[2016] WASCA 164

JURISDICTION	**:**	SUPREME COURT OF WESTERN AUSTRALIA
TITLE OF COURT	**:**	THE COURT OF APPEAL (WA)
CITATION	**:**	LCM -v- THE STATE OF WESTERN AUSTRALIA [2016] WASCA 164
CORAM	**:**	MARTIN CJ MAZZA JA BEECH J
HEARD	**:**	19 FEBRUARY & 7 APRIL 2016
DELIVERED	**:**	7 APRIL 2016
PUBLISHED	**:**	22 SEPTEMBER 2016
FILE NO/S	**:**	CACR 85 of 2015
BETWEEN	**:**	LCM Appellant AND THE STATE OF WESTERN AUSTRALIA Respondent

ON APPEAL FROM:

Jurisdiction	**:**	CHILDREN'S COURT OF WESTERN AUSTRALIA
Coram	**:**	REYNOLDS P
File No	**:**	CC 639 of 2015

Catchwords:

Criminal law and sentencing - Young offender - Manslaughter of infant child of offender - Sentence of 10 years' detention - Mental impairment - Foetal alcohol spectrum disorder - Relevance of FASD to sentencing - Whether new evidence of FASD suffered by offender meant a different sentence should have been imposed

Legislation:

Nil

Result:

Appeal upheld
Sentence of 7 years' detention substituted

Category: A

Representation:

Counsel:

Appellant	:	Ms K J Farley SC
Respondent	:	Ms A C Longden

Solicitors:

Appellant	:	Legal Aid (WA)
Respondent	:	Director of Public Prosecutions (WA)

Case(s) referred to in judgment(s):

AH v The State of Western Australia [2014] WASCA 228
Cowan v The Queen [2015] NSWCCA 118
DPP v Moore [2009] VSCA 264
JL v Morfoot [2005] ACTSC 77
Kelly v The Queen [2015] VSCA 340
Krijestorac v The State of Western Australia [2010] WASCA 35

R v Cameron [2014] QCA 55
R v FD [2016] ABPC 40
R v Friesen [2016] MBCA 50
R v Harper [2009] YKTC 18
R v Manitowabi [2014] ONCA 301
R v MBQ; ex parte A-G (Qld) [2012] QCA 202
R v Obed [2006] NLTD 155
R v Ramsay [2012] ABCA 257
R v RC; R v JM [2016] NSWSC 98
Thompson v The Queen [2005] WASCA 223; (2005) 157 A Crim R 385
TM v Karapanos [2011] ACTSC 74
Wheeler v The Queen [No 2] [2010] WASCA 105

1 **MARTIN CJ**: The joint reasons given by Mazza JA and Beech J effectively enunciate the reasons why I joined with the other members of the court in allowing this appeal against sentence and resentencing the appellant to a term of 7 years' detention, directing that he be eligible for supervised release after serving one-half of that term. However, I wish to add some observations of my own on the subject of foetal alcohol spectrum disorder (FASD).

The significance of FASD

2 A diagnosis that an offender suffers from one of the conditions within the spectrum of disorders caused by foetal exposure to alcohol can be of great significance to the sentencing process, in one or more of the ways to which I will refer. In this case, the appellant's diagnosis was of great significance, for the reasons given by Mazza JA and Beech J. As Dr Mutch observed in her evidence, the organic brain injury which LCM suffered before he was born compounded the consequences of his traumatic childhood, which included exposure to domestic violence, neglect, abandonment, relationships which were disruptive, and parental substance misuse. The combined effect of the organic deficit and childhood trauma, both of which were suffered through no fault on the part of LCM, produced the deficits identified in the evidence of Dr Mutch which were relevant to the sentencing process in the various ways enunciated by Mazza JA and Beech J.

Diagnosis and management of FASD

3 In ***AH v The State of Western Australia***[1] this court drew attention to the surprising lack of any FASD assessment of the appellant in that case, given its potential significance to the management of that offender.[2] Senior counsel for the appellant in this case[3] advised the court that despite those observations having been made 18 months ago, AH had still not been assessed for FASD.[4] The circumstances of this case, viewed in the context of that advice, suggest that the arrangements for the assessment and management of offenders suffering from FASD in this State remain quite inadequate.

4 In this case, the evidence established that one of the reasons LCM was taken into the care and protection of the State in early childhood was because of a recorded history of alcohol and substance abuse by his

[1] [2014] WASCA 228.
[2] ***AH*** [9] (Martin CJ, Mazza JA & Hall J).
[3] Who was also senior counsel for the appellant in ***AH***.
[4] Appeal ts 63.

mother, and continuing prolific substance abuse by other members of the family. In that context, when LCM's neurological deficits became apparent and manifest in his behaviour, including the various behavioural and intellectual difficulties he manifested as a young child, 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. As Dr Mutch observed, if 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.[5]

5 Nor do the arrangements for the assessment and management of FASD in the criminal justice system appear any better than in the child protection system, despite the publication last year to justice system professionals of a series of informative videos on the subject produced by the Telethon Kids Institute. When LCM was charged with the most serious offence known to the criminal law, namely murder, in a context in which the death was caused by unusual and unexplained circumstances, it is equally remarkable that neither the experienced defence counsel who represented LCM at first instance, or the author of the pre-sentence report, or the author of the psychiatric report, or the author of the psychological report, or the court identified 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. It should also be noted that the Community Development and Justice Standing Committee of the Legislative Assembly of Western Australia enquired into and reported upon the circumstances of this case without making any reference to the prospect that LCM might suffer from FASD, or should at least be assessed for that condition.[6] The fact of LCM's FASD only came to light coincidentally because LCM had been sentenced to a term of detention when the programme for screening for FASD undertaken by the Telethon Kids Institute was underway in that detention centre.

6 So, this is another case in which neither the agencies responsible for the care and protection of children nor those responsible for the assessment and management of offenders responded appropriately, or indeed at all, to the obvious prospect that LCM might suffer from FASD. As a consequence, the opportunity for early intervention and appropriate

[5] Report of Dr Mutch, p 12.
[6] Community Development and Justice Standing Committee, Parliament of Western Australia, *Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby* (March 2016).

management to which Dr Mutch referred was lost, and the sentencing process at first instance miscarried.

7 The inadequacy of the arrangements for the assessment of FASD in this State make it impossible to make any meaningful assessment of the extent to which that condition is suffered by offenders in this State. The screening programme currently underway in the Banksia Hill Detention Centre may shed some light on that question. What is clear, however, is that the current arrangements for the assessment and management of offenders with that condition are quite inadequate. 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***.

The relevance of FASD in the sentencing process

8 Before addressing the general significance of a FASD diagnosis in the sentencing process, it is important to emphasise that foetal exposure to alcohol can produce a variety of different disorders within a spectrum, and that the particular disorder caused may be suffered to an extent which varies from minor to profound deficit or disability. It follows that the relevance of a diagnosis of FASD in any particular case will depend critically upon the precise nature of the diagnosis, and upon the nature and extent of the disorder suffered as a consequence of foetal alcohol exposure. That is why the joint reasons of Mazza JA and Beech J appropriately provide significant detail with respect to the diagnosis made by Dr Mutch, and the effect which LCM's disorder has upon his capacities measured in differing fields.

9 In the reasons which follow it is convenient to refer to a diagnosis of FASD in generic terms. However, my generic use of that term should not obscure the vital fact that the relevance of a diagnosis of FASD in any particular case will turn critically upon the precise diagnosis made, the extent of the disabilities occasioned by the condition and the impact of those disabilities upon relevant sentencing considerations.

10 As Mazza JA and Beech J point out, the legal principles relating to the relevance of mental impairment to the sentencing process are well settled and were conveniently enunciated by Wheeler JA in ***Krijestorac v***

The State of Western Australia.[7] FASD is one of the conditions of mental impairment which may trigger the application of those principles. However, FASD, generically speaking, has some particular characteristics which are relevant to the sentencing process. As Professor Douglas pointed out:[8]

> 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. (footnotes omitted)

11 Professor Douglas also notes that FASD:[9]

> … should be identified in children as early as possible, around six years of age. It is easier to identify the disorder in young children from visual physical cues, plus the earlier it is identified, the earlier special programs and responses can be put in place so that secondary effects can be avoided. (footnotes omitted)

12 Professor Douglas' observation with respect to the compounding effect of FASD upon childhood development is consistent with the observation made by Dr Mutch in this case.

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[7] [2010] WASCA 35.
[8] Douglas H, 'The sentencing response to defendants with foetal alcohol spectrum disorder' (2010) 34(4) *Criminal Law Journal* 221, 223 – 225.
[9] Douglas, 221.

