NOTE: PUBLICATION OF NAME, ADDRESS, OCCUPATION OR IDENTIFYING PARTICULARS OF COMPLAINANT PROHIBITED BY SS 203 AND 204 OF THE CRIMINAL PROCEDURE ACT 2011.

IN THE COURT OF APPEAL OF NEW ZEALAND

I TE KŌTI PĪRA O AOTEAROA

CA36/2022
[2023] NZCA 299

BETWEEN	T (CA36/2022) Appellant
AND	THE KING Respondent

Hearing: 10 May 2023

Court: Miller, Woolford and Cull JJ

Counsel: H J Croucher and C A Hardy for Appellant
Z R Hamill for Respondent

Judgment: 17 July 2023 at 11.00 am

JUDGMENT OF THE COURT

A The application for leave to adduce further evidence is declined.

B The conviction appeal is dismissed.

C The application for leave to appeal sentence out of time is granted.

D The sentence appeal is allowed. The sentences on the charges of breach of a protection order in relation to NF are set aside and sentences of six weeks' home detention substituted, to run concurrently with the home detention sentences for doing an indecent act and breach of a protection order in relation to N. The appellant must resume his home detention sentence on 24 July 2023. His bail is revoked from that date.

REASONS OF THE COURT

(Given by Miller J)

[1] T was found guilty at trial on one charge of doing an indecent act on a child,[1] his 8-year-old daughter N, and one of breaching a protection order by doing that act.[2] He had pleaded guilty to three charges of breaching the protection order in relation to the child's mother, NF.[3] These charges related to communications in which he sought to resume his relationship with NF. Judge Moala sentenced him to concurrent sentences of eight months' home detention on all charges.[4]

[2] T appeals his convictions relating to N on the ground that there is fresh evidence tending to show he suffers from sexsomnia. He says that he has a viable defence of sane or insane automatism.[5]

[3] He appeals his sentence on the protection order charges relating to NF, saying that if his convictions relating to N are quashed then the sentence was excessive. The Crown agrees that a sentence of six weeks' home detention would be the appropriate sentence in that event, meaning he would be released because he served part of his sentence before being bailed pending this appeal.

The trial

[4] In 2019 T had shared care of N, who resided mostly with her mother but would visit T overnight at his sister's, where he was living at the time. On 14 July 2019, N told NF that he had touched her "privates" while she was in bed. In an evidential interview, N said that she was sleeping at her aunt's house and T came up onto her bed and touched her private parts underneath her pyjamas. (She had been in a bed and he had been on a mattress in the same room.) She then woke up and the morning alarm went off and she got dressed and went to school.

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1 Crimes Act 1961, s 132(3).
2 Family Violence Act 2018, ss 9(2)(b), 90(a) and 112(1)(a).
3 Domestic Violence Act 1995, ss 19(2)(b), 19(2)(e) and 49(1)(b); and Family Violence Act, ss 90(b) and 112(1)(a).
4 *Police v [T]* [2021] NZDC 24463 [Sentencing notes] at [14].
5 *C (CA223/2020) v R* [2021] NZCA 80, [2021] 3 NZLR 152 at [38]–[50].

[5] Trial counsel for T investigated a defence of sexsomnia, briefing Dr Antonio Fernando, a consultant psychiatrist and sleep specialist. Dr Fernando interviewed T and his sister (for any family history of parasomnias) and referred T for an overnight sleep study in a sleep clinic.

[6] Dr Fernando provided a first report on 20 May 2021. At that time the sleep study had not been completed but he had interviewed members of T's family of origin. T had no childhood history of sleepwalking or sleep talking, but relatives had adult parasomnias. T had reported two episodes in which he had, according to NF, performed sexual activities while he was asleep. T has a history of bipolar disorder but he said he was not experiencing symptoms at the time. T denied any memory of the incident. Dr Fernando could not exclude malingering.

