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22nd November 2013

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CONFIDENTIAL PSYCHIATRIC REPORT

on

Eleanor de FREITAS

(dob 26.09.90)

In the Crown Court at Southwark

1.0 INSTRUCTION:

1.1 This psychiatric report has been requested and been prepared at the instruction of EBR Attridge Solicitors, who represent Ms De Freitas.

1.2 From the advice of counsel Ms Poku, I understand that Ms De Freitas is charged with a single count of doing an act which had a tendency to pervert that the course of public justice with intent, in that she made a false allegation of rape against Alexander Economou to the Metropolitan Police Service. I understand that this is a private prosecution and that the Crown Prosecution Service are currently considering whether to adopt it.

1.3 The purpose of this report is to assist the Court in understanding Ms De Freitas' mental health. The defence seek to clarify Ms De Freitas':

- current diagnosis, prognosis and history of medical care;
- history of suicidal thoughts or behaviour in the past;
- decision-making around choosing to meet up with Mr Economou in light of their prior Facebook communications;
- treatment, its side-effects and interaction with alcohol, particularly in the early hours of 24th December 2012 when she sent a text message;

- ability to form the necessary intent at the time;
- inconsistent behaviour and the reliability of what she reported in relation to the effects of her illness after the events in question:
- current likelihood of receiving a fair trial in light of her medical condition;
- ability to cope with court proceedings, given the likely impact upon Ms De Freitas of threats allegedly made to her and her father by Mr Economou;
- need for an intermediary in court.

2.0 INTRODUCTION:

2.1 I am Dr. Tim Rogers, Consultant Forensic Psychiatrist to the North London Forensic Service, Barnet, Enfield and Haringey Mental Health NHS Trust.

2.2 I am currently approved under Section 12(2) of the Mental Health Act (1983) by the Secretary of State as having special experience in the diagnosis and management of mental disorder. I hold a Bachelor of Medicine and Bachelor of Surgery Degree (MB BS) having qualified as a doctor in the year 2000. I hold a Membership Examination for the Royal College of Psychiatrists (MRCPsych). My area of specialty has been that of mentally disordered offenders 'forensic psychiatry' since 2006. I completed this higher training at the Maudsley Hospital and Institute of Psychiatry in London. I hold a Master's Degree in Forensic Mental Health Science (MSc). I became a consultant in 2009. I now assess and treat high risk adults with mental disorder who are both detained in secure hospital care and who subsequently require supervision in the community. I have clinical experience in a wide variety of other psychiatric specialties. I have had involvement in preparing psychiatric trainees for examination through the Royal College of Psychiatrists. My areas of research interest include violent offending and reform of the law around fitness to plead, in which I have published peer-reviewed research and presented this internationally. I remain involved in work upon the Law Commission's review of unfitness to plead. I have formal training and broad experience in the provision of expert evidence to the courts. I prepare approximately 50 psychiatric reports each year and usually appear several times each month before some form of court or tribunal to give professional or expert evidence. The mainstay of my work is for the National Health Service.

3.0 CONFIDENTIALITY:

3.1 This report is written in line with the principles set out in the GMC document 'Confidentiality: Guidance for Doctors' (2009). As such, Ms De Freitas was made aware that I had been instructed to produce a psychiatric report for the Court. I informed Ms De Freitas that, should she agree to the production of a report, my opinions and the other information available to me may subsequently be made available to the Court. I explained that this is a public domain and for such reason, unlike a normal consultation with a doctor, I would not be able to give her the usual guarantee that what she told me would remain confidential. I was satisfied that this

was understood, that consent was given meaningfully and that she did not withdraw her consent at any stage.

4.0 Sources of Information:

4.1 Instructions from EBR Attridge Solicitors dated 7th October 2013.

4.2 A bundle of relevant case papers, including: the advice of counsel Ms Poku, undated; exhibits of DI Julian King references JK/01 & 02; exhibits of Caroline Collins reference CC/01 & 02; witness statement of Alexander Economou dated 6th August 2013; statement of Alexander Economou dated 27th August 2013; witness statement of Detective Inspector Julian King dated 13th August 2013.

4.3 Interview with Ms De Freitas at the offices of EBR Attridge Solicitors during the morning of 14th November 2013.

4.4 Two telephone conversations with Ms De Freitas treating consultant psychiatrist, Dr Chris Bench, on the 20th and 21st of November 2013. During the second of these, with Ms De Freitas' consent, we reviewed her medical records together.

5.0 Duty to the Court:

5.1 This report has been completed in line with Her Majesty's Courts Service good practice guidance for commissioning, administering and producing psychiatric reports for sentencing.