The Australian cases

13 My researches have identified only one Australian case in which specific consideration has been given to the effect which a diagnosis of FASD has upon the application of sentencing principles. That case is ***R v MBQ; ex parte A-G (Qld)***[10], which was a prosecution appeal against the sentence imposed upon a 12-year-old boy who pleaded guilty to raping a three-year-old girl on the grounds of manifest inadequacy. McMurdo P referred to the offender in these terms:[11]

> … He had no offending history. His limited intellectual capacity and the passage of time since the offending made it difficult to identify factors contributing to it. Lack of appropriate sexual education and developmental immaturity arising from foetal alcohol syndrome (FAS) may have contributed … Although he was 12 years old at the time of the offences, according to Dr Fama's report his intellectual age is less than his chronological age so that he was probably functioning more in the range of a nine-year-old boy at the time of the offending. He was then mixing with young children because of the demographics and remoteness of the community.

14 Her Honour went on to observe:[12]

> FAS may have indirectly contributed to his commission of the offences. It can result in cognitive and behavioural deficits including mental retardation, learning difficulties, hyperactivity, attention deficits and poor social skills. 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.

15 Dismissing the prosecution appeal against sentence, McMurdo P observed:[13]

> … The fact that the respondent had a mental age of nine years (that is, below the age of criminal responsibility) and had limited grasp of the consequences and moral blameworthiness of his actions at the time he committed the offences is highly relevant to the exercise of the sentencing discretion. It lessened his moral culpability for the offending so that the retributive, denunciatory and deterrent aspects of sentencing were less relevant than otherwise. (references omitted)

[10] [2012] QCA 202.
[11] ***MBQ*** [8].
[12] ***MBQ*** [9].
[13] ***MBQ*** [44] (Gotterson JA & Philippides J agreeing).

16 There are cases in which a diagnosis of FASD has been noted[14] and cases in which a possible diagnosis of FASD has been noted[15] but in which no particular consideration has been given to the impact which such a diagnosis had or might have had in relation to the sentencing process. The relative dearth of Australian case law on this topic stands in stark contrast to the position in Canada.

The response to FASD in Canada

17 The significance of an offender being diagnosed with FASD has received considerably greater attention and consideration over a longer period of time in Canada than it has in this country. The response of the Canadian justice system to the issue is comprehensively analysed in a seminal article published by Roach and Bailey in 2009.[16] 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.[17] 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[18] was published.[19]

18 There have been many decisions of Canadian courts on the subject. The cases to which I will now refer are not intended to provide an exhaustive summary of Canadian case law on the subject, but rather to identify some of the principles which have emerged in that jurisprudence.

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[14] ***DPP v Moore*** [2009] VSCA 264; ***JL v Morfoot*** [2005] ACTSC 77.

[15] ***R v Cameron*** [2014] QCA 55; ***R v RC; R v JM*** [2016] NSWSC 98; ***TM v Karapanos*** [2011] ACTSC 74; ***Kelly v The Queen*** [2015] VSCA 340; ***Cowan v The Queen*** [2015] NSWCCA 118.

[16] Roach K and Bailey A, 'The Relevance of Fetal Alcohol Spectrum Disorder in Canadian Criminal Law from Investigation to Sentencing' (2009) 42(1) *UBC Law Review* 1.

[17] Canadian Bar Association, *Resolution 13-12-A: Accommodating the Disability of FASD to Improve Access to Justice* (2013).

[18] Former Justice of the Supreme Court of Canada.

[19] Institute of Health Economics, *Consensus Statement on Legal Issues of Fetal Alcohol Spectrum Disorder (FASD)* (2013).

R v Obed [2006]

19 In ***R v Obed***[20] Fowler J observed;[21]

> … Governments now know that people with FASD will fill our prisons in increasing numbers because people with FASD have a very, very high likelihood of committing criminal offences in that they act on impulse, without consideration for the consequences. It is not difficult to predict that our jails will be overflowing with people with FASD if society somehow does not develop an understanding of how to deal with this serious problem while children are young enough to be helped. This is sadly the case in aboriginal communities to a higher degree than in any other segment of our society. More effort must be made to deal with this incredibly difficult problem in aboriginal communities … [T]his is not just an aboriginal problem, this problem is found at all levels of our society, in every community, in every walk of life, throughout our society and until something is done to curb this, then our crime rate will increase.
>
> 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.

R v Harper [2009]

20 In ***R v Harper***[22] Judge Lilles observed:[23]

> FASD has specifically been recognized as a factor that affects an offender's degree of responsibility so as to reduce the severity of a just sentence. Indeed, it may well be the 'main criminogenic factor' in an offender's life (***R. v Gray*** 2002 BCPC 58, at para 53).
>
> Where FASD is diagnosed, failing to take it into account during sentencing works an injustice to both the offender and society at large. The offender is failed because he is being held to a standard that he cannot possibly attain, given his impairments. As noted by Judge Barry Stuart in ***R v Sam*** (1993) Y.J. No. 112 (T.C.), FASD takes away someone's 'ability … to act within the norms expected by society' … and it is manifestly unfair to make an individual pay for their disability with their freedom. Society is failed because a sentence calculated for a 'normal' offender cannot serve the same ends when imposed on an offender with FASD; it will not contribute to respect for the law, and neither will it contribute to the maintenance of a just, peaceful and safe society.

[20] ***R v Obed*** [2006] NLTD 155.
[21] ***Obed*** [67] - [68].
[22] ***R v Harper*** [2009] YKTC 18.
[23] YKTC [37] - [39].

> The calculus of sentencing the average offender simply does not apply to an offender with FASD. Not only can traditionally calculated sentences be hopelessly ineffective when applied to FASD offenders, but the punishment itself, calibrated for a non-disabled individual, can have a substantially more severe effect on someone with the impairments associated with FASD.

R v Ramsay **[2012]**

21 In ***R v Ramsay***[24] the Court of Appeal of Alberta emphasised the need for a court to identify the precise extent of the impairment suffered by an offender diagnosed with FASD. The court observed:[25]

> … [S]entencing is an individualized process and courts should craft sentences for FASD-affected offenders with awareness of their unique neurological deficits and abilities. '[T]he brain abnormalities associated with FASD are different for every person with this disability' … Courts in dealings with persons with cognitive defects in the spectrum will encounter a 'wide range of effects resulting from prenatal alcohol exposure' … This broad diversity in the severity of impairments accounts for the marked disparity in IQ and other quantifiable indicia of cognitive ability among persons diagnosed with FASD, which should in turn alert courts to the 'danger of ignoring differences that may be relevant to the appropriate policies applied in each case' … (references omitted)

22 The court also made a number of general observations[26] with respect to the relevance of a diagnosis of FASD to the sentencing process:[27]

> Crafting a fit sentence for an offender with the cognitive deficits associated with FASD presents at least two identifiable challenges: accurately assessing the moral blameworthiness of the offender in light of the adverse cognitive effects of FASD; and balancing protection of the public against the feasibility of reintegrating the offender into the community through a structured program under adequate supervision. Medical reports assessing the prospect of the offender's rehabilitation and reintegration into the community are essential to the task and must be carefully analyzed.
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> This notion is concisely captured by Roach and Bailey who observed that:
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> > The determination of an appropriate sentence for the FASD offender is a challenging task for courts. Although it is increasingly recognized that FASD is a disability that can have a profound impact on the level of an offender's moral culpability, the mitigation that this consideration would normally have on the

[24] [2012] ABCA 257.
[25] ***Ramsay*** [20].
[26] Subject, of course, to the important qualification in the passage already cited.
[27] ***Ramsay*** [16] - [17], [24] - [25].