[7] Dr Fernando could not offer a confident diagnosis. There were multiple factors suggesting sexsomnia was remotely possible but not very likely, and only one factor which strongly suggested it. That factor was a reported statement by NF, who acknowledged to Dr Fernando in a phone conversation that T had "done things" to her in his sleep. She was otherwise uncooperative and declined to expand on this statement. Dr Fernando was unable to speak to a previous bed partner of T's.

[8] A further report was provided on 9 July 2021. Through the intervention of the police and defence counsel, NF had agreed to speak to Dr Fernando in the interim. She mentioned a single incident, in 2009, in which T had displayed abnormal sexual behaviour. When they were in bed he rubbed his hands on his genitals then put his hands on her face and mouth. He was quiet when she asked him what he was doing. She was unsure if he was asleep and said he was having a bipolar episode at the time. She reported that when manic he wanted sex all the time. She was not aware of any other unusual sleep-related behaviours.

[9] The sleep study had been completed. T was diagnosed with moderate obstructive sleep apnoea, and he also displayed periodic limb movements. These are known causes of sleep disturbance, which can trigger parasomnias. No other evidence of abnormal sleep behaviours was noted. The study did not support a diagnosis of

sexsomnia, but neither could a one-night study exclude it. The sleep history provided by T remained confusing.

[10] Dr Fernando concluded that the likelihood of sexsomnia explaining the alleged offending was low.

[11] The trial commenced on 2 August 2021. N and NF gave evidence, the latter to depose that N had reported the incident to her after the sleepover. Consistent with Dr Fernando's reports, the defence did not run sexsomnia. NF was not asked about any history of T exhibiting sexual behaviour during sleep.

[12] The defence was that N was mistaken about being touched. It was suggested that the complaint may have stemmed from conflict between T and NF over N's care.

[13] The jury found T guilty on both charges. As noted, he pleaded guilty to other breaches of the protection order involving NF.

The new evidence

[14] T appealed against conviction on 26 January 2022.

[15] NF and T have been engaged in Family Court proceedings over the care of N. His conviction has naturally raised questions about the extent to which he should have contact with N. He has maintained that he did not consciously touch her sexually. Both parents have sworn affidavits. On 14 March 2022 T deposed that NF had told him of one episode of sexsomnia during their relationship. NF responded in an affidavit dated 27 March 2022 that "[i]t is correct that [T] touched me while he was asleep."

[16] This statement led appellate counsel to seek a third report from Dr Fernando. It is dated 2 September 2022. He stated that because there were no other bed partners who could confirm or deny sleep-related sexual behaviour, NF's statement was "crucial" in making the diagnosis. He formed the opinion that the possibility of T

having sexsomnia "should be strongly considered".[6] He drew attention to supporting information, in the form of the family history of parasomnias and results of the sleep study.

[17] An application was filed to adduce fresh evidence on appeal. Affidavits were sworn by Dr Fernando (on 3 November 2022) and Dr Peter Dean (on 23 February 2023). Dr Dean is a consultant forensic psychiatrist called by the Crown. Both gave oral evidence before us. NF was not called, but we were provided with another affidavit which she swore in the Family Court proceeding, on 13 December 2022. There she sought to correct her statement that T had touched her when he was asleep. She said she had been too embarrassed to describe the incident fully. She now did so:

> 3. For a start, I never said it was an episode of sexsomnia. On the occasion in question [T] started touching me. I initially thought he was asleep. But then I believe he was awake because he was touching his genitals then rubbing my mouth and sticking his fingers in my mouth. Then he would smell his hand, he did this a few times, touching his genitals then rubbing them on my face. When I realised what he was doing I lay there shocked and disgusted until I grabbed his hand and moved it away and moved myself further away from him in bed. He then stopped. I believe he was awake as he was able to control his actions. There would have been no need for him to smell his hand if he was asleep. I got up and then went to the toilet to get away. When I came back, he had rolled over and I didn't say anything and faced the opposite direction, feeling sick to my stomach.

[18] It will be seen that NF was describing a single incident during their relationship. Her reaction suggests it was not normal sexual behaviour for them. She did not say that either spoke during the incident. (In her previous account she said that she had asked what he was doing but he did not speak.) She formed the opinion that he was awake because he was able to control his actions.

