



**Law
Commission**
Reforming the law

**Criminal Liability:
Insanity and Automatism
A Discussion Paper**

23 July 2013

Law Commission

Discussion Paper (July 2013)

CRIMINAL LIABILITY:

INSANITY AND AUTOMATISM

THE LAW COMMISSION

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THE LAW COMMISSION
CRIMINAL LIABILITY:
INSANITY AND AUTOMATISM
A DISCUSSION PAPER

CONTENTS

	<i>Paragraph</i>	<i>Page</i>
GLOSSARY		xvi
CHAPTER 1: INTRODUCTION		1
Our work on the linked topics of unfitness to plead and the defence of insanity	1.4	1
The relationship between the law on unfitness to plead and the defence of insanity	1.5	1
Unfitness to plead	1.7	2
The insanity defence	1.8	2
The way forward	1.10	2
The central question in this paper	1.18	4
The defences of insanity and automatism: the present law	1.23	5
Insanity	1.23	5
Automatism	1.27	5
Problems with the present law	1.30	6
(1) The requirement to prove D's "act"	1.31	6
(2) The interpretation of "defect of reason"	1.35	7
(3) Disease of the mind	1.37	7
(4) The "nature and quality of the act"	1.48	10
(5) "He did not know he was doing what was wrong"	1.49	10
(6) Incoherence	1.52	11

	<i>Paragraph</i>	<i>Page</i>
(7) The defence is not available in the magistrates' courts if there is no mental element to the offence	1.54	12
(8) The law is out of step with medical understanding	1.56	12
(9) The label "insanity" is stigmatising and inaccurate	1.59	13
(10) Burden of proof if the insanity defence is raised	1.63	13
(11) The risk of breach of the ECHR	1.65	14
Victims' rights	1.65	14
Defendants' rights	1.70	15
(12) Equality and discrimination	1.73	16
(13) The impact on children	1.77	17
Responses to the Scoping Paper and evidence of how the defences work in practice	1.80	17
Possible new defences	1.84	19
New defence and special verdict of "not criminally responsible by reason of recognised medical condition"	1.86	19
Illustration	1.97	21
Disposal following the new special verdict	1.106	22
Reformed defence of automatism	1.109	23
Prior fault and intoxication	1.115	24
Procedural issues	1.121	25
Burden of proof	1.123	26
Possible defence and special verdict of developmental immaturity	1.126	26
How our provisional proposals would improve the law	1.127	26
Acknowledgements	1.139	27
 CHAPTER 2: SHOULD THERE BE AN "INSANITY" DEFENCE AT ALL?		 29
No special defence	2.2	29
The arguments against a special defence based on mental disorder	2.4	29

	<i>Paragraph</i>	<i>Page</i>
No special defence is necessary or justifiable	2.5	30
Wrong in principle	2.10	32
No reason for distinguishing between different causes of non-responsibility	2.15	33
The arguments for a special defence	2.18	34
1: That if a person is non-culpable because of mental disorder, then that should be the true ground for the verdict, not the presence or absence of mens rea	2.18	34
2: Public protection requires the court to have special powers	2.23	35
3: What of cases where the mens rea existed, but resulted from a mental disorder?	2.30	37
4: The proposal must take account of defences	2.32	37
Conclusion	2.33	38
A mental disorder defence?	2.35	39
The connection with the defence of automatism	2.36	39
Uncertainty about the definition of “mental disorder”	2.43	40
The alternative	2.50	42
The shortcomings of a mental disorder defence	2.52	42
No reason to treat mental disorders differently from physical disorders	2.53	42
Reduced stigma	2.56	43
More appropriate labelling	2.57	43
Appropriate outcomes	2.60	44
Problem to be addressed with the recognised medical condition defence as well as with the mental disorder defence	2.62	44
Conclusion	2.63	45

	<i>Paragraph</i>	<i>Page</i>
CHAPTER 3: A NEW DEFENCE OF “NOT CRIMINALLY RESPONSIBLE BY REASON OF RECOGNISED MEDICAL CONDITION” (I): OVERVIEW		46
Introduction	3.1	46
<i>Total</i> lack of criminal capacity	3.2	46
Relevant criminal capacities	3.4	46
Applicable to all offences	3.7	47
Retaining the possibility of a simple acquittal	3.9	47
Burden of proof	3.10	48
The role of expert evidence	3.11	48
“Recognised medical condition”	3.12	48
Non-qualifying conditions	3.14	48
Acute intoxication exclusion	3.15	49
Anti-social personality disorders	3.16	49
The relationship between the new defence and automatism	3.17	49
The Relationship with the law on prior fault and intoxication	3.19	49
A new special verdict	3.21	50
Disposals following the new special verdict	3.22	50
Naming the new defence	3.26	50
CHAPTER 4: A NEW DEFENCE OF “NOT CRIMINALLY RESPONSIBLE BY REASON OF RECOGNISED MEDICAL CONDITION” (II): THE DETAIL		52
The relevant capacities	4.4	52
Practical reasoning/rationally forming a judgment	4.8	53
Conclusion	4.14	55
Capacity to appreciate wrongfulness	4.19	56
What kind of “wrongfulness” is in issue?	4.20	56
Why have a “wrongfulness” limb at all?	4.23	56
Conclusion	4.33	59
Capacity to control physical actions	4.34	59

	<i>Paragraph</i>	<i>Page</i>
The arguments for including in the defence an element reflecting the lack of capacity to control one's actions	4.37	60
Views of other bodies and jurisdictions	4.42	61
Arguments against an element reflecting an inability to control one's physical acts	4.48	63
Conclusion	4.53	65
"Recognised medical condition"	4.55	65
What is not covered	4.59	66
A question for the court	4.63	67
"Recognised" professionally	4.67	67
Difficulties of diagnosis	4.69	68
Application to children	4.71	69
Difficulties with experts using DSM-IV and ICD-10 and their successors	4.74	70
"Recognised medical condition" as a legal concept	4.79	71
"Recognised medical condition" in the defence of diminished responsibility	4.80	72
Acute intoxication	4.87	74
Antisocial personality disorder	4.93	76
What are personality disorders?	4.94	76
Views of other reform bodies and jurisdictions	4.98	78
Discussion	4.102	79
The role of expert witnesses in the determination of whether a condition is a recognised medical condition	4.117	82
The new defence	4.123	83
Who may raise the issue	4.131	84
The burden of proof	4.135	85
Satisfying the evidential burden	4.136	85
Connections with other defences	4.140	86
Consequences for other alleged perpetrators	4.142	86

	<i>Paragraph</i>	<i>Page</i>
Disposals following the special verdict	4.144	87
Hospital orders	4.145	87
Supervision order	4.149	88
Absolute discharge	4.152	89
Disposals for children and young people	4.153	89
Sanctions in the event of breach	4.154	89
Provisional proposals	4.158	91
Table comparing the outcomes of cases under the present law with outcomes under our proposed defence	4.169	92
Flowchart	4.170	94
CHAPTER 5: A REFORMED DEFENCE OF AUTOMATISM		96
The present law	5.2	96
Definition and scope of defence	5.2	96
Categories of automatism	5.11	99
The courts' general approach to sane automatism	5.18	100
Loss of control	5.22	101
Evidence required to support the defence	5.33	104
(1) Automatism resulting from a disease of the mind	5.36	104
Problems with this category of the present law	5.38	105
Arbitrary classifications	5.39	105
The mismatch between law and medicine	5.45	107
Risk of mis-categorisation	5.46	107
Incoherence in cases of non-physical external factors	5.47	107
Sleepwalking	5.55	110
Our provisional proposal	5.65	113
(a) Redefining the boundary between recognised medical condition and sane automatism	5.65	113
(b) Advantages of the proposal	5.69	114
(2) Automatism caused by an internal factor other than a disease of the mind	5.77	115

	<i>Paragraph</i>	<i>Page</i>
Problems of the present law	5.83	116
Our proposals	5.86	117
Advantages of our proposals for cases in this category	5.87	117
(3) Automatism caused by an external factor involving consumption of substances	5.89	117
Present law	5.90	117
Problems with the present law	5.99	119
Our provisional proposals	5.102	120
Advantage of our provisional proposals	5.103	120
(4) Automatism caused by an external factor <i>not</i> involving consumption of substances	5.104	120
Problems	5.105	120
Our provisional proposal	5.106	121
The reformed automatism defence	5.108	121
General features	5.108	121
No prior fault	5.111	122
Denial of actus reus or of mens rea?	5.112	122
Total loss of control or loss of effective control?	5.113	122
Conclusion	5.118	123
Relationship to the recognised medical condition defence	5.119	123
Burden of proof	5.121	124
Actions or conduct?	5.122	124
Provisionally proposed defence of automatism	5.123	124
CHAPTER 6: THE RELATIONSHIP TO THE LAW ON PRIOR FAULT AND INTOXICATION		125
Principles of prior fault and culpability	6.3	125
Theoretical justifications	6.3	125
(i) For which crimes will it be possible to convict the defendant on the basis of his or her prior fault?	6.6	126

	<i>Paragraph</i>	<i>Page</i>
(ii) Level of fault in losing capacity	6.8	127
Cases involving dangerous drugs or alcohol	6.9	127
Loss of capacity by non-dangerous drugs or other conduct	6.12	127
(iii) Degree of loss of capacity	6.29	131
The interaction of prior fault (including intoxication) principles and our provisionally proposed defences	6.30	132
Involuntary intoxication under our proposals	6.38	133
Provisional proposal	6.51	136
Voluntary intoxication	6.56	138
Voluntary intoxication leading to a specific intent offence	6.60	139
Voluntary intoxication by a dangerous drug leading to a basic intent offence	6.67	141
Voluntary intoxication by a non-dangerous drug leading to a basic intent offence	6.72	142
Prior fault in causing a loss of capacity despite having a recognised medical condition	6.75	142
No prior fault in causing a loss of capacity while having a recognised medical condition	6.80	144
Concurrent and successive causes of loss of capacity	6.81	145
The current law	6.81	145
Concurrent and successive causes under our proposals	6.84	146
CHAPTER 7: PROCEDURAL QUESTIONS		150
Summary	7.2	150
Should the special verdict of not criminally responsible by reason of recognised medical condition be available in the magistrates' courts?	7.7	151
Expert evidence on mental health in the magistrates' courts	7.11	152
Seriousness of offences	7.12	152
Other available disposals	7.16	153