> length of a sentence is frequently tempered by the practical need to protect the community. [Yet often] the programming available to an FASD-affected offender is inadequate and the resources to support and monitor such an individual in the community are severely lacking.
>
> …
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> Where the cognitive deficits experienced by the offender significantly undermine the capacity to restrain urges and impulses, to appreciate that his acts were morally wrong, and to comprehend the causal link between the punishment imposed by the court and the crime for which he has been convicted, the imperative for both general deterrence and denunciation will be greatly mitigated … We agree with the observation of the court in ***Quash*** that:
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> > That is not to say that the principles of general deterrence and denunciation have no place in sentencing FASD offenders. In certain cases there may be a role, depending on the nature of the offence and the degree of moral culpability of the offender, based upon the extent of his or her cognitive difficulties.
>
> The degree of moral blameworthiness must therefore be commensurate with the magnitude of the cognitive deficits attributable to FASD. The more acute these are shown to be, the greater their importance as mitigating factors and the less weight is to be accorded to deterrence and denunciation, all of which will serve to 'push the sentence … down the scale of appropriate sentences for similar offences'. (references omitted)

23 The decision in ***Ramsay*** was followed by the Court of Appeal of Ontario in ***R v Manitowabi*** [28] and by the Court of Appeal of Manitoba in ***R v Friesen***.[29]

R v FD [2016]

24 More recently in ***R v FD***[30] Judge Andrew observed[31]:

> 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

[28] [2014] ONCA 301.
[29] [2016] MBCA 50.
[30] [2016] ABPC 40.
[31] ***FD*** [7] - [8]

> 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 assumes 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.
>
> In summary, the traditional principles of sentencing such as deterrence, denunciation and separation are not effective because the organic nature of FASD impedes the individual's ability to adapt their behavior. Having said that, studies seem to indicate that with proper treatment and care such behavioral characteristics can be managed quite effectively. Deterrence and denunciation are problematic in that many FASD young persons are simply incapable of engaging in risk and consequence analysis …

Summary and conclusion

25 This case illustrates the significance which a diagnosis of FASD may have upon the application of established principles of sentencing. 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.

MAZZA JA & BEECH J:

Overview

26 On the evening of 15 February 2014, the appellant, who was then 15 years and 10 months old, violently assaulted his newborn son, L, in a room at the Bunbury Regional Hospital. On 24 February 2014, L died from the head injuries he received at the hands of the appellant.

27 The appellant had a severely deprived and dysfunctional childhood. Since the age of 6 years, he has spent a substantial length of time in State care. The appellant was a ward of the State when he killed L.

28 The appellant was originally charged in the Children's Court with L's murder. A trial on this charge was set down to commence on 23 February 2015. On 11 February 2015, the appellant, via his lawyer, made an offer to plead guilty to manslaughter. That offer was accepted by the State in satisfaction of the charge of murder. On 23 February 2015, the appellant was convicted on his plea of guilty of manslaughter. He was remanded to appear for sentence on 23 March 2015. The primary judge ordered the preparation of a pre-sentence report, as well as psychological and psychiatric reports (ts 19). In due course, those reports were prepared. The reports all remarked upon the appellant's highly dysfunctional background, but did not refer to any mental impairment or brain injury.

29 The primary judge imposed a sentence of 10 years' detention with an order that he be eligible for supervised release after serving half of that term. The sentence was backdated to commence on 16 February 2014. In his sentencing remarks, his Honour said that the appellant's personal history provided 'significant mitigation' (ts 52).

30 Originally, the sole ground of appeal was that the sentence was manifestly excessive. However, shortly before the hearing of the appeal on 19 February 2016, senior counsel for the appellant, Ms Farley SC, was informed that, after the appellant had been sentenced, he had been diagnosed by a research team from the Telethon Kids Institute (TKI) with Foetal Alcohol Spectrum Disorder (FASD). An essential element of this disorder is that the person has suffered a prenatal, permanent, organic brain injury as a result of maternal alcohol consumption in pregnancy. The existence of this condition was not known to anyone at the appellant's sentencing.

31 After hearing from counsel for the parties on 19 February 2016, the appeal was adjourned to 7 April 2016 to allow the appellant the opportunity to amend his grounds of appeal to deal with this development and to provide the court with further evidence about FASD and its impact, if any, on the appellant's case. The adjournment was also to enable the psychologist and psychiatrist who had provided the primary judge with reports to comment on the effect, if any, that the diagnosis of FASD had on their opinions.

32 On 31 March 2016, the appellant filed an application to amend his grounds of appeal by adding a further ground, which may be considered as ground 2, in these terms:

> Additional evidence not before the learned sentencing judge relating to the appellant having a mental impairment, namely FASD, has been obtained after sentencing which would have had a material impact on the sentence if it was known at the time of sentencing. The evidence subsequently obtained indicates that a miscarriage of justice has occurred in this case in that the sentence imposed failed to reflect a mitigating factor, that being the presence of impairment.

33 The appellant also applied to adduce additional evidence, most significantly being the (undated) TKI report in which the diagnosis of FASD was made and a subsequent report dated March 2016 by consultant paediatrician, Clinical Associate Professor Dr Raewyn Mutch (Dr Mutch).

34 At the resumption of the hearing on 7 April 2016, the appellant's application to amend his grounds of appeal and adduce additional evidence was granted (ts 27). The respondent was also given leave to adduce additional evidence being a report dated 6 April 2016 by Ms Kate Riordan, the psychologist who had provided a report to the primary judge. Dr Mutch gave oral evidence at the hearing.

35 The appellant's case focused on ground 2. In essence, the appellant argued that the appellant's FASD was a material mitigating factor unknown to the court at first instance. Had it been known, that court would have been bound to impose a lesser sentence. It was submitted that this court's intervention was required in the light of the additional evidence to prevent a miscarriage of justice.

36 The respondent did not dispute the diagnosis of FASD or that it was not apparent to the sentencing judge (ts 70). The respondent submitted that the additional evidence would have made no material difference to the sentence imposed at first instance. Accordingly, it was said, the appeal should be dismissed.

37 For reasons we will explain, it was necessary for this court to decide the appeal urgently. At the conclusion of the hearing on 7 April 2016, the court unanimously made the following orders:

> 1, The appeal is allowed.
>
> 2. The sentence imposed by the learned sentencing judge is set aside and, in lieu, the appellant is sentenced to 7 years' detention, to take effect from 14 February 2014 and the appellant shall be eligible for supervised release after serving one half of that term (ts 79).

38 What follows are our reasons for joining in the making of these orders.

The facts of the offending

39 The appellant and L's mother, C, met when the appellant was 12 years of age. C was only a few months older than the appellant. The appellant and C formed an intimate relationship in which the appellant became emotionally dependent upon C. Eventually, the appellant came to live with C at her family home. C's pregnancy was unplanned.

40 On 21 January 2014, C gave birth to L, six weeks prematurely, at the Bunbury Regional Hospital. C was 16 years of age. L received specialist hospital care in the maternity ward after his birth. He progressed well and it was planned that he would be discharged into the care of the appellant and C on 17 February 2014.

41 In preparation, C was re-admitted to the maternity ward on 15 February 2014 as part of a parent crafting program designed to assist in the transition from hospital care to the sole care of the parents. Although L was not allowed to leave the maternity ward during this period, the appellant and C were permitted to move the baby around the ward in a mobile cot and care for him in the room which had been allocated to C, room 224.

42 Up until the assault on L, the events of 15 February 2014 were normal. Observations made of L by the nursing staff were unremarkable. They expressed no concerns about his health or care.

43 At around 7.10 pm, the appellant, who had been in and out of the hospital during the day, arrived at the nursery. He moved L from there to room 224, using the mobile cot. At this time, C was in the kitchen warming up some food, leaving the appellant and L alone in the hospital room. In a time frame of 3 to 10 minutes, the appellant deliberately struck

L's head against a hard surface somewhere within the room, with considerable force. He delivered at least two blows, one to the right and left sides of L's head. These blows fractured L's skull and caused severe brain injuries.

44 C, unaware of what had occurred, returned to room 224 with the food she had prepared. The appellant was seen inside the room with L in his arms, saying, 'Son, son'. L's breathing had stopped and he was pale. C noticed a lump on the right side of L's head, near his ear. She immediately took L from the appellant and rushed the child to the nursery, where efforts were made to resuscitate him. While this was happening, the appellant and C went back to room 224 where the appellant said, 'He [L] just stopped breathing'.

45 Medical staff managed to stabilise L and x-rays were taken. These revealed the skull fractures and areas of bleeding in the brain. L was transported to Princess Margaret Hospital for further treatment. However, on 24 February 2014, L died from his head injuries.

46 On 16 February 2014, the appellant was arrested. He took part in two video recorded interviews that day. In essence, the appellant said that while he held L inside the hospital room, he accidentally bumped the baby's head into the wall or door frame as he was about to go out of the room. He said that he hit L's head with enough force to cause a 'pop' noise.

47 The pathologist who conducted the post-mortem examination of L, Dr Moss, determined that the cause of death was from complications of head injury. It is unnecessary to describe all of the pathologist's findings. The post-mortem examination revealed bilateral parietal skull fractures. He observed extensive subdural haemorrhage and severe brain swelling. There was significant evidence of trauma to L's head. In the pathologist's opinion, it was unlikely that the two separate areas of fracture, being on opposite sides of the skull, were caused by one application of force. While the pathologist considered whether the injuries could have resulted from one application of force, he concluded that the best explanation for the fractures was that there were at least two impacts to L's head. In his opinion, considerable force was required to fracture L's skull, more than the force that might result from bumping a baby's head on a hard surface on the way out of a room.