[19] In evidence Dr Fernando confirmed his opinion that sexsomnia is a possible explanation for the index offending and should be investigated. He could not go so far as to diagnose the condition based on the information available to him. He explained that what changed his previous opinion was NF's statement in her

[6] He expressed his conclusion in this way in his affidavit sworn on 3 November 2022. It is slightly more emphatic than the report itself, but we accept that the affidavit better reflects the considered opinion he had formed at that time.

27 March affidavit that T had touched her when he was asleep. He acknowledged that in her subsequent affidavit she denied that, saying that she believed T was awake, but he pointed out that she based this opinion on the mistaken assumption that a person cannot engage in complex actions when asleep.

[20] Dr Dean found the likelihood that sexsomnia explains the index offending was "almost completely absent". He did not interview T. He did interview NF, who disclaimed the statement in her 27 March 2022 affidavit, stating that it was due to a misunderstanding between her and her lawyer. She said that she had protested during the 2009 incident and did not believe that T was asleep. She appeared to be traumatised by the relationship; he indicated that she described a history of abusive behaviour. Dr Dean highlighted the absence of any history of parasomnia in T, the fact that he was not initially sleeping in the same bed as N but later got into bed with her during the alleged offending, and NF's claim that T had been suffering from a manic episode in 2009.

Sexsomnia and forensic diagnosis

[21] The term "sexsomnia" was coined in 2003, but the phenomenon of "sleep sex" had been identified in earlier literature.[7] It is a parasomnia, one of a large class of sleeping disorders in which patients experience undesirable events and sleep-related behaviours before, during or immediately after sleep.[8] Parasomnias include sleepwalking, sleep talking, sleep terrors, nightmares, restless legs, sleep eating, teeth grinding and sleep sex.[9] Sexsomnia is recognised in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[10] and the International Classification of Sleep Disorders (ICSD-3).[11] There is some evidence that it may be more common than initially assumed, though there is debate about the statistical quality of studies reporting it.

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7 Colin M Shapiro, Nikola N Trajanovic and J Paul Fedoroff "Sexsomnia — A New Parasomnia?" (2003) 48 Can J Psychiatry 311 at 314–315.

8 Brian J Holoyda and others "Forensic Evaluation of Sexsomnia" (2021) 49 J Am Acad Psychiatry Law 202 at 202.

9 At 202.

10 American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, American Psychiatric Association Publishing, Washington DC, 2013) at 399.

11 American Academy of Sleep Medicine *International Classification of Sleep Disorders* (3rd ed, Darien, 2014) at 232.

[22] The DSM-5 and ICSD-3 criteria for sexsomnia overlap extensively but are not identical. They were summarised in a 2021 article in the Journal of the American Academy of Psychiatry and the Law.[12] Dr Fernando was one of the authors. We summarise the criteria as:

(a) Recurrent episodes of incomplete awakening from sleep. The DSM-5 adds that these usually occur during the first third of the major sleep episode.

(b) Little or no dream imagery.

(c) Amnesia for the episodes (complete or partial).

(d) Substance use or a co-existing mental or physical condition do not explain the episodes.

(e) Clinically significant distress or impairment.

(f) Inappropriate or absent responsiveness to the efforts of others to intervene or redirect the person during the episode.

[23] Dr Fernando added that, while parasomnias are very rarely observed by a clinician, the person may exhibit behaviours during sleep that are consistent with parasomnia. The clinician may record an abnormally high number of awakenings from the N3 stage of sleep, or the person may exhibit signs of other sleep pathologies, such as sitting up or restless leg syndrome. These phenomena can be observed in a sleep study using video polysomnography. Sleep studies neither prove nor exclude sexsomnia but they do aid diagnosis. Sleep studies may also identify phenomena such as sleep apnoea that can disturb sleep and trigger parasomnias.

[24] The 2021 article recommended best practice for diagnosing sexsomnia:[13]

> … The diagnosis of sexsomnia requires a thorough clinical history, sleep history, and collateral history. In addition, an overnight sleep study with full

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12 Holoyda and others, above n 8.