	<i>Paragraph</i>	<i>Page</i>
Conclusion	7.17	153
If the special verdict is to be made available in the magistrates' courts, should the same disposal be available in the magistrates' courts as in the crown court?	7.18	154
Hospital orders with restriction order	7.20	154
Magistrates' current powers in relation to restriction orders	7.20	154
Magistrates' powers if the special verdict were available	7.23	155
Conclusion	7.27	155
Supervision orders	7.29	156
The current (lack of) powers in the magistrates' court	7.29	156
Provisional proposal	7.35	157
Should the law require two expert reports to support a plea of not criminally responsible by reason of recognised medical condition?	7.36	157
The reliability of psychiatric evidence	7.43	159
Arguments for requiring two expert reports to support the defence	7.47	160
Practical concerns	7.51	161
Conclusion	7.53	161
Is it necessary and desirable for the verdict to be returned by the jury or magistrates?	7.54	162
Court time and cost considerations	7.59	163
The interests of justice	7.61	163
The determination of the disposal	7.71	166
The defendant's interests	7.75	167
Unrepresented defendants	7.80	168
Magistrates' courts	7.83	169
Conclusion	7.84	169
Provisional proposal	7.87	170

	<i>Paragraph</i>	<i>Page</i>
CHAPTER 8: THE BURDEN OF PROOF		171
The current law	8.2	171
Automatism	8.2	171
Insanity	8.4	171
The presumption of innocence	8.9	172
Discussion	8.15	174
Arguments for placing the burden of proof on the prosecution	8.15	174
The presumption of innocence in the ECHR	8.20	175
Historical accident	8.22	176
Arguments for placing the burden of proof on the defendant	8.23	176
The views of other bodies and jurisdictions	8.39	180
Conclusion	8.43	181
The defences proposed in this paper	8.46	181
The defence of recognised medical condition	8.46	181
The practicability of putting the burden of proof on the prosecution	8.52	182
Automatism	8.59	183
 CHAPTER 9: A NEW DEFENCE OF “NOT CRIMINALLY RESPONSIBLE BY REASON OF DEVELOPMENTAL IMMATURITY”?		 185
Lack of capacity	9.3	185
Our recommendations on developmental immaturity in relation to the partial defence of diminished responsibility	9.5	185
What is developmental immaturity?	9.9	186
What capacities does developmental immaturity affect?	9.14	188
Developmental immaturity and age	9.16	189
Why this issue is distinct from the proposed recognised medical condition defence	9.18	190
Conclusion	9.21	191

	<i>Paragraph</i>	<i>Page</i>
CHAPTER 10: OUR PROVISIONAL CONCLUSIONS AND PROPOSALS		192
Should there be a mental disorder defence?	10.1	192
A new defence and special verdict	10.3	192
The relevant capacities	10.3	192
A new defence and special verdict	10.6	193
Disposal following the new special verdict	10.15	194
A reformed defence of automatism	10.17	194
Relationship to prior fault and intoxication	10.19	195
Application of the intoxication rules in the common law	10.19	195
Procedural questions	10.20	195
Availability of the special verdict in the magistrates' courts	10.20	195
Magistrates' powers of disposal	10.21	195
The number of experts from whom evidence is required to support a plea	10.24	196
Court's power to accept a plea	10.25	196
Burden of proof	10.26	196
The defence of recognised medical condition	10.26	196
Automatism	10.27	196
APPENDIX A: THE QUESTION OF CRIMINAL RESPONSIBILITY		197
APPENDIX B: ANALYSIS OF RESPONSES TO INSANITY AND AUTOMATISM SCOPING PAPER		224

GLOSSARY

This is a glossary of terms and abbreviations used in this discussion paper.

STATUTES

“the 1964 Act”	Criminal Procedure (Insanity) Act 1964
“the 1983 Act”	Mental Health Act 1983
“the 1991 Act”	Criminal Procedure (Insanity and Unfitness to Plead) Act 1991
“the 2004 Act”	Domestic Violence, Crime and Victims Act 2004
“the 2005 Act”	Mental Capacity Act 2005
“the 2007 Act”	Mental Health Act 2007

REPORTS

The Bradley report	Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system (April 2009)
The Butler report	Report of the Committee on Mentally Abnormal Offenders (1975) Cmnd 6244
Scot Law Com 195	Report on Insanity and Diminished Responsibility, Scot Law Com No 195 (2004)

LAW COMMISSION PUBLICATIONS

Law Com 143	Codification of the Criminal Law – A Report to the Law Commission (1985) HC 270 Law Com No 143
Law Com 177	Criminal Law: A Criminal Code for England and Wales (1989) Law Com No 177
Law Com 304	Murder, Manslaughter and Infanticide (2006) Law Com No 304
CP 197	Unfitness to Plead (2010) Law Commission Consultation Paper No 197

Analysis of responses to CP 197

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Mackay (1995)

R D Mackay, *Mental Condition Defences in the Criminal Law* (1995)

McAuley

F McAuley, *Insanity, Psychiatry and Criminal Responsibility* (1993)

Principles of Criminal Law

A Ashworth and J Horder, *Principles of Criminal Law* (7th ed 2013)

Smith and Hogan's Criminal Law

D Ormerod, *Smith and Hogan's Criminal Law* (13th ed 2011)

Simester and Sullivan's Criminal Law

A P Simester, J R Spencer, G R Sullivan and G J Virgo, *Simester and Sullivan's Criminal Law Theory and Doctrine* (4th ed 2010)

TERMS

“Mental disorder”

- 1 The statutory definition in the Mental Health Act 1983 is “any disorder or disability of the mind”: section 1(2) of the 1983 Act, as amended by section 1 of the Mental Health Act 2007.
- 2 At first glance, therefore, learning disabilities, being disabilities of the mind, fall within this definition of “mental disorder”. However, a person with a learning disability is expressly excluded from the definition of person suffering from mental disorder for the purposes of specific provisions in the 1983 Act, “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”. Those provisions confer a power on a court or tribunal to make an order for detention or treatment or to discharge a person from hospital or as a community patient.
- 3 A person with a learning disability “shall not be considered by reason of that disability to be ... suffering from mental disorder”, for the purposes of sections 3,¹ 7,² 17A,³ 20,⁴ 20A,⁵ 35 to 38,⁶ 45A,⁷ 47,⁸ 48,⁹ 51,¹⁰ 72(1)(b) and (c)¹¹ and 72(4)¹²

¹ Admission to hospital for treatment.

² Application for a guardianship order under the civil part of the Act.

³ A community treatment order.

of the 1983 Act, “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”.¹³ Some of the powers are not in this list: most notably admission to hospital for assessment (which is therefore available to those with a learning disability as well).

- 4 The Mental Health Act 1983 Code of Practice states that the “learning disability qualification” (referred to in the paragraph above) only applies to specific sections of the Act: “in particular, it does not apply to detention for assessment under section 2 of the Act” (para 3.15). Also, the qualification does not apply to autistic spectrum disorders including Asperger’s syndrome (para 3.16). That is, the definition of “mental disorder” in the 1983 Act includes the “full range of autistic spectrum disorders” (para 34.18).
- 5 Therefore, in assessing whether the definition of “mental disorder” at section 1(2) of the 1983 Act includes or excludes learning disabilities in any particular situation, one has to take account of which specific power set out in the Act is relevant, and also whether the disability is associated with particular kinds of conduct.
- 6 The relevance of dependence on alcohol or drugs is that:

Dependence on alcohol or drugs does not come within the meaning of “mental disorder” for the purposes of the Mental Health Act 1983 (section 1(3)). However, mental disorders which accompany or are associated with the use of or stopping the use of alcohol or drugs, even if they arise from dependence on those substances, may come within the meaning of “mental disorder” for the purposes of the Mental Act 1983.¹⁴

“Mental illness”

- 7 “Mental illness” was one of the four categories of “mental disorder” under section 1(2) of the 1983 Act before the 2007 Act replaced the categorisation with a single

⁴ The duration of authority for detention in hospital or guardianship.

⁵ Community treatment period.

⁶ Powers to remand a person in hospital or to order hospital admission, or make an interim hospital order.

⁷ Power of higher courts to order hospital admission.

⁸ Power to transfer a sentenced prisoner to hospital.

⁹ Power to transfer a prisoner on remand to hospital.

¹⁰ Further powers relating to detained persons.

¹¹ Powers of tribunals to discharge a person in hospital or as a community patient [(a) related to power to discharge a patient detained under s.2 (admission for assessment)].

¹² Power of tribunal to discharge a person from a guardianship order.

¹³ Section 1(2A) of the 1983 Act.

¹⁴ CPS, *Mentally Disordered Offenders*
http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/#a05 (last visited 15 Mar 2012).

definition of mental disorder.¹⁵ However, there was no statutory definition of mental illness in the 1983 Act.

- 8 The Mental Health Act 1983 Code of Practice defines “mental illness” as “an illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia” (Annex A).

“Mental distress”

- 9 This term is used by Mind,¹⁶ but it is not defined:

Mind generally uses this term as it more accurately reflects the broad spectrum of fluctuating symptoms people may experience and the fact that some people may not have been diagnosed with a condition. The term also avoids both the diagnostic implications of ‘mental health conditions’ and the negative connotations of ‘mental health problems’.¹⁷

“Personality disorder”

- 10 The Department of Health explains personality disorders in the following terms:¹⁸

Personality disorder is a recognised mental disorder. ... The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)¹⁹ currently defines personality disorder as “An enduring pattern of inner experience and behaviour that deviates markedly from the individual’s culture.” DSM-IV describes ten personality disorder types, split into three clusters:

Cluster A – (“odd or eccentric”) paranoid, schizoid, schizotypal;

Cluster B – (“dramatic, emotional or erratic”) histrionic, narcissistic, antisocial, borderline;

Cluster C – (“anxious and fearful”) obsessive-compulsive, avoidant, dependent.

Antisocial and borderline personality disorders are the most common in criminal justice settings. People with antisocial personality disorder will exhibit “traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is

¹⁵ The four categories were: mental illness, mental impairment, severe mental impairment and psychopathic disorder.

¹⁶ Mind is a leading mental health charity for England and Wales.

¹⁷ Mind, *Achieving Justice for Victims and Witnesses with Mental Distress: A Mental Health Toolkit for Prosecutors and Advocates* (2010) p 6.