5.2 I confirm that I understand my duty to the Court in writing this report. I have complied, and will continue to comply, with part 33 of the Criminal Procedure Rules 2010. Beyond the caveat outlined in paragraph 6.1, I believe that the facts contained within this psychiatric report are true.

6.0 Limitations to this Report:

6.1 It was not possible for me to corroborate all of the factual information told to me by Ms De Freitas. I have attempted to do this where possible with reference to the information above, however new or more accurate information might affect my opinions and recommendations.

7.0 Family Background:

7.1 Ms De Freitas told me the following about this. She is an only child. She has no half siblings. Her parents are married and remain together.

7.2 Her father is an associate partner at an international wealth management firm. He also has a military background. She gave a description of problem drinking in him.

She complained about his lack of compassion and social understanding: "always 10 paces behind, can't relate". She opined that he might suffer a slight autism spectrum disorder. She said that certain members of their extended family refused to allow her father in their houses.

7.3 She described her mother as a senior RGN [registered general nurse] with expertise in genitourinary medicine. She described a variety of past and present mental health difficulties in her mother. She considered these to include problems in controlling anger, "diagnosable" mood swings and enduring personality problems that resulted from problems with her own parenting. She said at the time of writing her mother was unable to work and was scared to leave the house.

7.4 Ms De Freitas told me that her extended family suffered from a variety of mental disorders. On her father's side of the family, she told me that her aunt was treated with antidepressant medication and her uncle suffered from more severe features of an autism spectrum disorder than her father. She implied that they too had emotional and personality problems that had arisen from the challenges of leading early lives spent without secure roots travelling the world and at boarding school. On her mother's side of the family, she told me that she had an uncle with severe bipolar disorder "one night without sleep and he suffers a breakdown".

7.5 Mrs De Freitas told me that she had never married and had no children of her own. She said that her biological grandfather and step-grandfather were both deceased, the former who had "sociopathic traits and alcoholism". She said that there had been domestic violence towards her maternal grandmother, contributing to the difficulties in her mother's early life. She spoke of members of her extended family who were of a Catholic cultural background but did not express strong religious beliefs or preferences of her own.

8.0 HISTORY OF DEVELOPMENT:

8.1 Ms De Freitas spoke of no period of neonatal ill health or any awareness of problems with her childhood development (such as the age at first learning to speak or attaining other milestones). On the contrary, she described herself in terms of being a gifted child in many areas.

8.2 Ms De Freitas told me of her memories of early life. She said that she had largely grown up in London, with several periods in South Africa, during which she received some parenting from extended family members who had emigrated. More broadly she considered that she had been "passed around" attachment figures as a child, also including her maternal grandmother. She said that her earliest memories were of parental discord, in which she would be sent to her room while she heard her parents arguing and throwing objects downstairs. She alleged that her father had been wont to visit prostitutes, information that her mother had provided her with, but which she considered to be correct. She expressed in disdainful terms the context

of her upbringing "always in a clichéd, middle-class house in Fulham". She described family conflict about the tenanting of their downstairs flat "with drug lords and prostitutes". She complained that she had "lived in fear" of these people or of bailiffs seeking entry to their house whilst she was still a child. She recalled that her father had repeatedly accrued debts and she remembered hiding under her bed "with a meat tenderiser". She was critical of him and said "sometimes I think it would be easier if he was dead". She told me that the periods during which she was sent to South Africa had occurred as a result of difficulties in her parents' finances and marital relationship. She believed that their family home had been "lost and somehow recovered" on one or more occasions.

9.0 History of Education:

9.1 Ms De Freitas gave the following detail of this. She said that she had attended an excellent nursery which had been a more stable environment than that at home. She reported that she had moved to the Merlin School in Putney, followed by the Fulham Preparatory School and finally Putney High School. She described these as fee paying schools. She said that the latter in particular was an establishment with extremely competitive entry requirements. By way of example she said that she had initially been among the top 87 of 600 applicants, going on to achieve towards the top of a year academically. She said that her parents had had difficulties in meeting the fees for these schools. She stated that she had on occasion won a scholarship or been excused these fees due to her level of ability. She said that she had achieved 10 GCSE 'a*' grade results and three A-level 'a' [before 'a*' were possible] results, the latter including general classics and English literature. She told me that she had been close to being made head girl prefect, but her personality of "charming secret rebel" had prevented this. She recalled describing her difficult family circumstances to teachers, who would in turn allow her for example to "write an essay plan instead of an essay".

9.2 In terms of other childhood psychiatric disorders, Ms De Freitas did not give an account of hyperactivity or inattention. She denied any element of conduct disorder, saying that she had been in no trouble at all: "never even a detention". She did not describe any difficulties in socio-emotional reciprocity arising here, saying that she had had no difficulty making strong friendships that had endured to the present day. She did however describe some rigidity, perfectionism and obsessionality as discussed below.