13 At 203–204 (footnotes omitted).

> electroencephalogram (EEG) and video monitoring should be obtained in an effort to capture nocturnal sexual behaviors. The clinical history should assess an individual's stress and fatigue levels, psychiatric comorbidities, medications, neurologic history, family history of sleep disorders, alcohol and illicit drug use, and history of violence. A detailed sleep history should screen for past and current sleep pathologies, including sleepwalking, sleep talking, sleep terrors, nightmares, other parasomnias, obstructive sleep apnoea, periodic limb movements, restless leg syndrome, and nocturnal enuresis. An evaluator should ask about shift work and the degree of sleep deprivation during the episodes of sexsomnia. In addition, one should ask the evaluee about environmental factors that disrupt sleep, including ambient noise, sleeping partner noise, and sleeping partner movements. As most people with sexsomnia have poor recall of the events, asking about recollection of the episode or assessing the degree of amnesia of the event is important. Obtaining collateral history from bed partners, victims, or family members who are aware of a childhood history of sleep abnormalities or have witnessed episodes of sexsomnia, parasomnic behaviors, or sleep-disordered breathing may also help support or refute a diagnosis.
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> Video polysomnography, or the "sleep study," may assist in diagnosing NREM parasomnias, including sexsomnia. In a recent descriptive study of patients complaining of NREM parasomnias, individuals reporting sexsomnia and those reporting other parasomnias both displayed an abnormally high number of awakenings from the N3 (or slow-wave) stage of sleep. Most patients with sexsomnia in this particular study did not show sexual behaviors during the study, however. In fact, there are very few published cases of actual sexsomnia observed during sleep studies. In general, NREM parasomnic behaviors are rarely captured in sleep laboratories. Sleep studies of parasomnias, including sexsomnia, are similar to the EEG study of seizure disorders, in that the diagnostic test may or may not identify the pathology in question. Failure to capture behaviors consistent with sexsomnia on a sleep study does not exclude the possibility that sexsomnia occurred during the alleged event. Conversely, capturing sexsomnia during a sleep study may be useful diagnostically but does not automatically allow the examiner to state that the alleged crime occurred as a result of sexsomnia. Despite these problems, some researchers have recommended the routine use of video polysomnography in cases of suspected NREM parasomnia due to their potential diagnostic yield and the identification of additional underlying sleep pathologies. Repeating sleep studies in the hope of capturing sexsomnia, however, may be impractical and of limited utility.

[25] It will be seen that triggers for parasomnia may include environmental factors that disrupt sleep, such as movement or noise from sleeping partners. A sexual history from bed partners is an important aid to diagnosis. Dr Fernando explained that bed partners may not know whether the person was asleep, but they can identify behaviours that differ in some way from normal sexual behaviour in the couple's relationship.[14] The behaviour itself is not always identical but it usually exhibits a theme, such as the manner of touching and lack of engagement with the partner.

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14 See *C (CA223/2020) v R*, above n 5, at [22].

[26] Dr Dean did not dispute that sexsomnia is now a recognised condition or disagree with the diagnostic criteria. However, he was plainly sceptical about sexsomnia as a likely explanation for alleged offending and wary of diagnoses ultimately resting on self-report. He cited a 2010 book stating that the discipline of forensic sleep medicine is at an embryonic stage and noting methodological and ethical difficulties in obtaining valid data.[15]

[27] Sleep practitioners such as Dr Fernando engage in the clinical diagnosis and treatment of sleep disorders, including sexsomnia. This is therapeutic rather than forensic work and it seems the patient commonly involves their bed partner in the therapy. There is no reason to doubt the accounts given by the person being diagnosed and their partner.

[28] But inappropriate sexual behaviour can have legal consequences, which introduces the possibility of malingering. Dr Dean remarked that it is remarkably common for people accused of an offence to disclaim any memory of the incident but rarely does parasomnia sustain a defence of automatism in practice. He explained that he has prepared more than 100 medico-legal reports per year since 2000 and in only two of the cases he has been involved in has the defendant successfully pleaded automatism.