¹⁸ Department of Health, *Consultation on the Offender Personality Disorder Pathway Implementation Plan* (2011) paras 13 to 15.

¹⁹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed 1994) DSM-IV, <http://allpsych.com/disorders/personality/index.html> (last visited 22 Jan 2012). A fifth edition of the manual has since been published.

manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others." (NICE, 2009)²⁰

Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide" (NICE, 2009).²¹

- 11 An alternative definition of personality disorder is given by Cooke and Hart²² who said that it can be described:

In terms of the three Ps: pathological (significantly deviating from the social norms), persistent (from a person's twenties onwards) and pervasive (present within personal and social contexts across the domains of cognitive, affective and interpersonal functioning).

- 12 The 1983 Act no longer distinguishes between different forms of mental disorder. It, therefore, "applies to personality disorders (of all types) in exactly the same way as it applies to mental illness and other mental disorders".²³

"Mentally disordered offenders"

- 13 The full definition given by Nacro²⁴ on their website of "offenders with mental health issues or learning disability" is as follows:

Those who come into contact with the criminal justice system because they have committed, or are suspected of committing, a criminal offence and:

who may be acutely or chronically mentally ill

who have neuroses, behavioural and/or personality disorders

²⁰ National Institute for Health and Clinical Excellence, *Antisocial Personality Disorder: Treatment Management and Prevention* (2009) <http://www.nice.org.uk/Guidance/CG77> (last visited 15 Mar 2012).

²¹ National Institute for Health and Clinical Excellence, *Borderline Personality Disorder Treatment and Management* (2009) <http://www.nice.org.uk/Guidance/CG78> (last visited 15 Mar 2012).

²² J Crassati, "The Paradoxical Effects of Stringent Risk Management" in N Padfield (ed) *Who to Release?* (2007) pp 218 to 219 citing D J Cooke and S D Hart, "Personality Disorders" in E V Johnstone and others (eds) *Companion to Psychiatric Studies* (7th ed 2004) p 503.

²³ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 3.18.

²⁴ Nacro is a crime reduction charity for England and Wales.

who have a learning disability or learning difficulties

who have a mental health problem as a function of alcohol and/or substance misuse

who are suspected of falling into one or other of these groups

who are recognised as having a degree of mental disturbance, even if this is not sufficiently severe to come within the MHA criteria

who do not fall easily within this definition but may benefit from psychological treatments – for example, some sex offenders and some abnormally aggressive offenders.

- 14 This broad definition reflects Nacro's concern to concentrate not just on a narrow group of offenders whose mental disorders fall within the Mental Health Act criteria. They also want to address the wider range of problems associated with people who have some degree of mental disturbance or learning disability and warrant a range of care, support and, in some cases, treatment.
- 15 The expression "offenders with mental health problems or learning disabilities" is used by the Crown Prosecution Service when referring to the wider policy context, but the statutory definition of "mentally disordered offender" (meaning an offender with a "mental disorder" as defined by section 1(2) of the 1983 Act) is referred to when discussing prosecutors' decision-making.²⁵

Learning disabilities and learning difficulties

- 16 In its report on the *No One Knows* programme²⁶ the Prison Reform Trust acknowledged that "learning disabilities" and "learning difficulties" are often used interchangeably, as, for example, in the Bradley report.²⁷ The Prison Reform Trust gives this overall description:

No One Knows has included in its scope people who find some activities that involve thinking and understanding difficult and who need additional help and support in their everyday living. The term learning disabilities or difficulties thus include people who: experience difficulties in communicating and expressing themselves and understanding ordinary social cues; have unseen or hidden disabilities such as dyslexia; experience difficulties with learning and/or have had disrupted learning experiences that have led them to function at a significantly lower level than the majority of their peers;

²⁵ CPS, *Prosecution of Mentally Disordered Offenders with Mental Health Problems* (June 2010)
http://www.cps.gov.uk/publications/research/offenders_with_mental_health_problems.html#definitionalissues (last visited 15 Mar 2012).

²⁶ This is a programme of work covering several reports. Prison Reform Trust, *Prisoners' Voices: Experiences of the Criminal Justice System by Prisoners With Learning Disabilities and Difficulties* (2008) p 2.

²⁷ The Bradley report, p 20.

[or] are on the autistic spectrum, including people with Asperger's syndrome.²⁸

- 17 The terms "learning disability" and "learning difficulty" can, however, be distinguished.

"Learning disability"

- 18 There are a number of definitions in use which we include here. We do not adopt any particular one in this consultation paper. This is the Department of Health definition, adopted by the Bradley report:

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning); and which started before adulthood, with a lasting effect on development.²⁹

- 19 The Joint Committee on Human Rights commented on this definition that it "covers people with an autistic spectrum disorder who also have learning disabilities, but excludes those with average or above average intelligence who have an autistic spectrum disorder, like Asperger's Syndrome".³⁰

- 20 There is a statutory definition, at section 1(4) of the 1983 Act:³¹

A state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.³²

- 21 The Code of Practice elaborates on the separate elements of the statutory definition:³³

Arrested or incomplete development of mind: An adult with arrested or incomplete development of mind is one who has experienced a significant impairment of the normal process of maturation of intellectual and social development that occurs during childhood and adolescence. By using these words in its definition of learning disability, the Act embraces the general understanding that features which qualify as a learning disability are present prior to adulthood. For the purposes of the Act, learning disability does not include people whose intellectual disorder derives from accident, injury or illness occurring after they completed normal maturation (although

²⁸ Prison Reform Trust, *Prisoners' Voices: Experiences of the Criminal Justice System by Prisoners with Learning Disabilities and Difficulties* (2008) p 3.

²⁹ Department of Health, *Valuing People: A New Strategy for Learning Disability for the 21st Century* (2001) adopted by the Bradley report at p 19.

³⁰ A Life Like Any Other? Human Rights of Adults with Learning Disabilities, Joint Committee on Human Rights (2007-08) HL Paper 40-I, HC 73-I, para 7.

³¹ Inserted by s 2(3) of the 2007 Act.

³² This does not include autistic spectrum disorders, including Asperger's syndrome, as they fall within the definition of mental disorder in the 1983 Act. It would be inconsistent to say that autistic spectrum disorders are included in the definition of learning disabilities given that they do not fall within the "learning disability qualification": see para 4 above.

³³ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 34.4

such conditions do fall within the definition of mental disorder in the Act).

Significant impairment of intelligence: The judgment as to the presence of this particular characteristic must be made on the basis of reliable and careful assessment. It is not defined rigidly by the application of an arbitrary cut-off point such as an IQ of 70.

Significant impairment of social functioning: Reliable and recent observations will be helpful in determining the nature and extent of social competence, preferably from a number of sources who have experience of interacting with the person in social situations, including social workers, nurses, speech and language and occupational therapists, and psychologists. Social functioning assessment tests can be a valuable tool in determining this aspect of learning disability.

- 22 The World Health Organisation uses the following definition:

A reduced level of intellectual functioning resulting in diminished ability to adapt to the daily demands of the normal social environment.³⁴

- 23 The Prison Reform Trust, in its report on the *No One Knows* programme, describes some common characteristics of people with learning disabilities:

People with learning disabilities, also referred to as intellectual disabilities, are likely to have limited language ability, comprehension and communication skills, which might mean they have difficulty understanding and responding to questions; they may have difficulty recalling information and take longer to process information; they may be acquiescent and suggestible (Clare, 2003) and, under pressure, may try to appease other people (Home Office Research Findings, 44).³⁵

“Learning difficulty”

- 24 The following definition comes from the Education Act 1996, and was adopted by the Bradley report:

A child has learning difficulty if: he has a significantly greater difficulty in learning than the majority of children his age, or he has a disability which either prevents or hinders him from making use of educational facilities of a kind generally provided for children of his age in schools within the area of the local education authority.³⁶

- 25 The Prison Reform Trust states:

³⁴ World Health Organisation, *ICD-10 Guide for Mental Retardation* (1996).

³⁵ Prison Reform Trust, *Prisoners’ Voices: Experiences of the Criminal Justice System by Prisoners with Learning Disabilities and Difficulties* (2008) p 85.

³⁶ The Education Act 1996 s 312 (1) and (2) adopted by the Bradley report at p 19.

Specific learning difficulties, of which dyslexia is the most common, cover a range of impairments including dyspraxia, dyscalculia, attention deficit disorder (ADD) and attention deficit hyperactive disorder (ADHD).³⁷

³⁷ Prison Reform Trust, *Prisoners Voices: Experiences of the Criminal Justice System by Prisoners with Learning Disabilities and Difficulties* (2008) p 85.

CHAPTER 1

INTRODUCTION

- 1.1 The criminal law provides a defence for people who, as a result of their mental condition, should not be held responsible for what would otherwise be criminal conduct. This is the defence of “insanity” and the present form of that defence dates from 1843.
- 1.2 The existing law has long been the subject of academic criticism for being unfair, out of date and failing to reflect advances made in medicine, psychology and psychiatry. Various bodies have reviewed the defence of insanity and recommended reform but the substance of the defence has remained unchanged, and so the faults persist.
- 1.3 In this chapter we start by explaining how the work contained in this paper links to the related issue of a defendant’s unfitness to plead, including why this is a Discussion Paper rather than a consultation paper. We then give a brief introduction to the law, review the problems with the law, and conclude with an overview of how the law could be reformed. This Discussion Paper allows us to publicise our provisional proposals for reform although we are not holding a consultation on them at this stage.

OUR WORK ON THE LINKED TOPICS OF UNFITNESS TO PLEAD AND THE DEFENCE OF INSANITY

- 1.4 We stated our intention to examine the law governing the test for unfitness to plead and to stand trial and the defence of insanity in our Tenth Programme of Law Reform in 2008.¹ Both the test for unfitness to plead and the insanity defence are founded on nineteenth century legal concepts which have not kept pace with developments in medicine, psychiatry and psychology.