48 Dr Fabian, a neuropathologist, expressed the opinion that the injuries to L were incompatible with shaking of the baby's head and the brain injuries were caused by severe blunt force trauma. She commented that the injuries to L were the most severe head or brain injuries that she had seen in an infant.

The appellant's antecedents

49 The appellant's upbringing has been completely dysfunctional. He is the youngest child in what was said, in Ms Riordan's report dated 25 February 2015, to be 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' (Ms Riordan's report, 25 February 2015, page 2).

50 In 2004, the appellant and his siblings were placed into the care of the Department for Child Protection (the Department) due to neglect (Tracey Cull's report, 18 March 2015, page 1). In 2008, the appellant was returned to the care of his family. However, not long afterwards, his father died suddenly. There is evidence that the appellant witnessed his father's death and may have had to render assistance (Ms Riordan's report, 25 February 2015, page 3). His father's death had a deep impact on the appellant (Ms Riordan's report, 25 February 2015, page 3).

51 In September 2010, as a result of neglect, including being exposed to illicit drug use, transience, being left alone for long periods without adult care and a failure to provide food, the appellant was taken into the care of the Department (Tracey Cull's report, 18 March 2015, page 1). The relationship between the Department and members of the appellant's family has been problematic. Even in the Department's care, the appellant did not have stable accommodation in which to live or proper supervision or care. He commenced using illicit substances at the age of 11 in the context of a family system in which substance abuse was normalised. The appellant became a regular user of cannabis and, on occasions, amphetamines, as well as alcohol (Ms Riordan's report, 25 February 2015, page 3).

52 The appellant has had limited education. After he completed year 7, he only attended school in year 8 for a short period before dropping out altogether. His literacy skills are limited, as are his vocational skills.

53 The appellant's criminal history is relatively brief, but involves some serious offending, including aggravated robbery (2011), aggravated burglary (2013) and acts or omissions causing bodily harm (2013) (AB 94 and 95). The last mentioned offence involved the appellant throwing a knife at C, which missed, and injured an innocent bystander (ts 51). At the time of L's unlawful killing, the appellant was subject to a nine-month conditional release order.

The psychological and psychiatric reports

54 Dr Gosia Wojnarowska, a consultant psychiatrist specialising in child and adolescent psychiatry, provided a report to the primary judge dated 20 March 2015. According to Dr Wojnarowska, the appellant described what happened to L as an 'accident' caused by his inability to hold the baby in the correct way (Dr Wojnarowska's report, 20 March 2015, page 3). Dr Wojnarowska said that there was no evidence of a major, or even transient, psychiatric disorder that could explain the appellant's violent behaviour towards L (Dr Wojnarowska's report, 20 March 2015, page 5). Under the heading 'Psychiatric diagnosis', Dr Wojnarowska said that the appellant did not present with a major psychiatric disorder, although he presented with antisocial behaviours which were consistent with the diagnosis of 'conduct disorder, childhood onset'. She expressed the opinion that the appellant's immediate risk to others was low. However, 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, the appellant did not require further psychiatric assessment and treatment, although she recommended 'psychological intervention' (Dr Wojnarowska's report, 20 March 2015, page 6).

55 In Ms Riordan's report dated 25 February 2015, she noted that, consistently with other statements made by the appellant, he described to her what occurred to L as an 'accident' (page 5). Ms Riordan noted that the appellant reported being the victim of 'extreme forms of violence across multiple settings' which she said appeared to be indicative 'of the community and family setting in which [the appellant's] growth and development has occurred'. Ms Riordan expressed the view that the violence the appellant experienced 'normalised' his reliance on 'reactive and instrumental aggression' as a response to perceived threat. In Ms Riordan's opinion, the appellant's offending was 'opportunistic and impulsive'. She found it difficult to make psychological recommendations for the appellant, given the prospect that the appellant would receive a lengthy term of detention. She recommended that the appellant would

benefit from long-term psychological intervention and that, closer to his release, he should be given 'carefully planned assistance to reintegrate to society as well as appropriate vocation and literary skills' (Ms Riordan's report, 25 February 2015, page 9).

56 None of the reports provided to the primary judge made any reference to the possibility of FASD, organic brain injury, or intellectual or cognitive deficits.

The victim impact statement

57 C provided a victim impact statement which highlighted the grief and pain she experienced as a result of losing L in such tragic circumstances. L's death has adversely impacted upon her relationship with her own family. Understandably, she has been unable to come to grips with the reason for L's death.

Plea in mitigation

58 Counsel emphasised the dysfunctional environment in which the appellant had grown up (AB 63 - 64). He submitted that in assessing culpability account must be taken of the influences to which the appellant was exposed (AB 67). Further, counsel submitted that the appellant's capacity to exercise judgment has been seriously distorted or affected by his exposure to trauma and substance abuse (AB 72).

59 Counsel did not say anything about any question of FASD, or organic brain injury, or intellectual or cognitive deficits.

60 The prosecutor emphasised that the psychiatrist's report concluded that there was no major psychiatric disorder to explain the origins of the appellant's violence (AB 74). The prosecutor also emphasised the appellant's lack of remorse (AB 76).

The sentencing remarks

61 His Honour described the appellant's conduct towards L as 'cowardly in the extreme', having regard to L's age and extreme vulnerability (ts 43).

62 His Honour then proceeded to describe the facts of the appellant's offending and the findings of Dr Moss and Dr Fabian. His Honour encapsulated his findings of fact in this way:

> So in summary … by reference to all of that, you deliberately used considerable force on at least two occasions to a defenceless, totally dependent 25-day old infant child which resulted in head and brain injuries to the young deceased of such extreme severity leading to his death (ts 47).

63 His Honour characterised the factual circumstances of the offence as being 'very serious' and were 'in the upper end of the range of seriousness for cases of manslaughter' (ts 47).

64 His Honour then addressed the question of the discount that the appellant should receive for his plea of guilty, pursuant to s 9AA of the *Sentencing Act 1995* (WA). His Honour related the chronological history of the proceedings, noting in particular that, on 28 July 2014, the matter was listed for trial to commence on 23 February 2015 and that, as late as 2 February 2015, the court had been informed that the matter would proceed to trial on that charge. His Honour expressed the view that it had been open to the appellant before and after the matter was listed for trial to approach the State with an offer to plead guilty to manslaughter. His Honour concluded that the plea of guilty to manslaughter had come about 'very late in the proceedings' in circumstances where the State's case with respect to manslaughter was 'very strong'. He gave a 10% discount for the plea of guilty (ts 48).

65 His Honour then turned to the question of remorse. His Honour found, based primarily upon his assessment of the appellant's video-recorded interview with the police, that the appellant was only minimally remorseful for what he had done to L. His Honour made particular reference to the second video-recorded interview and concluded that the appellant did not want to say what had happened in the hospital room because he was worried that he would expose himself to a charge of murder (ts 49). His Honour acknowledged that the appellant's ability to express his remorse was limited by his youth, immaturity and the fact that he had been normalised to aggression and violence (ts 50).

66 His Honour took into account as mitigating factors that the appellant was 'a product and a victim of a dysfunctional environment through no fault of your own' and his youth and immaturity (ts 50). The primary judge said that the appellant's youth was 'a significant mitigating factor' (ts 50).

67 His Honour acknowledged the applicability of the sentencing principles set out in the *Young Offenders Act 1994* (WA). In doing so, he said that he had regard to the appellant's rehabilitation, against which he

weighed the need for punishment and public protection. The last two factors he said should be accorded 'significant weight' (ts 50).

68 His Honour referred to the appellant's criminal history. He concluded, in effect, that it provided no mitigation (ts 51).

69 His Honour then returned to the appellant's personal history. He noted that the appellant had suffered neglect, exposure to substance abuse and violence, transience and instability. He described the history as chaotic. He summarised it in this way:

> In my view, this personal history provides significant mitigation because it is highly relevant to the level of your culpability and as Mr Sutherland has properly said, your dysfunctional environment provides an explanation for why your capacity to exercise proper judgment is distorted.

70 His Honour then went on to say that, when assessing the appellant's culpability, he was mindful of Dr Wojnarowska's opinion that the appellant did not present with any major psychiatric disorder (ts 52).