[29] Dr Fernando acknowledged that he is not an expert in malingering. He accepted that a forensic psychiatrist may be able to detect it, though there is no standard test. Where malingering is in issue, a sleep specialist and a forensic psychiatrist should work together. For his part, Dr Dean acknowledged that he is not a sleep expert, although he frequently deals with people who assert no memory of an event and is familiar with the literature on parasomnias. A forensic psychiatrist can evaluate information taken, as in T's case, from a patient's history. He agreed that sleep studies undertaken by a sleep expert can assist diagnosis, and he would defer to the opinion of a sleep expert where the outcome depended on such a study.

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15 Irshaad O Ebrahim and Colin M Shapiro "Medico-legal consequences of parasomnias" in Michael J Thorpy and Giuseppe Plazzi (eds) *The Parasomnias and Other Sleep-Related Movement Disorders* (Cambridge University Press, Cambridge, 2010), as referred to by Dr Dean.

[30] The authors of the 2021 article recommended that a forensic psychiatrist should obtain a detailed clinical history and collateral information.[16] The latter should include, when possible, information from previous sexual and bed partners. The authors identified indicators that a person is feigning sexsomnia: efforts to conceal behaviour, repeated episodes of sexual abuse after becoming aware of the sleep-related sexual behaviour, recollection of the episode, and new-onset sexsomnia presenting as a sole parasomnic behaviour.[17]

The appellate test

[31] We assess the new evidence against the settled criteria of freshness, cogency and materiality to verdict, bearing in mind that the ultimate criterion is the interests of justice.[18]

Is the evidence fresh?

[32] The new evidence on which the appeal rests is that of NF in her affidavit of 27 March 2022. It is her statement that T touched her while he was asleep that led Dr Fernando to change his opinion. That statement still underpins his opinion that sexsomnia should be considered in this case.

[33] Ms Hamill, for the Crown, contended that the evidence is not fresh. We accept that it recounts conduct which predated the trial and might have been the subject of evidence there. T had reported his claimed amnesia, and enquiries might have revealed that NF could confirm he had touched her while he was asleep. However, defence counsel did make enquiries. NF's position at the time was that she was unsure if T was asleep during the single 2009 incident she reported. In her 27 March 2022 affidavit, sworn after trial, she appeared to accept that T was asleep. In the circumstances we are prepared to treat the evidence in that affidavit as fresh, as are some of the details in NF's 13 December 2022 affidavit. We accept that had trial counsel known of this information an attempt may have been made to lay a foundation for a defence of insane or sane automatism.

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16 Holoyda and others, above n 8, at 205–206.

17 At 207–208.

18 *Lundy v R* [2013] UKPC 28, [2014] 2 NZLR 273 at [120]; *R v Bain* [2007] UKPC 33, (2007) 23 CRNZ 71 at [34] and [103]; and *Ieremia v R* [2020] NZSC 143, [2021] 1 NZLR 168 at [36].

Is the evidence cogent?

[34] The evidence led NF to offer a revised account, which we have summarised at [17] above. We have also noted what she said to Dr Dean. She gave evidence at trial, as a Crown witness, to recount what N said to her when reporting the alleged offence, but as explained earlier, she was not asked about sexsomnia. She is hostile toward T, understandably so from her perspective, and wishes to sever contact between him and N.

[35] We accordingly approach the question of cogency by assuming that when called at a retrial and asked about sexsomnia, NF would acknowledge that she said in her 27 March affidavit that T had touched her when he was asleep during the 2009 incident, but she would explain it by saying, as recounted in her 13 December affidavit, that it is not her opinion; rather, it is what she assumed at the time. She would otherwise confirm that the incident was abnormal behaviour and he did not speak during it. These features are consistent with sexsomnia. She would say he was experiencing a manic episode at the time, and expert evidence would confirm that is a possible explanation for T's behaviour. That can explain an abnormal conscious interest in sex. The jury would hear expert evidence that NF's disbelief rested on the mistaken assumption that a person who is asleep cannot perform complex behaviours. They would also hear that the sleep study identified possible triggers of sleep disturbance.