The relationship between the law on unfitness to plead and the defence of insanity

- 1.5 Unfitness to plead is concerned with the question of an accused’s mental state at the time of his or her trial and not at the time of the offence. If a person is unfit to plead, he or she cannot be tried in the same way as a person who is fit. An unfit accused is therefore subject to a hearing but not to a trial, whereas a person who pleads the defence of insanity goes through the normal criminal trial process. At the hearing for the unfit accused the prosecution seeks to establish whether the accused “did the act or made the omission” with which he or she is charged. As there is no trial for the person who is unfit to plead, there is no prospect of a conviction, whereas a trial in which a plea of insanity is raised offers the prospect of a special verdict – not guilty by reason of insanity – and the prospect of conviction if the plea fails.
- 1.6 The issues of insanity and unfitness overlap in that a mental disorder which an accused has at the time of his or her hearing may have affected him or her at the

¹ Tenth Programme of Law Reform (2008) Law Com No 311.

time of the commission of the offence, but they concern different kinds of capacity relevant at different stages of the criminal process.

Unfitness to plead

- 1.7 We started our work on these linked issues by publishing a consultation paper containing provisional proposals for reform of unfitness to plead in 2010.² Our analysis of the responses to that paper and the responses themselves were published in April 2013.³ We are now in the process of refining our proposals for reform on unfitness in light of the feedback from consultees, and we plan to publish a report in 2014.

The insanity defence

- 1.8 We are convinced, on the basis of our research to date, the vast wealth of academic literature and the reform proposals made by others, that there are significant problems with the law when examined from a theoretical perspective. There is, however, less evidence that the defences cause significant difficulties in practice and a dearth of published research into the operation of the defences. We therefore published a Scoping Paper in July 2012 in which we asked 76 questions of consultees to discover how the defences of insanity and automatism are working in the criminal law of England and Wales, if at all.⁴ Twenty written responses were received and one telephone response. Most of the written responses were sent on behalf of an organisation or represented the views of more than one person. An analysis of the responses to the Scoping Paper is published as appendix B to this paper.
- 1.9 We have considered issuing a similar paper to gain evidence of the problems that the law relating to unfitness to plead generates in practice, but found that the responses we received to our Scoping Paper on insanity provided that information.

The way forward

- 1.10 It was notable that the responses to the Scoping Paper elicited little evidence of a practical problem in relation to the operation of the insanity defence. Legal and medical practitioners said that while academic criticisms of the defences are justified, they work round the problems. They commented that as regards mental disordered offenders, there are other aspects of the criminal justice system which merit change ahead of the insanity and automatism defences. In particular, many respondents told us that the more practically-needed reform is to the law and procedures relating to unfitness to plead. We anticipate greater governmental support for reform where it is acknowledged that there is a practical need for it.

² Unfitness to Plead (2010) Law Commission Consultation Paper No 197 (“CP 197”), http://lawcommission.justice.gov.uk/docs/cp197_Unfitness_to_Plead_consultation.pdf

³ <http://lawcommission.justice.gov.uk/areas/unfitness-to-plead.htm>

⁴ Alongside the Scoping Paper we published supplementary material in which we examined the law in detail, including findings from existing research into the insanity defence in practice, the law in other jurisdictions, and the proposals of previous reviews. We set out the problems with the existing law briefly in the Scoping Paper, and at length in the supplementary material.

- 1.11 We have to prioritise our work, within our available resources, to deal with the area of reform in which we can have the most beneficial impact on the criminal justice system. In light of responses to the Scoping Paper, that means prioritising our work on reforming unfitness to plead.
- 1.12 It is also more logical to reach conclusions about reform of the test of unfitness to plead ahead of changes to the defences of insanity and automatism because of the filtering function that the test of unfitness to plead performs, as we now explain.
- 1.13 The question of whether a person is unfit to plead and to stand trial arises, in the criminal justice process, before a defence is put in evidence: the plea comes first. As we showed in CP 197, the legal criteria used to judge whether an accused is unfit to plead are, at best, not comprehensive and place a disproportionate emphasis on low intellectual ability. At worst, they set the threshold for unfitness too high. In the magistrates' courts there is not even a procedure available for assessing an accused's unfitness to stand trial. The law has the effect of limiting the number of people who are found unfit to plead and it could mean that many people are tried when they should not be.
- 1.14 If the legal test for unfitness to plead were reformed, then the number of people with serious mental disorder who face trial would decrease, and so the number of people who might need or seek to rely on a reformed insanity defence would be even smaller than it already is. Reforms to unfitness to plead would therefore have a direct effect on the impact of reforms to the defences of insanity and automatism.
- 1.15 For these reasons, we have decided to prioritise our work on unfitness to plead, and this paper is in the form of a discussion paper rather than a consultation paper. It seems to us that consultation would not be, at this time, the best use of resources, and we are not, therefore, inviting responses to this paper. We would like to return to the reform of insanity and automatism following progress on unfitness to plead.
- 1.16 This paper contains our provisional proposals for reform to the defence of insanity and the linked defence of automatism. In publishing these proposals we aim to contribute to the broader public debate on the reform of the criminal justice system as it relates to mentally disordered defendants. The Court of Appeal has recently stated that it welcomes our examination of the related issues of insanity, automatism and intoxication.⁵ We are conscious that these defences are only one part of a multi-faceted picture. As Professor Peay has written:

the relationship between the criminal justice process and the mental health world is amongst the most complex with which either has to grapple.⁶

- 1.17 It seems to us that a comprehensive review of mentally disordered offenders and the criminal law is needed, but that is outside the scope of this project and our current resources. It would also not attract government support at this time. In

⁵ C [2013] EWCA Crim 223 at [61].

⁶ J Peay, *Mental Health and Crime* (2011) p 199.

this paper, we therefore take account of what others are doing in respect of mentally disordered offenders,⁷ and offer our expertise on the narrower issues of the criminal defences.

THE CENTRAL QUESTION IN THIS PAPER

- 1.18 The question at the heart of this paper is whether the law has the right test to distinguish between those who should be held criminally responsible for what they have done, and those who should not because of their condition.
- 1.19 If it is right to excuse a person from criminal responsibility because of his or her mental state, what kind of mental disorder warrants not holding a person responsible in criminal law for what they do? More generally, what kind of disorder – whether mental or physical – justifies not holding a person criminally responsible?
- 1.20 We take the view that it is unjust to hold people criminally responsible when they could not have avoided committing the alleged crime, through no fault of their own. Put another way, a person should be exempted from criminal responsibility if he or she totally lacked capacity to conform to the relevant law. A necessarily brief discussion of the foundations of criminal responsibility appears at Appendix A to this paper.
- 1.21 Some commentators argue that there is no need for a separate mental disorder defence because the elements of an offence can provide a sufficient opportunity to take account of a defendant's lack of capacity. The usual principles of criminal law require the prosecution to prove the elements of an offence. If they cannot be proved then an acquittal results. These commentators would argue, therefore, that if mens rea (mental element of an offence) cannot be proved because of the mental illness that the accused was suffering at the time then the accused should be acquitted, and that if the elements of the offence can be proved then the accused should be convicted no matter how mentally disordered he or she was. We consider this argument in chapter 2 of this paper and reject it. Our view is that there should, at least, be a defence of non-responsibility based on a person's mental condition at the time of the alleged offence. In fact, we conclude that, where it leads to a total loss of capacity, there is no need to restrict a defence of non-responsibility to his or her mental condition; on the contrary, there is good reason to include physical conditions within a defence of non-responsibility where they also lead to a total loss of capacity.
- 1.22 We therefore provisionally propose a new defence of "not criminally responsible by reason of recognised medical condition" which would replace the existing insanity defence. The new defence is described in outline in chapter 3, including a discussion about what it should be called, and in full in chapter 4.

⁷ Such as the implementation of the recommendations in the Bradley report (see the glossary), and resources developed via the Advocate's Gateway: <http://www.theadvocatesgateway.org/> (last visited 22 May 2013). We use the phrase "mental disorder" to encompass all mental illnesses, disorders and disabilities of the mind including learning disabilities and difficulties. Some of the definitions that are commonly used are set out in the glossary, including those of "mental disorder", "learning disability" and "learning difficulty".

THE DEFENCES OF INSANITY AND AUTOMATISM: THE PRESENT LAW

Insanity

- 1.23 In order to be convicted of a crime, the prosecution must prove that the accused did what is alleged in the charge and, in most cases, that he or she did so with a particular mental element. The accused might rely on defences including that of “insanity”. The insanity defence is set out in “the M’Naghten Rules” as laid down by the House of Lords in 1843:

to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.

- 1.24 The defendant bears the burden of proving on the balance of probabilities that he or she is insane within that test. If the test is met, in the Crown Court the defendant is found “not guilty by reason of insanity” which is known as the “special verdict”.
- 1.25 A person found not guilty by reason of insanity has not been convicted of any crime and so he or she cannot be sentenced. The term “disposal” is therefore used to describe the ways in which a court may deal with such a person. Following a special verdict, the Crown Court has the power to make an absolute discharge, a supervision order,⁸ or to order that the person be detained in hospital, possibly with the restriction that he or she is not to be released until permission is given by the Secretary of State. Permission for release will depend on the person’s mental health and the risk to the public that he or she poses. The position is different in the magistrates’ courts, and the range of disposal powers is narrower.
- 1.26 The issue of disposal is important, but it is distinct from the question of who should be exempted from criminal liability in the first place.

Automatism

- 1.27 If a person totally lacked control of his or her body at the time of the offence, and that lack of control was not caused by his or her own prior fault, then he or she may plead not guilty and may be acquitted. This is referred to as the defence of automatism. It is a common law defence and it is available for all crimes.
- 1.28 Once the accused has called enough evidence to make automatism a live issue in the trial, the prosecution must disprove the defence; if they fail to do so the defendant will be acquitted. There is no special verdict.
- 1.29 The defence of automatism is evidently so closely related to that of insanity that reform of one entails reform of the other.

⁸ A supervision order is an order that requires a person to be under the supervision of a social worker or an officer of a local probation board (“the supervising officer”) for a period specified in the order of not more than two years: sch 1A to the Criminal Procedure (Insanity) Act 1964 (inserted by virtue of s 24(2) and sch 2, para 1 to the Domestic Violence, Crime and Victims Act 2004).