9.3 Ms De Freitas stated that she had left secondary education at the latest possible point, aged 18, and been successful in her application for undergraduate study at the University of Durham. She said that she had begun her in 2008 but "dropped out" during the Easter of 2009. She attributed this to the onset of mental health problems in a way that had affected her function more so than previously, as set out below.

10.0 History of Employment:

10.1 Ms De Freitas told me that she had done some paid work prior to leaving education, nannying and babysitting. After leaving university in the context of mental health problems, she said that she had been able to recover sufficiently to begin to work and earn money in a variety of other ways that had consistently allowed her to support herself. She stated that she had been paid for work as a 'plus size' model, posing for beauty and bridal pictures. She had brought along to our meeting a picture of herself which appeared professionally produced. She told me that she had occasionally done some work with or for her father, supporting his role in a significant international financial institution. She claimed that despite his employment as a financial professional, he had entrusted her to do his accounting since 2011. She reported that she had previously done some work relating to the sale of tantric massage services online. She spoke about having had a role in developing a business in this area and had since passed it on. She described other business activities that had arisen out of paid roles she had undertaken, including in the sale of cosmetics and lingerie. She said that, at different times in her life, these had involved positions both in retail and home selling, including in the training of 'Avon ladies'. She felt that she had used entrepreneurial activity "as a comfort blanket" at times. She alluded to some difficulty in her previous professional relationships with women, which she attributed to their jealousy.

10.2 Ms De Freitas told me that she was in part-time employment at the time of our meeting. She said that she was employed by the Bodyshop and that her "salary is £520 per calendar month, which is below the taxable personal allowance". She described having undertaken a number of financial examinations over the course of many months. She described these in terms of a hobby and a conduit for interaction with her father.

11.0 History of Relationships and Enduring Character:

11.1 Ms De Freitas identified herself as heterosexual in orientation. She described the ability to form and sustain a number of fulfilling intimate relationships. She said that the first of these came during late adolescence. The second lasted two years between the ages of 16 and 18, in which she also built good relationships with her boyfriend's family. She said that this relationship came to an end as they had begun to study at universities many miles apart. Her third significant relationship lasted between 2009 and 2012. She told me that this had been damaging rather than fulfilling. She said that her partner then have been hopeless, damaged and had manipulated her. She described an unwanted pregnancy. She stated that she had dated polo players at other times, "for the social aspect". She reported that she was in a supportive relationship at present, with a prior friend from university.

11.2 Ms De Freitas spoke at length, with a slightly increased rate and quantity of speech, about all aspects of her life including her enduring character and personality. She described herself as "definitely perfectionist", giving examples of enduring compulsive behaviours relating to cleanliness, locking or "not stepping on the cracks". She described a period during her earlier adolescence, when "everything used to have to be colour-coordinated". She said that this had been difficult at work on occasion. She spoke about certain obsessional ideas, for example a dislike for certain numbers that seemed irrational. She reported some unusual, intense interests, such as in the pharmacological half lives of her own and other medications. "I love the BNF, it has the answer to everything". She believed that she, like certain members of her family, might have traits of an autism spectrum disorder: "God yes!". She denied that she had felt or been told about any difficulty of empathy or of socio-emotional reciprocity. On the contrary she described herself as "very empathic, dangerously so" and said that she sometimes had to try to suppress exuberant feelings "through logic". She said she could be "Machiavellian and plotting if I need to be". As a teenager in high achieving school, she described rivalry and cattiness among her peers, including the head girl. She felt it reasonable to describe herself as an overachiever.

12.0 HISTORY OF DRUG AND ALCOHOL USE:

12.1 Ms De Freitas told me that she had never tried any street drugs. She accepted that stimulants such as cocaine powder were sometimes available in the social circles in which she had been a member, however she was somebody who "didn't do class As, not one line ever".

12.2 Ms De Freitas discussed her alcohol use. She said that there had been occasions when she had become drunk at an early age, including with her cousins as young as 7. She told me that her early onset drinking had not however developed into problem drinking in later life. Instead, she discussed a pattern of occasional drinking, typically only if a family gathering or party had been arranged. Towards the end of her secondary education she admitted that "drinking on Wimbledon Common happened, because this was a rite of passage" among her peer group. Nonetheless, she described herself as a control freak who never went beyond [consuming] 2 to 3 units [at a time] ordinarily. She said that she would typically be "nominated the designated driver" when socialising with others. She denied the features of alcohol dependence syndrome.