[36] We think the new evidence is not cogent, meaning it is not probative of sexsomnia as an explanation for the index charge. This conclusion is no criticism of Dr Fernando's expert evidence, which we found balanced and constructive. It rests rather on the quality of the evidence of fact. We make several points.

[37] First, there is very little collateral information to support a diagnosis of sexsomnia, which is an uncommon condition.

(a) T himself has no history of sleepwalking or sleep talking. That does not preclude a diagnosis of sexsomnia for T but does make it somewhat less likely; it appears that the majority of diagnosed cases have a history of childhood parasomnias.

(b) There is only a single incident in T's known sexual history that might be explained by sexsomnia. That does not preclude a diagnosis of sexsomnia either but does make it somewhat less likely.

(c) There is some collateral information pointing to an alternative mental health explanation for the 2009 incident.

(d) The sleep study neither confirms nor excludes sexsomnia; the most that can be said about sleep apnoea and leg movement is that they are known causes of sleep disturbance, which can trigger parasomnias.

[38] Second, the index offending differs materially from the 2009 incident. The complainant is a child, not an adult partner, and they were not in the same bed when they went to sleep. The behaviour cannot be said to fit a pattern.

[39] Third, we accept that a person may engage in complex behaviour, such as walking about, cooking or even driving, when asleep, but Dr Fernando told us that, while sleep sex is as varied as conscious sex, the most common behaviours are touching, fondling, masturbation and intercourse, and it seems that the other person is usually sleeping in the same bed. Partner movement or noise has been identified as a trigger for sleep disturbance. In this case, T moved from a mattress to N's bed during the episode and it would be speculative to suggest that the movement was triggered by anything she did.

[40] Fourth, the behaviour happened just before the morning alarm went off, suggesting that it was not in the early phase of T's sleep. As Dr Fernando pointed out, it is possible he had only recently fallen asleep, but again that seems less likely.

[41] Finally, for these reasons Dr Fernando is presently unable to confirm a diagnosis of sexsomnia. And as he was careful to explain, it need not follow from a diagnosis of sexsomnia that sexsomnia explains the index offending.

Might the evidence result in a different verdict?

[42] In its present state, the evidence is in our opinion insufficient to lead a jury, acting reasonably, to entertain a reasonable doubt.[19] A finding of automatism founded on sexsomnia could not be reached without expert evidence. The expert evidence here points only to a possible diagnosis which cannot be confirmed without further investigation, such as an interview with T's previous bed partner. In the absence of evidence an appellate court will not speculate on what such investigations might disclose.

[43] Indeed, the trial judge might decline to leave the defence to the jury on the evidence as it stands. The Court explained in *C (CA223/2020) v R* that classification of the defendant's condition as insane or sane automatism is a decision for the trial judge, guided by expert evidence, and, depending on the classification, the defendant faces a legal or evidential burden.[20]

The conviction appeal: conclusion

[44] We are not persuaded that the new evidence points to a miscarriage of justice. The application for leave to adduce further evidence is declined. The conviction appeal is dismissed.

The sentence appeal

[45] T brought his sentence appeal 84 days out of time, after being made aware of the fact that should his conviction appeal succeed, the sentences for the breaches of the protection order in relation to NF would remain at eight months' home detention. The sentence appeal was conditional on the conviction appeal succeeding because it makes no practical difference to T if he must still complete his sentences for the indecent act and breach of a protection order in relation to N.

[46] However, we agree with both counsel that the sentences for breach of protection order in relation to NF are manifestly excessive and in the circumstances

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19 *R v Bain,* above n 18, at [103].
20 *C (CA223/2020) v R,* above n 5, at [47], [58]–[59] and [82].

we think the correct course is to grant the extension of time, allow the appeals and reduce the sentences on those charges to six weeks' home detention, to be served concurrently with the home detention sentences for doing an indecent act and breaching the protection order in relation to N.

[47] T must now resume serving his sentence of home detention on 24 July 2023. That will give sufficient time for Corrections to make the necessary monitoring arrangements. His bail is revoked, with effect from that date.

Solicitors:
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