PROBLEMS WITH THE PRESENT LAW

- 1.30 We turn now to an examination of the problems with the present law.⁹ The precise wording of the central part of the M’Naghten Rules is as follows, with numbers added to assist in following the subsequent discussion:

Jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes until the contrary be proved to their satisfaction and that to establish a defence on the ground of insanity, it must be clearly proved that, (1) at the time of the committing of the act, (2) the party accused was labouring under such a defect of reason, (3) from disease of the mind as (4) not to know the nature and quality of the act he was doing, or (5) if he did know it, that he did not know he was doing what was wrong.¹⁰

(1) The requirement to prove D’s “act”

- 1.31 In the Crown Court, for the verdict of not guilty by reason of insanity to be given, the prosecution must prove that the accused “did the act or made the omission”.¹¹ This means that the prosecution have to prove “the ingredients which constitute the actus reus”,¹² and are not required to prove any mental element (mens rea).¹³ The actus reus can be described as the conduct element of an offence. For example, in the case of criminal damage, the actus reus is causing damage to property belonging to another.
- 1.32 It is not always easy to identify precisely what must be proved because in some instances the elements of an offence cannot easily be classified as either actus reus or mens rea. In cases where the actus reus realistically requires some awareness of the action (such as where a person possesses or keeps an item, or permits an activity)¹⁴ it is not so obvious. The case law acknowledges this difficulty but leaves it unresolved.¹⁵
- 1.33 This problem is not confined to only a few offences. In recent years, large numbers of offences have been created which blend a mental element into the actus reus. Difficulties would arise if a plea of not guilty by reason of insanity was raised by a defendant facing charges for such an offence.¹⁶

⁹ We set them out fully in the Scoping Paper and the Supplementary Material to the Scoping Paper.

¹⁰ *M’Naghten’s Case* (1843) 10 Clark and Finnely 200, 210, (1843) 8 ER 718, [1843-60] All ER Rep 229.

¹¹ Trial of Lunatics Act 1883, s 2(1).

¹² *A-G’s Reference (No 3 of 1998)* [2000] QB 401, 411.

¹³ *Antoine* [2001] 1 AC 340, 345.

¹⁴ See the commentary by Sir John Smith at [2002] *Criminal Law Review* 588, 589.

¹⁵ In *R (Young) v Central Criminal Court* the trial judge noted, “this distinction cannot be rigidly adhered to in every case because of the diverse nature of criminal offences and criminal activity”: [2002] EWHC 548 (Admin), [2002] 2 Cr App R 12 at [12], by Rose LJ.

¹⁶ See CP 197, paras 6.28 and 6.29 and *B* [2012] EWCA Crim 770, [2013] 1 WLR 499 for examples of such offences.

- 1.34 We asked consultees whether this problem had thrown up difficulties in practice. One respondent provided an example of a case of assault where the accused believed he was defending himself. The CPS pointed out a further consequence of this problem:

In cases where a mental element has been blended into the actus reus, the “trial of facts” is indistinguishable from the full trial so where the “actus reus” has not been proved beyond reasonable doubt the defendant is acquitted. The original purpose of the trial of facts was to protect the defendant from being subject to the power of the criminal court to commit him to hospital for an indefinite period, where there was no evidence that he had committed an offence. The purpose of the special verdict is also frustrated as in its absence the court has no power to make a hospital order for the therapeutic benefit of the defendant or a restriction order to protect the public.

(2) The interpretation of “defect of reason”

- 1.35 The term “defect of reason” has been interpreted to mean that for the defence of insanity to operate, the accused’s powers of reasoning have to be impaired at the time of the commission of the offence. A mere failure to use powers of reasoning is not enough.¹⁷ Momentary failure of concentration, even where caused by mental illness, is not insanity within the M’Naghten Rules.
- 1.36 The definition of “defect of reason” also excludes from the scope of the insanity defence abnormalities of mind such as an inability to control one’s emotions or compulsions.¹⁸ These do not reflect impaired powers of reasoning. This narrow construction of the defence has met with telling criticism from leading academics. As Professor Ashworth notes, “some forms of mental disorder impair practical reasoning and the power of control over actions”. He argues that it follows that the power of controlling one’s actions “should clearly be recognized as part of a reformed mental disorder defence”.¹⁹

(3) Disease of the mind

- 1.37 The M’Naghten test requires the accused to be suffering from a “defect of reason from disease of the mind”. The kind of disorder that is relevant is not necessarily a disease in the ordinary sense of that word, and the word “mind” is not interpreted to mean “brain”.
- 1.38 Significantly, therefore, “disease of the mind” is not limited to mental illness: “it means a disease which affects the proper functioning of the mind”.²⁰ “Mind” here

¹⁷ *Clarke* [1972] 1 All ER 219, 221, by Ackner J.

¹⁸ *Kopsch* (1927) 19 Cr App Rep 50; *A-G of South Australia v Brown* [1960] AC 432.

¹⁹ *Principles of Criminal Law* p 145.

²⁰ *Hennessy* [1989] 1 WLR 287, 292, by Lord Lane CJ.

means, in the words of Lord Diplock, “the mental faculties of reason, memory and understanding”.²¹ What matters is the effect of the impairment, as he explained:

If the effect of a disease is to impair these faculties so severely as to have either of the consequences referred to in the latter part of the rules, it matters not whether the aetiology of the impairment is organic, as in epilepsy, or functional, or whether the impairment itself is permanent or is transient and intermittent, provided that it subsisted at the time of commission of the act.²²

- 1.39 Judges give the phrase a more modern interpretation in practice: in the guidance given to judges on how to direct the jury “disease of the mind” is described as “an impairment of mental functioning caused by a medical condition”.²³
- 1.40 Some conditions are clearly going to be regarded as diseases of the mind, for example, schizophrenia. However, one consequence of the courts’ broad interpretation of “disease of the mind” is that people with conditions that would not be described generally as mental disorders have been held to come under the M’Naghten understanding of insanity. These include, for example, sleepwalkers, and people with epilepsy or diabetes.²⁴
- 1.41 This has come about because the law has not distinguished between mental disorders and physical disorders so that the latter are outside the notion of “disease of the mind” in M’Naghten. Instead, it has adopted a distinction between whether the cause of the accused’s lack of control was due to an “internal factor” (ie some malfunctioning of the person’s body) or an “external factor” (such as a blow to the head or substances taken). Involuntary conduct caused by an “internal factor” is classed as insanity and that leads to the special verdict. Involuntary conduct caused by an “external factor” is classed as (sane) automatism, leading to a simple acquittal. This leads to illogical results. The “line drawn between sane and insane automatism can never make medical sense”.²⁵ It “makes illogical, hair-splitting distinctions inevitable, allowing some an outright acquittal while condemning others to plead guilty or take the risk of a special verdict”,²⁶ and, as Lord Justice Hughes has recently said:

²¹ *Sullivan* [1984] AC 156, 172. The defendant claimed that he had committed the alleged assault while suffering a seizure caused by psychomotor epilepsy. He argued that his defence of “non-insane automatism” ought to have been left to the jury. The Court of Appeal rejected the appeal, as did the House of Lords.

²² *Sullivan* [1984] AC 156, 172.

²³ Judicial Studies Board, *Crown Court Bench Book* (March 2010) p 327.

²⁴ About 600,000 people in the United Kingdom have been diagnosed as having epilepsy: Epilepsy Action, <http://www.epilepsy.org.uk/info/basics/living-with-epilepsy> (last visited 24 Apr 2013). More than 2.7 million people in England and Wales have diabetes: <http://www.diabetes.org.uk/Professionals/Publications-reports-and-resources/Reports-statistics-and-case-studies/Reports/Diabetes-prevalence-2012-March-2013/> (last visited 24 Apr 2013).

²⁵ P Fenwick, “Automatism, Medicine and the Law” (1990) 17 *Psychological Medicine, Monograph Supplement* 23.

²⁶ W Wilson, I Ebrahim, P Fenwick and R Marks, “Violence, Sleepwalking and the Criminal Law: Part 2: The Legal Aspects” [2005] *Criminal Law Review* 614, 617.

It is well known that the distinction drawn in *Quick* between external factors inducing a condition of the mind and internal factors which can properly be described as a disease can give rise to apparently strange results at the margin.²⁷

1.42 The application of the law to diabetics demonstrates this most starkly. Diabetics may suffer excessively high blood sugar (hyperglycaemia) or excessively low blood sugar (hypoglycaemia), and both states may be caused by “external factors” (alcohol or insulin) or “internal factors” (lack of food or insufficient insulin). In *Hennessy*,²⁸ the defendant had a hyperglycaemic episode caused by his failure to take a prescribed dose of insulin. His loss of control was created by a factor internal to him so his reliance on that at trial was classified as a plea of insanity. In contrast, in *Quick*²⁹ the loss of control arose when a diabetic suffered a hypoglycaemic attack following his failure to eat after taking insulin. His loss of control was an external cause and was therefore classified as an automatism plea. The Court of Appeal held that there will be no “disease of the mind” under the M’Naghten Rules where a malfunction was “caused by the application to the body of some external factor such as violence, drugs, including anaesthetics, alcohol and hypnotic influences”.

1.43 The upshot is that a diabetic who, without fault, fails to take insulin and then commits an allegedly criminal act would be treated as insane. In contrast, a diabetic who took insulin in accordance with a medical prescription would be acquitted if he or she was an automaton at the time of committing an allegedly criminal act, whether that was because he or she had an unexpected reaction to the insulin or because having taken the insulin he or she failed to eat through no fault of their own. As Professor Ashworth has written:

There can be no sense in classifying hypoglycaemic states as automatism and hyperglycaemic states as insanity, when both states are so closely associated with such a common condition as diabetes.³⁰

1.44 Beyond its application to diabetes, another basis for criticism is that with some conditions, both internal and external factors may operate simultaneously, as in sleepwalking or hypnosis: some people are more susceptible to sleep disorders, but then there may be an external trigger (an interruption to sleep) which also plays a part in loss of capacity.

1.45 A yet further difficulty with this boundary between internal (insanity) and external (automatism) has arisen in so-called “psychological blow” cases where the accused enters into a dissociative state following a traumatic event. We discuss this in the context of automatism (see paragraph 5.47 and following below).

²⁷ C [2013] EWCA Crim 223 at [20], [2013] All ER (D) 06 (Apr).

²⁸ [1989] 1 WLR 287.

²⁹ [1973] QB 910.

³⁰ Principles of Criminal Law p 94.