71 His Honour referred to the opinions of Dr Wojnarowska and Ms Riordan as to why the appellant committed the offence against L. In the end, his Honour made no finding as to the reason for the offending (ts 53). His Honour concluded as follows:

> ... putting all of that together, it's my view that the nature of this offence, bearing in mind that it carries a statutory maximum of life imprisonment, and also as at - as I said at the outset that one needs to be mindful that when deciding the appropriate sentence for an offence of this kind that there has been a loss of a human life.
>
> So given that in combination with the seriousness of the factual circumstances as I've outlined, it involving such deliberate and conduct on your part against such a defenceless child, only 25 days old, indeed your own son and the need for personal deterrence, general deterrence and the protection of the community, all of those things in combination in an overall consideration significantly overwhelm the combination of your plea of guilty, youth and matters personal to you in your personal circumstances that I've outlined such that while applying the objectives and principles in the Young Offenders Act only immediate detention and for a very long time is the only appropriate sentence.
>
> I'm very mindful that detention is the sentence of last resort, and that when it comes to the length of time, it needs to have regard to your sense of time as a young person - and you're now just short of 17 years of age - and I'm also mindful of the principle that it should be for the shortest necessary time.

> Putting all of that together … it's my view that the appropriate sentence for this offence of manslaughter committed by you is 10 years' immediate imprisonment.
>
> You'll be eligible for a supervised release order after serving half of that term, and the term can be backdated to commence from the time that you went into custody (ts 53 - 54).

The appeal to this court

72 The appeal to this court was filed one month out of time. The reason for the delay has been adequately explained. An extension of time should be granted.

73 Initially, the sole ground of appeal relied upon by the appellant alleged that the sentence was manifestly excessive. Leave to appeal was granted in respect of that ground (AB 4).

74 The appeal was listed for hearing on 19 February 2016. Shortly before that date, Ms Farley SC, counsel for the appellant, became aware that sometime after the appellant was sentenced, he was assessed by the FASD Team at the TKI. This assessment was part of research work being undertaken by the TKI into FASD and other cognitive impairments in juvenile offenders, including those incarcerated at the Banksia Hill Detention Centre (appeal ts 3). The appellant consented to the assessment and, in due course, a report was prepared. The report concluded that the appellant fulfilled the diagnostic criteria for FASD (report page 17) described as a 'Neurodevelopment Disorder - Alcohol Exposed'. Later, we will refer to the contents of the report in greater detail. It is sufficient to note at this stage that the document is not a forensic report; it is a diagnostic assessment. Accordingly, it did not deal with a number of issues potentially relevant to the appellant's sentencing, including:

(a) any link between FASD and the appellant's offending;

(b) the implications of the diagnosis on the assessments made by Dr Wojnarowska and Ms Riordan;

(c) the impact of the diagnosis on the appellant's prospects of rehabilitation and the question of recidivism.

75 At the hearing on 19 February 2016, counsel for the respondent, Ms Longden, indicated that she did not consent to the admission of the TKI report on the basis that, while the diagnosis was unchallenged, it did not justify the imposition of a different sentence.

76 Ms Farley SC made oral submissions on the question of manifest excess. Ms Longden then made submissions in response. In the course of those submissions, Ms Longden properly drew the court's attention to the fact that the appellant turned 18 years of age in early April 2016 and that, if this court came to resentence the appellant after he turned 18, he would, by virtue of s 50B of the *Young Offenders Act*, be resentenced as an adult, although according to the principles of juvenile justice. A potential consequence of being sentenced as an adult is that the provisions in the *Sentencing Act* with respect to parole would apply, in particular s 89 and s 93. It is unnecessary to set out their terms. It is enough to say that they are less advantageous than those in the *Young Offenders Act* relating to supervised release and would, in a practical sense, render any success in this appeal nugatory. It is this factor which gave rise to some urgency in this case.

77 The hearing of the appeal was adjourned to 7 April 2016, to enable further expert opinion to be obtained with respect to the appellant's FASD and to enable senior counsel for the appellant to amend the grounds of appeal and adduce further evidence. The court made the following procedural orders:

> 1. The appellant be at liberty to file with the court and serve on the respondent, and to provide to Dr Gosia Wojnarowska and Ms Riordan, any further reports relating to the diagnosis of foetal alcohol spectrum disorder covering the topics identified in the course of argument with counsel.
>
> 2. Subject to any contrary direction from the court, the appellant has leave for Dr Wojnarowska and Ms Kate Riordan to provide supplementary reports in respect of any matter arising from the further reports referred to in paragraph 1 above.
>
> 3. The parties be at liberty to file and serve any written submissions dealing with the further reports referred to in paragraphs 1 and 2 above by 5 April 2016.

Appellant's application filed 31 March 2016

78 On 31 March 2016, the appellant filed an application to adduce additional evidence in the appeal pursuant to s 40(1)(e) of the *Criminal Appeals Act 2004* (WA) and to add a new ground of appeal.

79 The additional evidence the appellant sought to adduce comprised the TKI report and a report written by Dr Mutch, dated March 2016.

80 The proposed additional ground of appeal (ground 2) reads as follows:

> Additional evidence not before the learned sentencing judge relating to the appellant having a mental impairment, namely FASD, has been obtained after sentencing which would have had a material impact on the sentence if it was known at the time of sentencing. The evidence subsequently obtained indicates that a miscarriage of justice has occurred in this case in that the sentence imposed failed to reflect a mitigating factor, that being the presence of impairment.

Additional evidence sought to be adduced by the respondent

81 The TKI report was provided to Dr Wojnarowska and Ms Riordan. The respondent provided the court with a further report from Ms Riordan dated 6 April 2016. At the hearing on 7 April 2016, the respondent made an oral application to adduce the report as additional evidence in the appeal.

82 No additional report was received from Dr Wojnarowska.

83 At the hearing on 7 April 2016, the court allowed the appellant's application to adduce additional evidence and add ground 2. The court also gave leave to the respondent to adduce, as additional evidence, the report of Ms Riordan dated 6 April 2016. The only witness who gave oral evidence at the hearing on 7 April 2016 was Dr Mutch.

What is FASD?

84 Dr Mutch, whose expertise in the area of FASD was not challenged in this appeal, explained to the court what FASD is, in these terms:

> Can you explain to the court what FASD is?---So Foetal Alcohol Spectrum Disorders, so foetal really gives you the timing of when the disease occurs, so it occurs prenatally; alcohol because alcohol is attributed as the toxic agent that causes brain damage during foetal life; spectrum because there are ranges of impairments; and disorders because disorders can mean impairment as well, so people drink different quantities at different frequencies and different timings across a pregnancy, different things happen across a pregnancy, and in the first trimester is when the primary organ development happens, and then, really, for the second and third trimester, those organs grow, the body grows, but throughout pregnancy, the brain grows, so timing of alcohol exposure in the first trimester may be manifest in external organs that we can see like the face or the eyes or the lips, but for the remainder of the pregnancy, the damage that alcohol does to the brain you cannot necessarily see, and if the brain is severely damaged, then the size of the skull is smaller, so you will have microcephaly - micro, small; cephaly, head; but if perhaps the alcohol

> intake occurred in the later stages of the pregnancy, at that point the external structures of the baby have grown and so the insult to the brain is hidden behind a normal sized skull, and then that damage to the brain will be manifest as the child grows, and there may be behaviours, even as an infant, that you might be able to attribute to that prenatal alcohol exposure, and then later on that prenatal alcohol exposure will corrupt the child's ability to optimise good things that happen to them and also corrupt the child's ability to manage when noxious things happen to them (appeal ts 30 - 31).

85 Dr Mutch explained that the brain damage caused by prenatal alcohol exposure continues through life and gives rise to 'secondary consequences' (appeal ts 31). She also explained that, while some individuals with FASD exhibit physical characteristics of the disorder, others do not. Often those who have the disorder are diagnosed only when it is noticed that their behaviours become difficult (appeal ts 31).

86 Dr Mutch explained that the best way of diagnosing FASD is by way of a multidisciplinary team that comprises a medical practitioner, usually a physician or a paediatrician, but someone with advanced specialist training, a psychologist, preferably a neuropsychologist, a speech and language pathologist and an occupational therapist (appeal ts 32). She testified to the effect that, if there is proof of prenatal alcohol exposure and if a child or adult is found through standardised testing to be impaired in three or more domains by negative two standard deviations away from the mean, a diagnosis of FASD may be made. Negative two standard deviations away from the mean equates to the subject of the assessment being in the lowest 2% of the population (appeal ts 34).

