to

end her life by jumping in front of traffic. She made further attempts at self-harm and was violent at times in her behaviour even though in custodial detention. She was also made subject to guardianship by an order of the State Administrative Tribunal on the basis that it was determined that she was incapable of looking after her own health and safety, unable to make reasonable judgments in respect of matters relating to her person, and in need of oversight care or control in the interests of her own health and safety.

At Kalgoorlie Hospital, Ms Lowick's behaviour could not be contained, so she was transferred to Graylands Hospital where she resided in a secure unit and received extensive assessment and treatment under a behavioural management plan. At Graylands, Ms Lowick improved in all areas of functioning to a point where Dr Pascu described her as 'warm and reactive' and experiencing 'no biological indicators of a major depressive or other psychiatric illness' (at [65]). However, Dr Pascu noted Ms Lowick remained unable to engage in 'forward planning' and was 'at risk of wandering if not in a secure environment or not closely supervised'. She was of the opinion that Ms Lowick remained liable to exploitation and that her impaired forward planning left her at risk of self-neglect or misadventure. While she was compliant with her medication, Ms Lowick lacked the cognitive capacity to manage the medication herself. Her tolerance and threshold for frustration were very low.

Similarly, Dr Claassen was of the opinion that Ms Lowick's disease had progressed to the point of obvious and significant physical and cognitive issues rendering her incapable of independent living and unsupported decision-making outside of a specialised supportive environment (at [66]).

Dr Pascu stated that ideally Ms Lowick would reside in a Huntington's-specific nursing home but that such a residence would have difficulty accepting her because her behaviour was not sufficiently contained. A dementia-specific nursing home was not

appropriate for the same reason. Thus, her view was that there was no realistic alternative but for her to reside at Graylands Hospital where she was permitted to have contact with her family in the grounds and had been allowed to spend some days at home with her children.

Justice Fiannaca classified a number of factors as falling within the 'public interest' that he was required to consider, including the risk of harm to the community, the risk of harm to Ms Lowick and the need for proper medical and humanitarian treatment of the mentally ill. He observed that the factors that weighed in favour of a custody order were:

the nature of the alleged offences; the circumstances of the alleged offending; the instances of self-harm and aggression while the accused has been hospitalised; the accused's apparent attempt at suicide by jumping in front of moving vehicles within one day of her first release from Kalgoorlie Hospital in November 2015; her inability to perform 'forward planning' or manage herself; her history of substance abuse; and her continuing suicidal ideation (at [71]).

In addition, the fact that she had attained a level of stability in a secure facility weighed in favour of ensuring that she remained in such an environment. He also took into account the fact that it was the view of both psychiatrists that her condition would worsen over time and that, as a consequence, her cognition, emotional state and behaviour would also be likely to deteriorate. He noted too that the motivation which caused her criminal behaviour – to end her life – remained. This had important consequences: 'Given her impaired judgment, her lack of impulse control and her motivation, the risk that the accused will do something that would put the lives or safety of others at risk, as well as her own, is a significant factor in determining whether to release her unconditionally or make a custody order' (at [74]).

He took into account the fact that Ms Lowick's lifespan was limited, but expressed

the view that 'the tragic expectation of a reduced lifespan does not justify the making of an order which would allow the immediate release of the accused when weighed against the other factors I have referred to. It will no doubt be a consideration when the accused's custody comes to be reviewed under the Act' (at [77]).

The main argument advanced on behalf of Ms Lowick was that she was, and was likely to continue to be, an involuntary patient because of her cognitive impairment and her risk of harm to herself and the community, so an unconditional release by the court would not in fact result in her release from a secure environment. Justice Fiannaca accepted that an unconditional order would provide her treating team with flexibility in management of Ms Lowick, enabling them to achieve the most humanitarian outcome of placement in a facility close to her home and family if it was considered that her behaviour could be properly managed.

However, ultimately he concluded that notwithstanding the recommendations from both psychiatrists:

[T]he need for a custody order to ensure the protection of the accused and the community from the risk of harm that she poses at present outweighs the desirability for flexibility to achieve what is perceived to be the best outcome for her from a humanitarian perspective. I am not satisfied that adequate measures could be put in place to safeguard against the risk of harm presented by the accused to herself and the community, if she were to be released unconditionally (at [85]).