- 1.46 We noted in the supplementary material to the Scoping Paper³¹ that a diabetic who falls into a hyperglycaemic coma and then commits an offence may be surprised and offended to hear a court rule that, following precedent, because his or her loss of voluntary control was *internal*, namely arising from the condition of diabetes, if he or she wishes to plead not guilty on the basis of the medical condition, it must be a plea of not guilty by reason of insanity. One respondent to the Scoping Paper wrote that it was “unpalatable” that he, as a diabetic, should be labelled “insane” in law, and Lord Justice Davis wrote that the distinction between internal and external conditions is “illogical, little short of a disgrace and should be abolished”. Lord Justice Davis presided over the trial of Brian Thomas, who was charged with murder of his wife. His defence was that he killed her when he was in the throes of “night terror violence” (akin to sleepwalking). The prosecution decided not to proceed with the case.³² Other than this case, however, only one other instance was provided of a sleepwalking case which ought, in the respondent’s view, to have been dealt with under the M’Naghten Rules.³³
- 1.47 Despite the breadth of the definition of disease of the mind, the other elements of the M’Naghten Rules are construed so narrowly that the defence will be denied to many with serious mental disorders. We turn now to consider the core elements of the defence.

(4) The “nature and quality of the act”³⁴

- 1.48 One way in which a defendant might satisfy the M’Naghten Rules, and thereby be found insane, is by showing that he or she did not know the nature and quality of his or her act. This nature and quality limb of the defence may be thought too narrow in two ways. First, it is based on an unduly narrow concept of what must be known. The courts have held that the insanity defence is unavailable if the defendant has knowledge of the *physical* aspects of the act alleged even if he or she does not have knowledge of the moral aspects of his or her act.³⁵ It is clear that in this (physical) sense it will be very rare indeed for a person with a relevant medical or physical condition not to know the nature and quality of his or her actions. Secondly, an exclusive focus on cognitive questions excludes other sorts of problems in the functioning of minds and brains, such as mood disorders or emotional problems.

(5) “He did not know he was doing what was wrong”

- 1.49 The second way in which the defendant might rely on insanity is if he or she can satisfy the “wrongfulness limb” of the M’Naghten Rules by showing that even if he or she was aware of the nature and quality of the act he or she was not aware that it was wrong. The issue of interpretation that has troubled the courts here is whether “wrong” means “contrary to law”, or “morally wrong”.

³¹ See para 1.31 of the Supplementary Material to the Scoping Paper.

³² For further details see para B.63 in Appx B below.

³³ See para B.61 in Appx B below.

³⁴ See para 2.37 and following of the Scoping Paper.

³⁵ *Codère* (1917) 12 Cr App Rep 21, 27. See also R D Mackay, “Mental Disability at the Time of the Offence” in L Gostin and others (eds), *Principles of Mental Health Law and Policy* (2010) p 723.

- 1.50 English law has adopted an unusually, and arguably unjustifiably, narrow interpretation of the “wrongfulness” limb. In *Windle*,³⁶ Lord Goddard interpreted it as meaning that if the accused knew that what he or she is doing was against the law, then the insanity defence is not available. The effect has been:

To close off the possibility of expanding the interpretation of the word “wrong” ... to include situations where the accused’s mental disorder prevented him from realizing that his actions could not be rationally justified.³⁷

- 1.51 Consider, as an example, the US case of Andrea Yates.³⁸ Yates, a woman with a history of mental illness, drowned all five of her children in a bath. Believing that Satan had been conversing with her, she concluded she needed to kill her children while they were still innocent to save them from an eternity of torment in hell. Yates knew she was killing her children and a sign of her premeditation was her awareness of the special problem her eldest child Noah (aged 7) would pose to her course of action, given his developing physical strength. According to the “nature and quality” limb as interpreted by *Codère*,³⁹ Yates did know the nature and quality of her acts. Someone in her position would not be able to rely on this limb of the insanity defence in English law.

(6) Incoherence

- 1.52 A further theoretical problem, and one with potentially significant practical consequences, is that it is unclear whether the insanity defence is essentially a denial of mens rea,⁴⁰ or a denial of responsibility for the crime. Our view is that the true rationale of the defence is to deny criminal responsibility, not merely to deny mens rea. This follows from the view that it would be fundamentally unfair and unjust to hold someone criminally responsible for their conduct if, through no fault of their own, they lacked the capacity to obey the law.
- 1.53 If a defence of insanity is merely a denial of mens rea, then the defence is irrelevant if there is no mens rea element to the offence. Conversely, if a defence of insanity is a denial of criminal responsibility, then the availability of the defence should not depend on whether there is a mens rea element to the offence.⁴¹ This is not merely a theoretical concern. Consider the following example. The accused is charged with the offence of causing a water discharge activity, in other words, polluting surface water,⁴² which is a strict liability offence, punishable in the magistrates’ courts by up to £50,000 and/or 12 months’ imprisonment, and in the

³⁶ [1952] 2 QB 826.

³⁷ F McAuley, *Insanity, Psychiatry and Criminal Responsibility* (1993) p 31.

³⁸ See D W Denno, “Who is Andrea Yates? A Short Story about Insanity” (2003) 10 *Duke Journal of Gender Law and Policy* 1.

³⁹ *Codère* (1917) 12 Cr App Rep 21.

⁴⁰ See, eg, G Williams, *Textbook of Criminal Law* (2nd ed 1983) pp 642 to 647. The argument was raised in *Felstead* [1914] AC 534 but the House of Lords’ answer was ambiguous.

⁴¹ C Wells, “Whither Insanity?” [1983] *Criminal Law Review* 787, 794.

⁴² Environmental Permitting (England and Wales) Regulations 2010, SI 2010 No 675, regs 38(1)(a) and 12(1)(b). We thank HHJ Atherton for this example.

Crown Court by an unlimited fine/up to 5 years' imprisonment. The accused, who suffers from delusions, including that he has been entrusted by a supernatural power with the task of saving the world, pollutes the water because he believes he has been commanded to do so. If the insanity defence is only relevant to mens rea, then he would be held responsible and convicted (unless dealt with outside the criminal justice process).

(7) The defence is not available in the magistrates' courts if there is no mental element to the offence

- 1.54 The defence of insanity can be pleaded in the magistrates' courts, but, according to one interpretation of the law in *Director of Public Prosecutions v Harper*,⁴³ it is only available if there is a mental element in the offence. For example, a charge under section 47 of the Offences Against the Person Act 1861 involves a physical element (that the accused caused actual bodily harm to the alleged victim) but also that the accused had a particular state of mind when that happened. For other offences there is no mental element, such as the offence mentioned above of causing a water discharge activity (polluting surface water).⁴⁴
- 1.55 The judgment of *Director of Public Prosecutions v Harper* has been cogently criticised by leading academics,⁴⁵ and we think it is mistaken. It leads to the anomaly that if a person is charged with an offence where there is no mental element, then he or she can plead the insanity defence if the case is tried in the Crown Court but not if it is tried in the magistrates' courts.

(8) The law is out of step with medical understanding

- 1.56 Terms like "insanity" and "disease of the mind" are not medical terms, but outdated legal terms. There have been calls for the M'Naghten Rules to be brought into line with modern medical knowledge for at least 60 years.⁴⁶ Many other jurisdictions have met these concerns by recently reforming their insanity test by legislation (Scotland in 2010,⁴⁷ Ireland in 2006) or at common law (Canada, Australia).⁴⁸
- 1.57 The practical consequences of a legal test that is so out of step with modern medicine is that it may impede expert evidence of "insanity". Experts ought not to have to translate a psychiatric condition into an outmoded legal concept.
- 1.58 We thought that the mismatch between the legal test and modern psychiatry is striking, and this was commented upon by consultees. Dr J Reed wrote that "the present test does not really relate in any meaningful way to the practice of psychiatry. Therefore diversions into discussions about the M'Naghten rules are

⁴³ [1997] 1 WLR 1406.

⁴⁴ See para 1.53 above.

⁴⁵ Eg, T Ward, "Magistrates, Insanity and the Common Law" [1997] *Criminal Law Review* 796.

⁴⁶ Report of the Royal Commission on Capital Punishment (1953) Cmd 8932, para 248.

⁴⁷ Criminal Justice and Licensing (Scotland) Act 2010, s 168, which inserts a new s 51A into the Criminal Procedure (Scotland) Act 1995.

⁴⁸ Though a recent review of the law in New Zealand concluded that, although there are faults with the law, no change was the best option. See New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010).

not very helpful in conveying an understanding of the clinical situation to the court". The RCP commented that the law requires definitive statements, to which psychiatric assessment does not always lend itself.

(9) The label "insanity" is stigmatising and inaccurate

- 1.59 The very name of the defence might be off-putting or even offensive to many people, and this was something that respondents to the Scoping Paper commented on.
- 1.60 Sometimes a label contained in a criminal offence is itself so offensive that it deserves to be changed for that reason alone, as was surely the case with the (now defunct) offence of "procur[ing] a woman who is a defective to have unlawful sexual intercourse".⁴⁹ Whether "insanity" is quite in the same category is debateable. However, it is doubtful whether the term "insanity" has any purpose beyond identifying the class of persons the law recognises as not responsible based on a mental or physical condition – it plainly has no currency among psychiatrists and mental health professionals. If it is highly stigmatising, it may be desirable to change the label.
- 1.61 However, there is an argument that with mental illness, whatever label is chosen, stigma will persist.⁵⁰ Some argue that the stigma that attaches to "the insane", though real and regrettable, attaches more to mental disorder in general rather than to the specific word.⁵¹
- 1.62 As noted, the broad interpretation of the term "disease of the mind" results in epileptics, diabetics and others with mental conditions that would not be described generally as mental disorders being classified as "insane". Those people might understandably be reluctant to plead the defence. Ashworth has referred to "the gross unfairness of labelling [such people] as insane in order to ensure that the court has the power to take measures of social defence against them".⁵²

(10) Burden of proof if the insanity defence is raised

- 1.63 The general approach to the burden of proof in English law is that stated by Lord Sankey: "Throughout the web of the English criminal law one golden thread is always to be seen, that it is the duty of the prosecution to prove [beyond a reasonable doubt] the prisoner's guilt". That statement was followed by his recognition of an exception at common law for the defence of insanity.⁵³ If the defendant pleads insanity, then the burden of proof lies on the defence. This means that the accused has to prove all the elements of the defence on the balance of probabilities.

⁴⁹ Sexual Offences Act 1956, s 9(1).

⁵⁰ Professor Thomas is currently undertaking work for us on the jury and on public attitudes to mental disorder and to crime and dangerousness.