13.0 HISTORY OF OFFENDING:

13.1 Ms De Freitas appeared to speak about this freely. She did not report any prior history of offending behaviour. I understand from her legal representative that he is not aware of any previous convictions being recorded against her.

incorrect

14.0 History of Mental and Physical Health:

14.1 Ms De Freitas gave me the following account of this. She recalled that as early as the age of 10, there had been periods in her life when she had experienced low mood and "feeling shit". She said that she had coped with this by throwing herself into academic study. She told me that around the age of 13 there had been episodes of "stress, anxiety and insomnia" for which she had self medicated using sedative antihistamines available over-the-counter without prescription. Her recollection was that by the age of 14 she had "known that something was wrong, feeling more down than [she] should have done". She complained that when she had confided in her mother about this, she had been told to stop "making stories up". As she progressed into the later stages of adolescence, Ms De Freitas told me that she had researched and purchased the homoeopathic remedy St John's Sort from Holland and Barrett. She said that she had taken this – unprescribed – for some years with effect. Her memory was that she developed a variety of other coping strategies such as the use of exercise, chocolate, chilli and the purchase of treatments for seasonal affective disorder such as high intensity lamps and a sunrise clock.

14.2 Ms De Freitas told me that these were sufficient until she began university, when bereavement, adaptation to a period of change and issues in her intimate relationships contributed to what she described as her first breakdown. She described this in terms of a depressive episodes, for which she was prescribed the antidepressant citalopram, without good effect. She said that she considered herself to be correctly diagnosed with bipolar disorder, and was able to present me with the letter and number under which this is coded in the International Classification Of Diseases (ICD – 10). She said that there had been a number of low and high points in her life, in which changes in her mood had been abnormal and not short lived. In between times she considered herself to be "always a bit high". During periods of mood elation she described features such as overspending, excessive shopping and unrealistic or expansive intentions such as impulsively seeking to buy a flat. She spoke about a reduced need for sleep at these times. In contrast, doing periods of mood lowering, she described "quite a lot" of suicidal feelings and rumination. She said that she had found herself "too stubborn" to actually go through with any plan to harm herself. Despite this she described numerous expressions of suicidal related distress, such as will writing and consideration of the methods of suicide. She felt that some of these occasions had represented "angry gestures towards [her] parents". She described a single episode of hospitalisation as she approached the age of 22. She said that this had been under section 2 of the Mental Health Act (1983). She recalled that precipitants for this crisis had included her boyfriend at the time losing his job and her "having abusive parents". She was somewhat boastful about the ease with which she had subsequently persuaded a mental health review tribunal to release her. She told me of a variety of precautions that she had since taken, to minimise the chances of any forcible readmission to hospital. She said that her father had at times

* Boastful *

held the threat of hospitalisation over her, such as when prompting her to take night-time sedative tablets.

14.3 Ms De Freitas told me that she had attended six sessions of systemic family therapy aged around 20, in which her parents had chosen not to participate.

14.4 Ms De Freitas provided me with a copy of a psychiatrist's outpatient clinic letter, which referred to her recent care. Without repeating this in full, it referred to her diagnosis of bipolar disorder, consistent with what she had told me. It listed her treatment with various psychotropic medications including regular use of the antipsychotic Quetiapine, the anticonvulsant and mood stabiliser Lamotrigine, and her as required use of the hypnotic Zopiclone and the sedative and anxiolytic treatment Diazepam. She had confided in her psychiatrist about difficulties at home, in which she believed that her parents had deliberately left a mortgage arrears statement in a position where she could find this and feel concerned or responsible about it. In mental state, her psychiatrist Dr Bench noted in mid October 2013 that "it is easy to see that she could quickly become irritable at home. Overall my impression is that she is generally improving though not yet quite back to her normal self".

14.5 I had the opportunity to discuss Ms De Freitas at length on two occasions, by telephone, with her treating psychiatrist Dr Bench. In general he considered that the extent of what he could say about her was somewhat limited by her tendency towards guardedness during appointments. He said that he had on many occasions however received corroborating information about her mental health or behaviour from her parents. He understood there to be a difficult relationship between Ms De Freitas and her parents, characterised either by their infantilisation of her or – in contrast – their their over-reliance upon her at different times. Dr Bench understood that Ms De Freitas parents' had consistently experienced financial difficulty "struggled to make ends meet", despite their outwardly prosperous social appearance. In terms of Ms. De Freitas mental health diagnos(es) it was Dr. Bench's settled opinion that she had suffered "definitely one, probably two" episodes of mania. This was consistent with the clinic letter she had provided me with, in which he described bipolar disorder. Dr. Bench had previously met Ms. De Freitas' father and, having done so, did not dispute her assertion that he might suffer from traits of an autism spectrum disorder 'ASD'. He believed that Ms. De Freitas' own obsessionality (a known characteristic of ASD) might also relate to such traits or, alternatively, a degree of obsessive-compulsive disorder. Dr Bench did not believe that there were the features of personality disorder in Ms De Freitas. From the information available to him (including long before the incident in question) he understood that she had been "on course to be a high performer until her first year at university". He believed that this precipitous change in her function around the commencement of adulthood was consistent with a diagnosis of mental illness in her case.