The TKI report

87 The appellant was assessed by a multidisciplinary team which consisted of a paediatrician (in this case, Dr Mutch), a speech pathologist, an occupational therapist and a psychologist with expertise in clinical neuropathology. The multidisciplinary team assessed the appellant as having FASD.

88 It was confirmed that the appellant's mother consumed alcohol and engaged in 'varied recreational substance' consumption throughout her pregnancy (TKI report, page 4). The appellant himself reported polysubstance use 'at high risk levels' from the age of 11 (TKI report, page 5).

89 The appellant was assessed over eight domains. The assessment for each domain involves standardised tests. The authors of the TKI report noted that norms specifically for Aboriginal children are not available for these tests, and that this factor should be taken into consideration when interpreting the results of the tests.

90 The eight domains that were tested were:

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.
8. Motor skills.

91 The appellant was assessed as being impaired (that is negative two standard deviations away from the mean) in cognition, executive function, language, academic functioning and motor skills. As to memory and learning, the overall assessment was that the appellant's memory for verbal and visual information was borderline impaired. With respect to adaptive functioning, social communication and social skills, the authors of the TKI report made no specific comment, except to observe that no concerns were raised by officers at Banksia Hill Detention Centre regarding the appellant's social communication and social skills. As to academic functioning, the assessment revealed that the appellant has moderate to severe difficulties with sequencing and telling a story that is understandable to a listener.

92 With respect to motor skills, the appellant's particular deficits were in fine motor skills and body proprioception.

93 The authors of the TKI report made a number of recommendations, including that a full specific cognitive assessment be undertaken to determine if the appellant meets the criteria for intellectual disability. The appellant is not without some strengths. These were summarised in the report as follows:

- Remembering verbal information, especially with context (eg short story)
- Ability to hold basic information in his mind while working with it (working memory)
- Category fluency, which is the ability to think of related things (eg animals)
- Finding things on a page (visual scanning)
- Switching between basic information
- [The appellant] is demonstrating age appropriate balance skills
- [The appellant] has strengths with gross motor skills including ball skills: aiming and catching
- Handwriting is readable, however [the appellant] has difficulty writing at a good speed
- [The appellant] is able to understand and explain the meanings of the limited amount of words he does know
- Able to have a short informal conversation with another person. Although the content is basic, he does have these interaction skills in listening and responding appropriately
- [The appellant] uses some emotive and cognitive vocabulary ('hungry', 'sad', 'thinking about')
- Forming sentences using Aboriginal English.

94 However, the appellant'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 (eg picture)
- When information becomes more complex or had extra components that he had to process at the same time he had difficulty inhibiting or remembering (eg picture) and therefore any tasks with an extra cognitive load results in a decrease in his ability
- [The appellant's] fine motor coordination skills are impaired, and proprioception difficulties are present

- Remembering information
- Understanding information
- [The appellant] has a limited vocabulary so his language use is basic and not age appropriate
- [The appellant] can remember some key detail from a short story however not all key elements
- [The appellant] will have 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)
- Stories lack key information and have limited grammatical structure. This makes his stories sound confusing. This will have an impact on explaining events correctly, including the setting, planning of events, attempting actions and outcomes of events
- Providing enough information to the listener so they can understand which character he is talking about (character reference)
- [The appellant] does show some abstract thought and ability to make some inferences however this is limited and his story contains mostly a series of events

Report of Dr Mutch

95 Dr Mutch has met the appellant and medically examined him. She referred to the TKI report and explained that the appellant had been exposed to 'significant (prenatal) high-risk alcohol exposure' and was significantly impaired in the five domains identified in that report.

96 Dr Mutch noted that even in the domains which did not reach the level of significant impairment, the appellant had a measured degree of impairment which may have negatively impacted upon his functioning (report, page 6).

97 As to cognition, Dr Mutch observed that the appellant's level of impairment fulfilled a cut-off point 'for assignation of intellectual disability'.

98 Turning to executive function, Dr Mutch compared impaired executive function to 'like losing the orchestra's conductor or the referee for a match'. Executive functions allow a person to meet novel or

unanticipated challenges, resist temptation and stay focused. Core executive functions are self-control, the ability to resist temptation and impulsivity, working memory and cognitive flexibility, including thinking 'outside the box', seeing something from different perspectives and quickly and flexibly adapting to changed circumstances.

99 In the opinion of Dr Mutch, the appellant has impairment in 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' (report, pages 8 and 9).

100 Dr Mutch assessed the appellant's core language abilities at the level of 'a 9 to 12-year-old'. In her opinion, his ability to function at this level was unlikely in a stressful environment such as a police station, and would be made worse again by emotional stress. Dr Mutch noted that the appellant had 'moderate to severe difficulties with sequencing and telling stories comprehensible to a listener'. In her opinion, the finding that the appellant had a significant language impairment had 'significant meaning for all of his interviews'. Further, the appellant requires a language specialist to 'buddy with him' when interviewed by police (report, page 9).

101 With respect to the appellant's academic functioning, Dr Mutch noted that the appellant 'has moderate difficulties reading simple words, spelling and completing simple maths'. All three of these areas were, as she put it, 'essential for real world functioning' (report, page 9).

102 As to the appellant's motor skills, Dr Mutch noted that balance was difficult for the appellant, and he had proprioceptor difficulties. This meant that the appellant cannot judge where his body parts are in space. In her opinion, these impairments may singularly or together have influenced the nature of the offence (report, page 10).

103 Dr Mutch expressed the view that the appellant's 'limitations of function, his lived trauma and outstanding health needs had a direct effect on [his] [overall] function, contribute to how and why he is and why he behaved in the manner he did, and are a component of his offending' (report, page 11). In her opinion, the appellant does not have the cognition nor the executive function to reason logically and in priority order. Further, he does not have the language to express his thoughts or his reasoning and is unable to address complex ideas with reasoned thoughts.

104 With respect to the appellant's explanation that his offending was 'accidental', Dr Mutch wrote:

> The post-mortem reports indicate that force and violence was applied to the victim. [The appellant] maintained he had 'accidentally' completed the events. [The appellant's] adherence to the term 'accidental' may reflect [the appellant's] genuine belief that his physical actions were accidental, this understanding held by [the appellant] is in keeping with [the appellant's] diminished ability to think and act 'deliberately' and reason through consequence of the action. So the assignation of 'deliberately' or 'violently' to [the appellant] may not necessarily reflect his actual cognitive ability and action. Also, [the appellant] may understand 'accidental' and may not be fully cognisant of the meaning of deliberate; [the appellant] possesses a combination of restricted core language skills equivalent to a person of aged 9 to 12 years. [The appellant] has diminished cognition, impaired (executive) function and proprioception impairment (that is a diminished ability to perceive his actual position in space); singularly and together each of these impairments warrants consideration as relevant to the sentencing (report, page 12).

105 Dr Mutch concluded as follows:

> In my opinion the TKI research report contains well considered and reliable information that is relevant to understanding [the appellant's] thinking, actions and behaviours and therefore the TKI report is relevant for inclusion when sentencing [the appellant].
>
> The diagnosis of FASD and recognition of [the appellant's] vulnerabilities arising from his many domains of significant impairment should be considered by the courts.
>
> Tragically, if a detailed nature of [the appellant'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 [the appellant's] sentencing (report, page 12).

Report of Ms Riordan dated 6 April 2016

106 Ms Riordan was provided with the TKI report and Dr Mutch's report of March 2016.

107 With respect to the appellant's cognitive assessment, Ms Riordan noted (as did the TKI report) that the scale of intelligence administered to the appellant (the Wechsler Abbreviated Adult Scale of Intelligence (2nd ed)) was not normed or standardised on Australian Aboriginal children or adults, and therefore should be interpreted with caution. In Ms Riordan's

opinion, the appellant's scores on the scale are likely to represent an underestimate of his true intellectual ability. In her opinion, the results reported in the TKI report were a preliminary estimate of the appellant's cognitive functioning, with his true cognitive ability yet to be determined by a full cognitive assessment.

108 With respect to the appellant's adaptive behaviour, that is the ability to function in the real world, Ms Riordan noted that adaptive behaviour tests administered to the appellant have been criticised for a lack of norms for Aboriginal populations, the inherent bias of the cultural relevance of the test material, the cultural knowledge of the assessor and considerations given to the use of Aboriginal English. She said that when she prepared her first report, no information was provided to her which raised any specific concerns about the appellant's ability to carry out tasks of daily living, although that was not a specific area she was requested to assess (report, page 4).

109 Based on her own observations of the appellant, Ms Riordan considered that the appellant's responses indicated a 'low level of suggestibility' on the appellant's part, that is, he did not incorporate suggestions made to him during questioning in his answers.