⁵¹ N Sartorius, "Stigma of Mental Illness: A Global View" in L B Cottler (ed), *Mental Health in Public Health: the Next 100 Years* (2011) pp 213 to 222. See also N Sartorius and H Schulze, *Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association* (2005).

⁵² Principles of Criminal Law p 143.

⁵³ *Woolmington v DPP* [1935] AC 462, 481.

- 1.64 This gives rise to the problem that a jury may think that on the balance of probabilities the defendant was not insane while not being sure of this fact. That will result in him or her being convicted of the offence. However, that conviction will be secured without the jury necessarily being satisfied beyond all reasonable doubt that he or she was guilty. It will be sufficient that they were satisfied to the civil standard that the accused was not insane (and that could be as low as being 51% sure of his not being insane). Plainly that means that someone may be convicted of an offence when there is more than a reasonable doubt that he or she is insane and thus ought properly to be exempt from criminal responsibility. We explore this issue in full in chapter 8 below.

(11) The risk of breach of the ECHR

Victims' rights

- 1.65 A person's rights to life (article 2), not to be subjected to inhuman and degrading treatment (article 3) and to a private life (article 8) could all be breached by a criminal act. The European Court of Human Rights has confirmed that states:

have a duty to protect the physical and moral integrity of an individual from other persons. To that end, they are to maintain and apply in practice an adequate legal framework affording protection against acts of violence by private individuals.⁵⁴

This means that there are duties on the state to prevent breaches of the rights contained in articles 2, 3 and 8.⁵⁵

- 1.66 The "right to life" contained in article 2 of the ECHR requires the state to protect its citizens from those people who represent a risk of life-threatening harm to others. The law regulating pleas of insanity and the disposal powers of courts must ensure that dangerous individuals are managed in such a way as to address that risk, including the possibility of detention in prison or hospital. The same point applies in relation to people's rights under articles 3 and 8.
- 1.67 Detention in hospital could in some cases contribute to the fulfilment of the state's duties if treatment makes it less likely that the individual will reoffend: reoffending rates are seemingly lower for those released from secure hospital than from prison.⁵⁶
- 1.68 The duty on the state "to maintain and apply in practice an adequate legal framework affording protection against acts of violence" means that adequate powers ought to be available in relation to offences which are summary only – meaning that they can only be tried in the magistrates' courts – as well as in

⁵⁴ *Hajduová v Slovakia* App No 2660/03 at [46] citing *X and Y v The Netherlands* [1986] 8 EHRR 235 (App No 8978/80) at [22] and [23]; *Costello-Roberts v UK* [1995] 19 EHRR 112 (App No 13134/87) at [36]; *DP v UK* [2003] 36 EHRR 14 (App No 38719/97) at [118]; *MC v Bulgaria* [2005] 40 EHRR 20 (App No 39272/98) at [150] and [152]; and *A v Croatia* App No 55164/08 at [60].

⁵⁵ See, eg, *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [101]; *Renolde v France* (2009) 48 EHRR 42 (App No 5608/05); *Z v UK* (2002) 34 EHRR 3 (App No 29392/95) at [73]; and *R (Howard League for Penal Reform) v Secretary of State for the Home Department* [2002] EWHC 2497 (Admin), [2003] 1 Family Law Reports 484.

⁵⁶ Firm data on this point is not available.

relation to offences which can be tried in the Crown Court. For example, a stalker might commit an offence contrary to section 2 or section 2A of the Protection from Harassment Act 1997 (summary only offences). If the magistrates do not have the power to make an appropriate order (such as a hospital order or a supervision order with a treatment requirement), the potential victim could be left without adequate protection against harm and violation of his or her article 8 right.

- 1.69 We had also noted in the Scoping Paper that the law fails to provide adequate public protection in cases where the disorder is not of a kind which requires psychiatric treatment. Respondents found three kinds of difficulty in the kinds of disposals available. (1) There was perceived to be a gap between absolute discharge and hospital order which the supervision order is unsuitable to fill, even if a supervision order could be made. (2) There is the difficulty of a disorder which does not require psychiatric treatment leading to a special verdict, but no appropriate disposal powers.⁵⁷ (3) There is the position of mentally disordered offenders under 18. The CPS gave a very full answer on this issue, culminating in the point that:

the result [of the current law] is that young people who are charged with criminal offences are seen as being immune from criminal justice intervention which undermines the confidence of victims and communities in the youth justice system, particularly where the offending behaviour is violent, sexual or persistent. There is also a risk that unless there is appropriate intervention to tackle such behaviour, both the offending and the mental disability will deteriorate and the youth will add to the growing number of prisoners with mental health problems when he reaches adulthood. An amendment to the legislation to allow the youth court to make a supervision order following a finding that the youth had committed the actus reus, would place a youth under the supervision of a member of the youth offender team and could include conditions to engage in programmes to address the causes of the offending behaviour with the aim of preventing further offending.

Defendants' rights

- 1.70 Because of the limitations of the insanity defence as it currently stands some people who suffered serious illness at the time of the offending cannot plead it. As a result they are detained in custody rather than receiving treatment in hospital. In consequence, they are at greater risk of suicide and self-harm in prison. The state, which owes duties to those held in custody and especially to those held in custody who suffer from mental illness, risks violations of their right to life (article 2).⁵⁸ Children who are detained in custody are, of course, exceptionally vulnerable.⁵⁹

⁵⁷ Since this response was sent in, the conditions for a mental health treatment requirement to be made have been relaxed (see the Legal Aid, Sentencing and Punishment of Offenders Act 2012, s 73).

⁵⁸ See Equality and Human Rights Commission, *Human Rights Review 2012* p 26.

⁵⁹ We discuss the situation of children and young offenders in Part 4 of the Supplementary Material to the Scoping Paper, and in ch 9 below.

- 1.71 The same argument applies in relation to the right not to be subjected to inhuman and degrading treatment (article 3) because someone who is held in custody may suffer harm short of death.⁶⁰ In *Keenan v United Kingdom*,⁶¹ the European Court of Human Rights found that a lack of psychiatric advice about K's confinement in segregation, and ineffective monitoring of his condition amounted to a breach of article 3.
- 1.72 As we stated in the Scoping Paper, we feared that the defence does not fairly identify those who ought not to be held criminally responsible as a result of their mental condition, and so some of those vulnerable people remain in the penal system, to their detriment, and to the detriment of society at large.⁶² Experienced defence solicitors commented that "prison healthcare facilities are still wholly inadequate" for those with mental illnesses.⁶³

(12) Equality and discrimination

- 1.73 The right of a person with mental disorder not to suffer unlawful discrimination is stated in, and may be derived from, a variety of legal instruments, both domestic and international.⁶⁴
- 1.74 We think that, because of the current interpretation of the M'Naghten test, a person with a disability within the meaning of section 6 of the Equality Act 2010 (which may include a person with a mental illness and/or learning difficulties) may be put at a disadvantage, as compared with a person without a disability. This can amount to unfair indirect discrimination contrary to section 19 of the Equality Act 2010. The disabled person who cannot plead insanity will face additional hardships in securing parole (and may therefore end up serving a longer sentence).
- 1.75 The proportion of people in custody with a disability is higher than the proportion of the general population on many measures. For example, Ministry of Justice research estimated that 36% of prisoners surveyed were considered to have a

⁶⁰ The European Court of Human Rights has recently affirmed that "the assessment of whether the particular conditions of detention are incompatible with the standards of article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment. The feeling of inferiority and powerlessness which is typical of persons who suffer from a mental disorder calls for increased vigilance in reviewing whether the Convention has (or will be) complied with." *Aswat v UK* App No 17299/12 at [50].

⁶¹ (2001) 33 EHRR 38 (App No 27229/95). Mark Keenan suffered from serious mental illness, probably schizophrenia. He had acute psychotic episodes with paranoia. He was charged with assault and remanded into custody. He was subsequently released on bail, convicted, and sentenced to four months' imprisonment. He was known to be potentially suicidal. He assaulted prison staff. Nine days before the end of his sentence he was ordered to serve seven days' segregation and a further 28 days' extra sentence for a breach of prison discipline. Whilst serving the additional term he committed suicide.

⁶² See para 2.122 of the Scoping Paper and K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009).

⁶³ The 2012 annual report of HM Chief Inspector of Prisons (HC 613) gives a more mixed picture: see p 7 of the report.

⁶⁴ On the international front, see, eg, the UN Convention on the Rights of Persons with Disabilities; Council of Europe Recommendation Rec (2004) 10; the International Covenant on Civil and Political Rights; and the Charter of Fundamental Rights of the EU.

disability,⁶⁵ and the proportion of people in custody with learning difficulties is higher than the proportion of people in the general population with learning difficulties.⁶⁶

- 1.76 It follows from the principle of non-discrimination that the law should protect mentally disordered offenders from arbitrary detention as it protects any other kind of offender.

(13) The impact on children

- 1.77 It is a statutory requirement for a court to have regard to a child's welfare,⁶⁷ and it is stated in the United Nations Convention on the Rights of the Child that the best interests of the child shall be a primary consideration.⁶⁸ We therefore give particular consideration to the position of children with mental illness and learning disabilities/learning difficulties.
- 1.78 In the Scoping Paper we asked whether there is a particular problem as regards youth defendants in that the orders a court could make, if an insanity defence succeeded, would not produce the outcomes which are seen as being in the defendant's interests, or in the public interest. It was clear from the responses that the answer to this question is "Yes".⁶⁹
- 1.79 It seems to us that the insanity defence and the available disposals are particularly ill-suited to dealing with children with mental health problems and/or learning difficulties.

Responses to the Scoping Paper and evidence of how the defences work in practice

- 1.80 As we have explained, the defences of insanity and automatism have been the subject of much academic criticism over many years, and the comments made by respondents to the Scoping Paper bolster many of those criticisms. However, the primary purpose of the Scoping Paper was to draw out evidence of how the

⁶⁵ Ministry of Justice Research Summary 4/12, "Estimating the Prevalence of Disability amongst Prisoners" (2012). In this estimate the MoJ did not specifically ask about learning difficulties. As regards people with mental health problems, the screening test used in the research only detected anxiety and depression, and not other mental disorders. 10% is the estimated proportion of the prison population which is seriously mentally ill: Michael Spurr, Operational Head of HM Prison Service on BBC Radio 4 (2008), "Life on the Inside at HMP Liverpool", Evan Davis interviews Alan Brown and Michael Spurr, cited by K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009) p 6.