In these circumstances, he found that, as a mentally impaired person under a custody order, she would be detained in an authorised hospital, a declared place, a detention centre or a prison, as determined by the Mentally Impaired Accused Review Board. While she could not be detained in an authorised hospital (such as Graylands Hospital or the Frankland Centre which catered to persons with

HD and was on the grounds of Graylands), unless she had a treatable mental illness, Justice Fiannaca did not regard this as an impediment on the basis that she was being treated for the symptoms arising from what was technically a mental illness. This meant that she would not need to be sent to prison, which would be therapeutically inappropriate, but could be treated in a hospital environment which could contain her and provide necessary care.

In addition, he found that Ms Lowick could still be released from the custody order at the discretion of the Governor on the report of the Mentally Impaired Accused Review Board ('the Board'), which is obliged to provide an initial report within eight weeks of the making of a custody order and thereafter every 12 months. Such a report must recommend whether the accused should be released by the Governor and, if so, under what conditions, if any. For the purpose of its reporting, the Board could require Ms Lowick to be examined and a risk assessment could be made to enable suitable conditions to be fashioned, taking into account humanitarian considerations. This led Justice Fiannaca to conclude that the risk posed by Ms Lowick was best managed by that system which allowed for conditional release albeit that she would be on a custody order. In this way, any conditions considered necessary to protect her and the community could be balanced with humane considerations.

In determining the issue of where Ms Lowick should be detained, Justice Fiannaca found that she was being treated for her illness, even though it could not be cured, and expressed the expectation that:

in light of all of the information presented in the hearing, that the accused will be held in an authorised hospital if that is at all practically possible. The evidence supports the conclusion that to hold the accused in either a prison or Frankland Centre (notwithstanding it is an authorised hospital) is likely to cause her distress of a kind that may exacerbate her condition. In those circumstances,

while the custody order serves the purpose of protecting the community and the accused, humanitarian considerations should inform the determination of the place of custody, so that the accused is detained in the least restrictive facility that circumstances will allow. However, it is, of course, a matter for the Board on advice from those who are responsible for the administration of Graylands Hospital, and the treatment of the accused, to make the appropriate determination in light of all relevant considerations (at [100]).

He observed pointedly that Ms Lowick was not to be regarded as a convicted offender:

The fact that the accused was charged and the nature and circumstances of the alleged offences are relevant considerations in determining whether to release the accused or make a custody order, but it is clear that a mentally impaired accused who is found to be unfit to stand trial is to be dealt with in accordance with pt 5 of the Act, and may be held in an authorised hospital (at [102]).

He quashed the indictment and made a custody order in respect of Ms Lowick.

Discussion

State of Western Australia v Lowick [2016] WASC 339 is an important example of a scenario in which a person accused of a serious criminal offence is unfit to stand trial by reason of symptomatology that has its origin in a degenerative neurological condition that has psychiatric sequelae. Such conditions, when prodromal, or even in their early phases, can be difficult to diagnose, but at their heart is a significantly reduced capacity on the part of the accused person to participate meaningfully in the criminal trial process.

While Justice Fiannaca found that the conduct of Ms Lowick was purposeful and engaged in deliberately in order to terminate her life, the expert psychiatric evidence before him persuaded him that she had neuro-cognitive deficits arising from Huntington's disease which precluded her from key aspects of her capacity to engage in the trial process. These were not remediable by explanation or counselling.

This meant, in Western Australia, that, as her condition was not going to improve over the succeeding six months – in fact, it was only going to deteriorate – the indictment against her needed to be quashed. A consequence of that was that an order either releasing her unconditionally or placing her under a custody order needed to be made. Unsurprisingly, Justice Fiannaca concluded that he could not release Ms Lowick unconditionally, given the risk she posed to the community as well as to herself. It was evident that his preference would have been to release her on a conditional order, but such a disposition is not open under Western Australia's fitness to be tried legislation. It should be. Law reform to enable such an order is necessary. In the event, though, he identified a reasonably acceptable compromise in that an assessment of her condition and needs would be undertaken by the Mentally Impaired Accused Review Board which would report to the Governor. That would enable the Governor to make a clinically informed order that could balance risk and humanitarian considerations for a person suffering from a cruel and intractable degenerative disease. Such a device is less than ideal because it necessarily involves the political process. It is to be hoped that it affords sufficient flexibility to cater to the sad but dangerous circumstances of Ms Lowick.