110 Ms Riordan expressed the view that the appellant's self-control and his capacity to realise the thoughts and feelings of others and appreciate how his actions may be perceived remained intact and was age appropriate (report, page 6).

111 Ms Riordan accepted that the appellant exhibited difficulties commonly associated with FASD, including impulsivity, susceptibility to peer influence, difficulties with emotional regulation and executive functioning, and that the majority of these factors had been outlined in the pre-sentence reports prepared by her and Dr Wojnarowska. She said that there was significant overlap between the factors outlined by her and Dr Wojnarowska and those described by Dr Mutch (report, page 7). Ms Riordan concurred with Dr Mutch as to the 'pervasive nature of [the appellant's] chronic experience of trauma across his childhood development', and that such trauma and maltreatment has been found to be associated with cognitive impairment.

112 In Ms Riordan's opinion:

> [I]t is 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 tetragons apart from the

> impact of the cumulative impact of [the appellant'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 [the appellant'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. [The appellant'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 (report, page 7).

Evidence of Dr Mutch

113 Dr Mutch disagreed with Ms Riordan's view that it was not possible to disaggregate the neurological deficits caused by prenatal exposure to alcohol from the impact of the appellant's traumatic life events (appeal ts 47). In her opinion, the key point was that the appellant has 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 (appeal ts 47 - 48). Further, the appellant's lived trauma compounds and exacerbates the likely consequences of the appellant's brain injury (appeal ts 49).

114 Relevantly to the appellant's capacity for rehabilitation, Dr Mutch referred to the appellant's strengths and said that, with the right support, mentoring and care, he has some capacity for learning and for positive change (appeal ts 60).

The appellant's submissions

115 Ms Farleys' submissions to this court on behalf of the appellant focused on ground 2.

116 With respect to that ground, Ms Farley submitted that the additional evidence established that the appellant suffered from FASD. As a consequence of the prenatal organic brain damage he suffered, the appellant had intellectual, cognitive, linguistic and executive functioning

deficits which were not known to the primary judge and which would have materially affected the outcome.

117 Further, the additional evidence cast doubt on some of his Honour's findings, including those relating to the appellant's deliberate and forceful behaviour in carrying out the offence, his apparent lack of remorse and his reluctance to tell the police what had happened in the hospital room.

Submissions by the respondent

118 Ms Longden did not challenge the diagnosis that the appellant suffered from FASD. She agreed that his prenatal organic brain injury was not known to the primary court, and that the appellant's capacity to exercise proper judgment was affected not just by the appellant's background, but also by his organic brain injury (ts 70).

119 Nevertheless, counsel for the respondent submitted that no different sentence should be imposed because his Honour took into account the appellant's 'lived trauma' which, it was said, was not qualitatively different from the effects of FASD.

Disposition - ground 2

Additional evidence in sentencing appeals

120 The relevant principles relating to the admission of additional evidence in sentencing appeals were explained by Owen JA in ***Wheeler v The Queen [No 2]*** [2010] WASCA 105 in these terms:

> Generally an appeal court must decide an appeal on the evidence and material before the primary court: s 39(1) *Criminal Appeals Act 2004* (WA). However, an appellate court has a broad power to 'admit any other evidence' under s 40(1)(e) of the Act.
>
> The well known distinction between 'fresh' and 'new' evidence is of importance in deciding whether additional material should be admitted in an appeal against conviction. The distinction is of lesser significance in an appeal against sentence, although a court may be guided by similar considerations. An appeal against the sentence can only succeed where an appellate court concludes that a different sentence ought to have been imposed: s 31(4) *Criminal Appeals Act*. The test to be applied in determining whether additional evidence should be admitted, be it fresh or new evidence, is whether, had the evidence been before the sentencing judge, a different sentence should have been imposed. But the capacity of an appellant to adduce additional material in the appeal is not at large. Each case has to be assessed according to its own facts. The circumstances in which the additional material came to light and its

probative value will be significant considerations in deciding whether an appellant should have leave to adduce it [52] - [53].

The relevance of mental impairment to sentencing

121 FASD is a mental impairment. The relevant legal principles with respect to mental impairment in sentencing are well settled and uncontroversial, and were explained by Wheeler JA in ***Krijestorac v The State of Western Australia*** [2010] WASCA 35:

> So far as the effect of mental or psychological problems falling short of insanity is concerned, the relevant principles have been enunciated in this court on a number of occasions, including ***Lauritsen v The Queen*** [2000] WASCA 203; (2000) 22 WAR 442; and ***Thompson v The Queen*** [2005] WASCA 223; (2005) 157 A Crim R 385. Counsel for the appellant also drew the court's attention to the Victorian case of ***R v Verdins*** [2007] VSCA 102; (2007) 16 VR 269. That case contains a useful survey of decisions from a number of Australian jurisdictions. In ***Verdins***, the court accepted that the principles identified in ***R v Tsiaras*** [1996] 1 VR 398 and applied in a number of Australian jurisdictions since that date continue to apply. They are that a mental or psychological condition falling short of insanity may be relevant to sentencing in a number of ways:
>
> > '**First**, it may reduce the moral culpability of the offence, as distinct from the prisoner's legal responsibility. Where that is so, it affects the punishment that is just in all the circumstances and denunciation of the type of conduct in which the offender engaged is less likely to be a relevant sentencing objective. **Second,** the prisoner's illness may have a bearing on the kind of sentence that is imposed and the conditions in which it should be served. **Third**, a prisoner suffering from serious psychiatric illness is not an appropriate vehicle for general deterrence, whether or not the illness played a part in the commission of the offence. The illness may have supervened since that time. **Fourth**, specific deterrence may be more difficult to achieve and is often not worth pursuing as such. [**Fifthly**], psychiatric illness may mean that a given sentence will weigh more heavily on the prisoner than it would on a person in normal health. [***Verdins*** at [1], quoting ***Tsiaras***)'
>
> ***Verdins*** is useful, however, for its consideration of two aspects of ***Tsiaras*** principles. First, it makes it clear that, as has in my view been previously understood in this State, the principles enunciated are not confined to "serious psychiatric illness", but are applicable in any case where the offender is shown to have been suffering at the time of the offence, or is suffering at the time of sentencing, from a mental disorder, abnormality or impairment of mental function, whether or not the condition can be properly labelled a serious mental illness (at [5]). Second, the court listed the various ways in which impaired mental functioning has been held to be capable of reducing moral culpability. The court said impaired mental

functioning at the time of offending may reduce the offender's moral culpability if it had the effect of (at [26]):

(a) impairing the offender's ability to exercise appropriate judgment;

(b) impairing the offender's ability to make calm and rational choices, or to think clearly;

(c) making the offender disinhibited;

(d) impairing the offender's ability to appreciate the wrongfulness of the conduct;

(e) obscuring the intent to commit the offence; or

(f) contributing (causally) to the commission of the offence.

The court in ***Verdins*** noted that the list was not exhaustive. For myself, I would have considered that pars (a) through to (e) are all examples of the way in which a mental disability may contribute causally to the commission of the offence and, in my view, that is how the concept of causal contribution has usually been understood in this State [17] - [19].

122 In ***Thompson v The Queen*** [2005] WASCA 223; (2005) 157 A Crim R 385 Steytler P said [53] - [55]:

Of course, moral culpability would only be lessened where there is a causal connection between the psychiatric illness and the commission of the offence or offences, in the sense that the psychiatric condition must have contributed to the commission of the offence: ***R v Richards*** [1999] WASCA 105; ***R v Paparone*** (2000) 112 A Crim R 190 at [50] and [51] per Murray J; and ***R v Payne*** (2002) 131 A Crim R 432 at [40]. It must necessarily be the case that, the greater the contribution of the psychiatric illness, the more the moral culpability will be lessened. To the extent that there is a moral lessening of culpability, that should be reflected in the penalty imposed, as it often has been: see, for example, ***R v Juli*** (1990) 50 A Crim R 31 at 37; ***R v Hurd*** (1988) 38 A Crim R 454 at 461, 465; ***Tsiaras***, above, at 400; ***R v Balchin*** (1974) 9 SASR 64 at 68; ***R v Reynolds*** (1983) 10 A Crim R 30; and ***Lauritsen v The Queen*** (2000) 22 WAR 442 at 456 - 459.

As to personal deterrence, as is implicit from what was said in ***Tsiaras***, much depends upon the nature and effect of the illness. The notion of personal deterrence assumes some rational analysis or reasoning in the course of comparing the likely gains from the crime against the prospect, and likely severity, of punishment, and, where the illness affects the person's ability to make that analysis, there is no justification for affording that consideration the same measure of significance as it might have in the case of a well person: see ***Payne***, above, at [43].