14.6 I reviewed with Dr. Bench Ms. De Freitas' mental health progress notes around the time of the events in question. He had personally seen her as an outpatient on a number of relevant occasions. One was on the 25th October 2012, when he noted that she had been "pretty well...mild symptoms of anxiety around some financial exams she had been taking...experiencing two nights disturbed sleep each week but still managing to work OK". Dr. Bench saw her next on the 20th December 2012, when he noted that she had "described feeling even better [than the last appointment]...still slight anxiety...working 30 hours week and been given a bit of extra responsibility...no sign of elation". Dr. Bench later found out that Ms. De Freitas' friends had – in contrast – been concerned about her mental health at a gathering on the 21st December 2012. Dr. Bench understood that Ms. De Freitas' father had called mental health workers on the 27th December 2012 to express concern about his daughter (the details of this were not recorded). The next contact occurred whilst Dr. Bench was on leave over the festive period, on the 28th December 2012, by telephone. A covering colleague had recorded in her notes "worried...been vomiting...had a panic attack over Christmas...reported not sleeping". On this day her mental state was [insofar as it could be judged without a face-to-face meeting] noted to be "speech normal in tempo...appropriate...not disinhibited over the telephone". She agreed a contingency plan with the doctor, again by phone.

* Relevant time.

14.7 The next contact was a telephone call to Ms De Freitas by Dr. Bench on the 31st December 2012. In this she told him that "something traumatic had happened that she did not want to disclose". Dr. Bench also spoke to her mother on that date, who reported "signs of a manic relapse since just before the 24th December 2012". As a result Dr. Bench arranged for Ms De Freitas to be seen in person the same day. At this review she reported that her "recall for the 24th [December 2012] was not clear...she was wondering if she had been given the date rape drug Rohipnol...she had not yet made any report to the Police". She continued that after the events had occurred she "went to work...started to drive on the motorway [to attend Christmas celebrations with family members]...received a threatening communication from her alleged attacker by phone". Dr. Bench noted that she had then given "a confused account of having been disoriented and lost, having run out of petrol and waiting on the hard shoulder...visiting a GP near her family in Northampton where she was diagnosed with a urinary tract infection, treated with antibiotics and given emergency contraception". Still referring to the 31st December 2012 Dr. Bench noted her mental state to convey a "sense of battling to remain in control...presenting a little grandiose in manner...feeling anxious and activated...displaying no delusional thinking but appearing in a mixed affective state at that stage...refusing an increase in her anti-manic Quetiapine treatment but agreeing to use [the hypnotic] medication zopiclone...became irritable when her parent(s) entered. Ms. De Freitas' mother told Dr. Bench then that this abnormal presentation was nevertheless more settled than that she had witnessed earlier in the festive period.

* clearly incorrect same time *

14.8 Dr Bench reviewed Ms. De Freitas on the 7th January 2013, when he noted her to have seemed "better in mental state...presented quite well...remained slightly over-inclusive...just a bit imperious and abnormally self important". In summary, Dr. Bench opined two things. Firstly, he stated his belief that when high [during periods of manic symptomatology] Ms. De Freitas became prone to behave in a more promiscuous way that made her sexually vulnerable. Secondly, he felt no doubt that during the festive period of 2012 she had experienced a period of disturbed mental health, which had included elements of abnormal manic elation.

14.9 Ms De Freitas told me that she suffered from no significant physical illnesses. She said that she had had laser eye surgery without complication. She believed herself to be at future risk of diabetes mellitus, given her family history.

15.0 INDEX OFFENCE:

15.1 I will not repeat the detail of this in full, as a variety of witness statements are already before the Court. In brief, it is common ground that Ms De Freitas and Alexander Economou had known each other for a few years by the time of the allegations around the festive period in 2012. Between the 23rd and 24th December 2012, it is common ground that they engaged in a variety of sexual activities together, including unprotected penetrative vaginal sex and bondage. It is agreed that they also spent time together, away from Mr Economou's flat, visiting various retailers. On the 4th January Ms De Freitas made an allegation of rape. In her interview, she alleges that she was put in fear, that she was drugged without her consent and that in relation to their sexual activity she "didn't say yes, or no, didn't say anything". She continued "I wasn't in control of my body, I was groggy, I didn't know what was going on". Mr Economou was arrested but never charged. In his statement, dated the 6th August 2013, he gives a different account in which Ms De Freitas arranged, suggested and willingly participated in the sexual activity between them. His witness statement describes a situation, context and exchange of messages between them which, if accepted by the Court as correct, are not suggestive of rape. No further action was taken against Mr Economou, on the basis of the credibility of Ms De Freitas as a witness. Her account is not corroborated. Due to the time lapse in her report, her assertion of having been drugged could not be proven. The scene examination of the suspect's accommodation did not support the alleged victim's evidence. Ms De Freitas made the allegation after she received communication from the suspect stating that he was en route to a police station to report her harassment of him. She had earlier apologised to him "for any trouble" she may have caused. There is CCTV footage of both individuals after the allegation in which they appear to be fine together. Mr Economou then arranged for a private prosecution of Ms De Freitas in which she is charged with a single count of doing an act which had a tendency to pervert that the course of public justice with intent, in that she made a false allegation of rape.

15.2 Ms De Freitas gave me her account once more. This differed little from the contents of her interview. I will not therefore repeated it in full. She concluded however that she had had "neither consent nor capacity" at the time as she had been "spiked". I spent some time with Ms De Freitas getting from her an account of her mental health around this period. She said that she had been able to work at the Bodyshop, including having been given responsibility as a key-holder at the Kings Road store. She told me that her sleep had been disturbed for numerous preceding nights due to false intruder alarms at the premises. She stated that she had been under stress and under pressure to meet targets. She stated that she had failed a financial exam. She remembered that she had felt anxious and depressed but had been sleeping okay, as she had been "so exhausted". In contrast, she drew a diagram of her mood state at the time that illustrated her to have been in a state of "high energy". She told me that she had been partying also. She described having had an accident with a piping hot branded iron pan. She said that she had spent several hundred pounds buying Christmas presents in Harrods. Perhaps in contrast, she denied recklessness, overspending or having experienced an increased libido at the time. This is contradicted by the statement of Mr Economou. At paragraph 3, he states that Ms De Freitas had sent him a text message to arrange a "mutual massage session". He said that they had had a conversation on the 22nd December 2012 that was of an inherently sexual nature, in which she had asked him what his sexual fantasies were and in which they had discussed sex. He states that Ms De Freitas later sent him a text message stating that she was "too horny" and another message shortly afterwards stating that she "needed to watch some porn".

16.0 MENTAL STATE EXAMINATION ON 14TH NOVEMBER 2013:

16.1 Ms De Freitas attended for her appointment with me promptly. She presented as an attractive young Caucasian woman who was smartly turned out, wearing make up, with neither any impairment in self-care nor any flamboyant, extravagant or overly colourful dress. She made eye contact in a normal way and was appropriate in behaviour and manner throughout. There was no sustained evidence of abnormal psychomotor changes, such as a marked increase in levels of activity, restlessness or fidgeting. There were slight abnormalities in her speech. Specifically, she was over inclusive and provided an excessive amount of detail in response to questions asked. Without my requesting it, she would repeatedly pause our conversation to write down what she had said to me on scraps of paper, which she handed to me one by one. Occasionally there was an unduly pedantic quality to her speech, for example in the way that she discussed her exact salary and taxable allowance. The interview took longer than it otherwise might have done for these reasons. Her speech was not however pressured and she was interruptible. It was necessary for me to manage our conversation and guide her back to the original question I had put to her, after she digressed on a number of occasions. She described her subjective mood as "currently not very well, vomiting and not sleeping". Objectively her affect was suggestive of a slight elevation in mood. There was no gross flight of ideas however there were one

or two occasions when she jumped between topics. One example I wrote down included the following: "it was called Balalaika...1946 and 2009...that makes...I need my calculator...I've got off diazepam through my own will... he was 63 when he died". At times the rate of her speech was increased, but this was not the case throughout.

16.2 In her themes of speech, there were occasions when she was self aggrandising. Examples included telling me that her extended family included a famous shoemaker, somebody who had painted with Monet and – many generations ago – someone who was the sister of Anne Boleyn. She said that all of these claims could be independently verified and suggested to me that she "had no delusions of grandeur". I did not clearly elicit any delusional beliefs from what she said to me. I found her somewhat boastful, for example about her intellect, achievements or general superiority. She described herself as a gifted child. She was somewhat dismissive of those she considered inferior to her, for example discussing Oxford Brookes University in a derisory way in contrast to Oxbridge (which she did not attend). There was no suggestion of any perceptual disturbance. I did not formally test her cognition using any psychometric tools. I found her use of vocabulary and conceptual reasoning to suggest that she was intelligent. This appeared consistent with what she had told me about her educational achievement. In terms of insight, she accepted her diagnosis of major affective disorder, was fully aware of her medical treatments and accepting of them. She was able to speak in a detailed and reflective way about a wide variety of mental disorder, including in her own family.