> As to general deterrence, this is a factor which should often be given little weight in the case of an offender suffering from a mental disorder, such an offender not being an appropriate medium for making an example to others: ***R v Scognamiglio*** (1991) 56 A Crim R 81 at 86; ***Anderson v The Queen*** [1981] VR 155 at 159. In an extreme case, considerations of general deterrence might be totally outweighed by other factors. However, in every case, the relevant factors must be balanced in a manner no different from that which is involved in every sentencing exercise: ***R v Letteri***, unreported; CCA SCt of NSW; Library No 60497 of 1991; 18 March 1992 at 14, per Badgery-Parker J and ***R v Engert*** (1995) 84 A Crim R 67 at 70-71, per Gleeson CJ.

123 By its nature, and as its name indicates, FASD involves a spectrum of disorders. The particular disorder of an individual with FASD may be severe, it may be minor. FASD may lead to a varying number of deficits of varying intensity. Thus blanket propositions about how a diagnosis of FASD bears on the sentencing process should be avoided. Rather, attention must 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.

Analysis of ground 2

124 Our analysis of ground 2 begins with two factual propositions which the respondent accepts. First, the appellant has FASD, that is, he has suffered an organic brain injury and is mentally impaired. Second, at the time the appellant was sentenced, these facts were not known to anyone and certainly not the primary judge. The question raised by ground 2 is, had the additional evidence been before the primary judge, should a different sentence have been imposed? In our opinion, and contrary to the submissions of the respondent, that question should be answered in the affirmative.

125 Although it was known when the appellant 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. Those deficits were identified in the TKI report and in the report and evidence of Dr Mutch and have already been summarised in these reasons.

126 While acknowledging that the tests administered to the appellant to measure his intellectual ability and adaptive behaviours were not normed or standardised for indigenous persons and that some further testing was required, in our view the evidence clearly established that the appellant's

powers of reasoning, logical thought and self-control were all compromised. So too was his ability to deal with traumatic events. This is all in addition to the effects of his lived trauma, which itself compounded the effects of his FASD.

127 We accept Dr Mutch's opinion that the appellant'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.

128 The appellant's FASD 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 the appellant was to be seen as lacking remorse, and the weight to be given to that;

(5) it bore on the significance of the appellant's failure to call for treatment immediately after the offence, a matter on which the primary judge made an adverse finding; and

(6) the appellant's impaired language skills may well explain the appellant's persistent adherence to the position that his actions were an 'accident', a position which the primary judge regarded negatively.

129 The offending was impulsive and unexpected. The appellant 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.

130 The respondent's submissions on 7 April 2016 were based to some degree on Ms Riordan's view that it was not possible to 'disaggregate' the neurological deficits caused by FASD from the appellant's lived trauma. As we have said, in oral evidence Dr Mutch explained why she did not

agree with that view. Ms Riordan did not give oral evidence. We prefer Dr Mutch's evidence on this point because her expertise in FASD is more extensive than that of Ms Riordan.

131 Moreover, while the sentencing judge accepted counsel's submission that the appellant's capacity to exercise judgment was affected by his background of lived trauma, that generalised proposition cannot be equated with the expert opinion now before the court that the appellant has the various significant deficits we have outlined.

132 For these reasons, we are satisfied that the appellant's FASD was a significant mitigating factor which was not known when the appellant was sentenced. Had it been known, a different sentence should have been imposed. Ground 2 has been made out. This court's jurisdiction to resentence the appellant has been enlivened. In these circumstances, it is unnecessary to decide ground 1.

Resentencing

133 In the course of argument before this court, two questions arose which were potentially relevant to the appellant's resentencing. First, does s 9AA of the *Sentencing Act* apply to the sentencing of a juvenile offender under the *Young Offenders Act*? Second, if s 9AA applies, could it be said that the appellant entered his plea of guilty to manslaughter at the first reasonable opportunity?

134 Section 9AA of the *Sentencing Act* is in these terms:

> **Plea of guilty, sentence may be reduced in case of**
>
> (1) In this section -
>
> ***fixed term*** has the meaning given in section 85(1);
>
> ***head sentence***, for an offence, means the sentence that a court would have imposed for the offence if -
>
> (a) the offender had been found guilty after a plea of not guilty; and
>
> (b) there were no mitigating factors;
>
> ***victim*** has the meaning given in section 13.

> (2) If a person pleads guilty to a charge for an offence, the court may reduce the head sentence for the offence in order to recognise the benefits to the State, and to any victim of or witness to the offence, resulting from the plea.
>
> (3) The earlier in the proceedings the plea is made, the greater the reduction in the sentence may be.
>
> (4) If the head sentence for an offence is or includes a fixed term, the court must not reduce the fixed term under subsection (2) -
>
> (a) by more than 25%; or
>
> (b) by 25%, unless the offender pleaded guilty, or indicated that he or she would plead guilty, at the first reasonable opportunity.
>
> (5) If a court reduces the head sentence for an offence under subsection (2), the court must state that fact and the extent of the reduction in open court.
>
> (6) This section does not prevent the court from reducing the head sentence for an offence because of any mitigating factor other than a plea of guilty.

135 In our opinion, s 9AA of the *Sentencing Act* applied to the sentencing of the appellant in the Children's Court, and to the resentencing of the appellant in this court.

136 The appellant was a young person as defined in the *Young Offenders Act* at the time he was found guilty of the offence of manslaughter, and at the time he was resentenced by this court. Pursuant to s 50A of the *Young Offenders Act*, it was open to this court to impose a term of detention pursuant to s 118(1)(b) of the *Young Offenders Act*. This court is required by s 46 of the *Young Offenders Act* to sentence the appellant in accordance with the principles and considerations to be applied to young offenders set out in s 46 of the *Young Offenders Act*, including the general principles of juvenile justice enumerated in s 7 of the *Young Offenders Act*.

137 Section 46A of the *Young Offenders Act* sets out how the *Sentencing Act* applies in respect of the sentencing of a young person. It states:

> (1) The Sentencing Act 1995 applies to and in respect of the sentencing of a young person -
>
> (a) in a case to which section 50B applies; or

> (b) to the extent that section 50A or 118 provides for it to apply; or
>
> (c) subject to subsection (2), to the extent that this Act does not provide for a matter that is provided for in the Sentencing Act 1995.

138 Unlike s 9AA of the *Sentencing Act*, there is no provision in the *Young Offenders Act* which provides for the discount which is to be given to an offender in respect of a plea of guilty.

139 In these circumstances, by virtue of the operation of s 46A(1)(c) of the *Young Offenders Act*, s 9AA of the *Sentencing Act* applies to the sentencing of the appellant under the *Young Offenders Act*.

140 We turn to the question of the timing of the plea of guilty and when in the proceedings it could reasonably have been indicated or made. Initially, there was some argument before this court on these issues. However, after inquiries were made of the counsel who appeared in the Children's Court, it became evident that the first formal offer to plead to manslaughter was made on 11 February 2015, approximately 12 days before the appellant's trial on the charge of murder was due to commence (appeal ts 76). There is nothing before this court to indicate that the offer to plead guilty to the alternative charge of manslaughter could not reasonably have been made at an earlier stage in the proceedings. The primary judge gave a discount of 10% for the plea of guilty pursuant to s 9AA of the *Sentencing Act*. While it is for this court to decide for itself the extent of any discount under s 9AA on a resentencing, we regard a discount of 10% as appropriate.

141 Manslaughter carries a maximum penalty of life imprisonment. Without question, the offence committed by the appellant was extremely serious. The victim could not have been more vulnerable. The acts which resulted in the child's death involved at least two violent blows to the head. The appellant's FASD and his traumatic life did not deprive him of the capacity to know that what he did was wrong.

142 The risks of reoffending and the need to protect the community must also be weighed in the sentencing exercise.

143 In addition to the plea of guilty, there was significant mitigation in the case, having regard to the appellant's FASD, his dysfunctional upbringing and, of course, his youth. As we have already indicated, the prenatal brain damage suffered by the appellant has left him more vulnerable to the traumas he has suffered. The appellant has some relative

strengths. If he is provided with appropriate mentoring and care, he has, as Dr Mutch said in her evidence, some capacity for learning and positive change. Having regard to all relevant factors and bearing in mind the general principles of juvenile justice and the sentencing principles set out in s 46 of the *Young Offenders Act*, a sentence of 7 years' detention was appropriate. The appellant should be eligible for supervised release after serving one half of that term.