INSIGHT

17.0 THE QUESTION OF HER CURRENT DIAGNOSIS AND PROGNOSIS:

17.1 On the basis of the available historical information and her mental state as I found it, I agree with the view of her treating consultant psychiatrist that a diagnosis of bipolar disorder is appropriate in her case. Ms De Freitas describes the features of both autism spectrum disorder 'ASD' and major affective disorder among members of her family. This view was corroborated by her psychiatrist. In herself, she reports perfectionism and at interview there was evidence of pedantic and over-inclusive speech at times. She was of the view that she too has some features of autism spectrum disorder, in addition to her bipolar disorder. The presence of mild obsessionality was corroborated by her psychiatrist. No formal diagnosis of 'ASD' has been made, however. Ms De Freitas spoke in ambivalent terms about her parents. As set out above, she variously described them in terms of their emotional unavailability and unpredictability. Her psychiatrist corroborated this account of an unusual family dynamic in which their parenting of her remained inconsistent, veering between infantilisation and inappropriate over-reliance upon her at different times. A diagnosis of personality disorder has not previously been made in her case. I agree that it was the onset of major mental illness in her which heralded a deterioration in function as she entered adulthood. In my view, however, it seems likely that the elements of early adversity that are described are likely to have had an additionally adverse impact upon her adult interpersonal function and enduring

character. This is a difficulty that is likely to be separate from the effects of her mental illness upon her behaviour. In my opinion Miss De Freitas' propensity to remain susceptible to the problems above is likely to be enduring and lifelong. Most people with bipolar disorder suffer numerous recurrent episodes of mood disturbance over the course of their lifetime, predominantly of lowered mood (depression). This said, there are a number of features of Ms De Freitas' case that suggest a better prognosis for her. Most significantly these include her intelligence and insight into her own problems and her willingness to consistently adhere to medical treatment and monitoring. The apparent absence of a predilection for substance misuse in her is also a reassuring sign.

18.0 THE QUESTION OF SUICIDAL THOUGHTS OR BEHAVIOUR IN THE PAST:

18.1 Ms De Freitas did disclose this to me, as set out above. It is well recognised that there is a chronic and significant risk of completed suicide in those who suffer major affective disorder. She is no different and she requires long-term mental health care. If she were to be punished by imprisonment, she would require referral to prison inreach mental health services and her risk of self harm would be significantly increased.

19.0 THE QUESTION OF DECISION-MAKING AROUND CHOOSING TO MEET UP WITH MR ECONOMOU IN LIGHT OF THEIR PRIOR FACEBOOK COMMUNICATION:

19.1 Ms De Freitas' treating psychiatrist, Dr Bench, felt no doubt that during the festive period of 2012 she had experienced a period of disturbed mental health, which had included elements of abnormal manic elation. The details of this are set out above. I agree with Dr Bench about this issue. For the assistance of the Court, I have included a table below that lists the features of such a period of illness related affective disturbance.

FEATURES SUGGESTIVE OF HYPOMANIA
Persistent mild elevation of mood for at least several days on end
Increased energy and activity
Marked feelings of well-being, physical and mental efficiency
Increased sociability
Talkativeness or pressure to keep talking
Over-familiarity or boorish behaviour

Decreased need for sleep
Irritability
Conceitedness, inflated self-esteem or grandiosity
Distractibility or impaired concentration and attention
Appearance of new interests, ventures, investments or activities that might be risky or foolish
Over-spending or unrestrained buying sprees
Increased sexual energy, activity or sexual indiscretions
Flight of ideas or subjective experience that thoughts are racing
Interference with or disruption in work or social activity

19.2 The Court may form its own view about which of these might have affected her decision-making at the time. It is my experience however that those with abnormal mood elevation, suffering from increased energy and activity, increased sociability, distractibility or impaired concentration and attention, the appearance of new interests, ventures, investments or activities that might be risky or foolish, together with increased sexual energy, activity or sexual indiscretions are clearly at risk of making unwise decisions that are affected by their illness, and which they would not ordinarily do. Ms. De Freitas' treating consultant, Dr Bench, opines that her illness can make her prone to behave in a more promiscuous way that results in her becoming sexually vulnerable. I agree with this.

not had he raped her neither here nor there!

20.0 THE QUESTION OF HER TREATMENT, ITS SIDE-EFFECTS AND INTERACTION WITH ALCOHOL:

20.1 In my opinion, this may be of some significance to what is alleged to have occurred. It is difficult to be certain about what medication she took and when. I understand however that her psychotropic treatments have included the antipsychotic Quetiapine, the hypnotic Zopiclone and the anxiolytic Diazepam at different times. The potentially relevant issue here is that all of these have sedative effects that would or could have been potentiated by her consumption of alcohol at the time. This could have contributed to her perception of having felt groggy or not having known what was going on. The Court may benefit from the expert view of a mental health pharmacist or pharmacologist in respect of her medications.

No answer – will not be drawn on this! alcohol consumption v low.

21.0 THE QUESTION OF HER ABILITY TO FORM THE NECESSARY INTENT AT THE TIME:

21.1 There is an account of Ms De Freitas' mental state on the 7th January 2013 available in her mental health notes. This is close in time to the date she made the allegation. It came from a review of her by her treating clinician, Dr Bench. He noted her to have seemed "better in mental state...present[ing] quite well...remain[ing] slightly overinclusive...just a bit imperious and abnormally self important". In my view, therefore, there is evidence of a degree of recovery in Ms De Freitas around the time of the allegation on 4th January 2013. On balance it is not my view that she would have been unable to form the necessary intent or that she would have been unaware that making such an allegation would result in the Police conducting an investigation into Mr Economou. aware + did it anyway.

22.0 THE QUESTION OF HER INCONSISTENT BEHAVIOUR AND THE RELIABILITY OF WHAT SHE REPORTED IN RELATION TO THE EFFECTS OF ILLNESS:

22.1 It is helpful to return here to the table inserted at paragraph 19.1. Thus, her illness would at the time have likely conferred upon her the features of talkativeness or pressure to keep talking, conceitedness, inflated self-esteem or grandiosity, distractibility, impaired concentration and attention and a general degree of disruption in her function. As discussed, it is my view that elements of early adversity may also have affected her underlying interpersonal function, coping skills and emotional resources. All of these things could have explained her inconsistent behaviour and could have affected the reliability of what she reported. These features both make her more vulnerable and also impair her ability to come to terms with episode(s) in her life that she may come to regret or find distressing. Mr Economou's account of her suicidal thinking may in my view be illustrative of this.

23.0 THE QUESTION OF LIKELIHOOD OF RECEIVING A FAIR TRIAL:

23.1 This issue is tied up with the other questions put to me in completing this report, including her ability to cope with court proceedings, given the likely impact upon her of threats allegedly made to her and her father by Mr Economou. Her fitness to stand trial is a dynamic issue that is prone to change over time, in concert with fluctuations in her mental health. Clearly, such a trial would be an extremely stressful event and there is no doubt that this could be a de-stabiliser for her, precipitating an episode of affective illness. At the time of my meeting with Ms de Freitas, I found her mildly symptomatic, as above. It was not therefore my view that she was so severely disordered that she was at that point unable to plead to the indictment, understand evidence, give instructions, follow proceedings or that she would have been unable to challenge a juror to whom she objected. Her illness is such, however, that this could quickly change. Whether or not and when this would occur is difficult to predict accurately. During the course of any trial, it would be necessary for the Court to remain mindful that she might need a re-assessment of her

mental health at short notice. Her ability to give evidence in her own defence is also key to this question, as per the case of R v M [2003]. As above, Ms De Freitas remained mildly symptomatic when I met her, despite her apparent adherence with a variety of recommended medical treatments. Although I did not find her to be overtly hypomanic, the suggestion of undue talkativeness, inflated self-esteem or boastfulness in her (alternatively described by Dr Bench as "just a bit imperious and abnormally self important") is likely to be problematic in relation to the impression any jury might form of her whilst she gave evidence. It would therefore be my suggestion that the jury would need to be aware of the medical evidence about her in advance of any trial, such that jurors did not draw an unfair adverse inference. It would certainly be my view that the Court or jury should not draw such inferences from any refusal in her to give evidence. Ms. De Freitas' mental condition is one that would reasonably be considered to make it undesirable for her to do so as per (s.35(2)) of the Criminal Justice and Public Order Act (1994). not giving evidence

24.0 THE QUESTION OF MS DE FREITAS' NEED FOR AN INTERMEDIARY IN COURT:

24.1 In my view Ms De Freitas is a highly able and intelligent woman who would be better placed than most defendants without legal training to grasp the narrative of court proceedings to which they were party. I would be somewhat concerned about her ability to make best use of an intermediary, to take their advice or to feel that this was necessary for her, given her intellect and her outward expression of self confidence or self importance. Instead, it would be my suggestion that her effective participation in any trial would be better supported by a pre-arranged increase in the frequency of contact with and monitoring from her mental health team for the duration of any proceedings. I would be happy to offer a re-assessment of her nearer the time or to offer further advice to the Court as necessary.

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Approved under Section 12 (2) of the Mental Health Act 1983