⁶⁶ The proportion of people in the general population with learning disabilities can be assumed to be around 2%: study commissioned by the Department of Health cited by E Emerson and C Hatton, *People with Learning Disabilities in England* (Centre for Disability Research Report, 2008) p i. A study of three prisons found that just under 7% of the prison population were assessed as learning disabled and over one quarter as borderline learning disabled: K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009) p 29.

⁶⁷ Children and Young Persons Act 1933, s 44.

⁶⁸ Article 3(1). The Convention was ratified by the United Kingdom in 1991. Prosecutors must have regard to obligations arising under this Convention: *R (HC) v Secretary of State for the Home Department* [2013] EWHC 982 (Admin) at [35], [2013] All ER (D) 26 (May). See also the European Rules for Juvenile Offenders Subject to Sanctions or Measures, adopted by the Council of Europe in 2008.

⁶⁹ See para 1.69 above.

defences work in practice. Given that one of the difficulties we had identified was the lack of data, we were not surprised that little further data was provided. The nature of many of the responses was anecdotal,⁷⁰ but our aim was to assess the feel of those who work and appear in the criminal courts for the problems the current law creates.

1.81 It had seemed to us that the defences are little used, and this view was borne out by the responses. The picture that emerged was that insanity is rarely pleaded, and is pleaded only if it is likely to be a successful plea. The outdated terms of the M’Naghten Rules were one reason for this, but many other reasons related to the position of the mentally disordered defendant in the criminal justice system looked at as a whole.⁷¹

- (1) people who might otherwise have “qualified” for the special verdict will have been diverted from the system, or found unfit to plead, or the case will have been dropped on public interest grounds;
- (2) there can be disagreements between the police, CPS and clinicians on what level of information is required to make a decision on prosecution;
- (3) not all legal practitioners are well-informed about an insanity plea and its consequences;
- (4) it is difficult for the defence practitioner to raise the issue with the client;
- (5) the accused, though fit to plead and to stand trial, may be unwilling to plead “insanity”, or lack insight into his or her condition and therefore not accept that an insanity plea could be suitable;
- (6) cases where the alleged offence was committed in hospital may be filtered out by medical staff without reaching the police or the CPS;
- (7) it is difficult to obtain funding for an expert report;
- (8) it is difficult to obtain evidence of a person’s state of mind after the event; and
- (9) a conviction can be the outcome to aim for in the long term management of high risk patients because it is advantageous to be able to refer to a historical conviction for an offence when doing risk reduction work.

1.82 The main reason, however, that insanity and automatism are rarely pleaded, is that practitioners take a pragmatic approach, and achieve the “correct” outcome, in the view of the practitioner and/or the accused, without having to consider the insanity defence: defendants often prefer the certainty of a prison term to the uncertainty of a release date from hospital.

⁷⁰ A possible weakness of the Scoping Paper, as Professor Peay wrote: J Peay, “Insanity and Automatism: Questions from and about the Law Commission’s Scoping Paper” [2012] *Criminal Law Review* 927, 928.

⁷¹ See further para B.6 of the analysis of responses, and A Jackson, N Wortley and N Wake, “Insanity and Automatism – A Response to the Law Commission: Part II” (2012) 52 *Criminal Law and Justice Weekly* 176.

- 1.83 The crux of the insanity defence is, as we say at the beginning of this chapter, that in some cases, a person’s mental condition is such that he or she should not be held criminally responsible. While there are a great many people convicted of offences who have mental health problems and/or learning difficulties, the number who completely lack criminal responsibility as a result is small. This is the impression we have gained from the feedback to the Scoping Paper, and it may be that this would remain the case even if the defences were brought up to date. Thus the defences of insanity and automatism are only a small part of the jigsaw of the ways in which mentally disordered offenders are dealt with in the criminal justice system, as reflected in the responses. Respondents were more concerned about the law relating to unfitness to plead and emphasised to us that reform to that area of the law would have greater impact. Therefore, as we explain above, that is where we plan to concentrate our resources next.

POSSIBLE NEW DEFENCES

- 1.84 Although the practical evidence does not make reform of the defences of insanity and automatism urgent, it is still needed. Respondents to the Scoping Paper told us they find them outmoded, inappropriate, and complicated, and they supported several of the academic criticisms.⁷² It therefore seems to us that it is valuable for us to contribute to the public debate by publishing ideas about how the insanity and automatism defences could be reformed.
- 1.85 Professor Ronnie Mackay, a member of our Advisory Board, has described our provisional proposals for the reform of the insanity defence as “radical”, and stated that in his view “a ‘radical’ change to the M’Naghten Rules is precisely what is needed”. We agree.

New defence and special verdict of “not criminally responsible by reason of recognised medical condition”

- 1.86 We provisionally propose that the common law rules on the defence of insanity be abolished.
- 1.87 We provisionally propose the creation of a new defence of “not criminally responsible by reason of recognised medical condition”. This would be a defence founded on complete loss of capacity; mere impaired capacity, even substantially impaired capacity, would not be enough for the defence to succeed. This is such a significant “bright line” that a court would address it first: if the accused could not adduce sufficient credible evidence that he or she had wholly lacked a relevant capacity⁷³ as a result of a recognised medical condition, then the court would not allow the defence to go forward.
- 1.88 As just noted, the lack of capacity must arise out of a “recognised medical condition”. Determining what constitutes a “recognised medical condition” here involves a question of law, not of medicine. It is a term of art and an essential component of the defence. It is therefore a term to be interpreted by the court.

⁷² See para 1.30 and following above.

⁷³ The relevant capacities are set out at para 1.93 below.

- 1.89 Not all medical conditions will qualify as a “recognised medical condition”. There are, in our view, good policy reasons for some medical conditions not to qualify as criminal defences. For example, the criminal law has already developed rules to deal with the criminal liability of those who are intoxicated, and it would not be right for a defence of non-responsibility to undermine those rules.
- 1.90 Similarly, it would also not be right for a person to be able to rely on this defence if the accused’s condition consists of a personality disorder characterised solely or principally by abnormally aggressive or seriously irresponsible behaviour; in other words, the evidence for the condition is simply evidence of what might broadly be called criminal behaviour.
- 1.91 We provisionally conclude that these two conditions should be explicitly excluded from the proposed new defence.
- 1.92 There are no doubt other kinds of condition which may be diagnosed for medical purposes but which would not qualify as the foundation for a defence of non-responsibility. We provisionally conclude that the best approach is for the courts to have discretion, with the guidance of the Court of Appeal, to decide whether any condition which is not specifically excluded is nevertheless not a qualifying condition. We see this approach as preferable to the alternatives, such as providing an exhaustive list of qualifying conditions, which we regard as unworkable, or not excluding any conditions from the proposed defence, thus leaving interpretation solely to the courts in all cases, risking the possibility of inconsistent decision-making.
- 1.93 In sum, the party seeking to raise the defence must adduce evidence from at least two experts that at the time of the alleged offence
- the defendant wholly lacked the capacity:
- (i) rationally to form a judgment about the relevant conduct or circumstances;
 - (ii) to understand the wrongfulness of what he or she is charged with having done; or
 - (iii) to control his or her physical acts in relation to the relevant conduct or circumstances
- as a result of a qualifying recognised medical condition.
- 1.94 In other words, a defendant should not be held responsible where he or she could not have reasoned rationally about what he or she was doing, could not have understood that it was wrong, or could not have controlled his or her physical actions. The defence would not apply where the accused simply found it difficult to do any of those things.
- 1.95 The defence would be available in relation to any type of offence, not just those which require proof of mens rea, and it would be available in the magistrates’ courts and the Crown Court.

- 1.96 The relevant expert from whom evidence would be required before the defence could even get off the ground need not be a medical practitioner, but where the relevant expert is a psychiatrist, he or she should continue to be one who is “approved” under the Mental Health Act 1983 (“the 1983 Act”).⁷⁴

Illustration

- 1.97 D lives in a flat. He has a history of sleepwalking. One night, he gets up, puts toast under the grill, turns the grill on and returns to bed. The kitchen catches light and the fire spreads to neighbouring flats. D is woken by the sirens of the fire engines. No one is hurt but several flats are badly damaged. He is charged with arson. His defence is that he was asleep throughout, including when he turned the grill on.
- 1.98 In this case, the prosecution would have to prove that D damaged the flats, without lawful excuse, and intending to damage them or being reckless as to whether they would be damaged.⁷⁵ D will be “reckless” in this context where he was aware of a risk that the flats would be damaged by his actions and it was, in the circumstances known to him, unreasonable to take that risk.⁷⁶ D’s case will be that his actions were not voluntary, and that he did not have any such awareness.
- 1.99 Under the current law this should be treated as a plea of insanity, but the court might treat it as a plea of automatism. The former is hardly an acceptable label, but the latter, if it succeeds, does nothing to prevent D doing the same thing again.
- 1.100 Under the proposed new defence, the first issue for the court is whether there is evidence to support the accused’s contention that he was wholly incapable at the time of thinking rationally, of appreciating that he should not put toast under the grill and leave it, or of controlling his actions. If the expert reports tendered by D do not support this contention, then there will not be sufficient evidence for the defence to proceed further.
- 1.101 The second issue for the court is whether the condition which D claims to have is a qualifying recognised medical condition. Sleep disorders are recognised medical conditions, and we do not propose that they are specifically excluded from the defence. The condition would be a qualifying recognised medical condition.
- 1.102 The next question for the judge is whether D has adduced evidence on which a properly directed jury could reasonably conclude that the defence might apply. D would have to adduce evidence from at least two experts in the condition and satisfy the court that

the condition is a medical condition recognised by the relevant profession; and

⁷⁴ In other words, approved for the purposes of s 12 of the Mental Health Act 1983 by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder.

⁷⁵ Contrary to section 1(3) of the Criminal Damage Act 1971. See *Archbold* para 23-24.

⁷⁶ *G* [2003] UKHL 50, [2004] 1 AC 1034.

that condition could cause a lack of capacity as D claims.

- 1.103 If the court is satisfied that a properly directed jury could reasonably accept the expert evidence, then the defence can go to the jury and it is then for the prosecution to disprove the defence beyond reasonable doubt.
- 1.104 The first issue for the jury would be whether they are sure that: D turned the grill on, the fire started as a result of the toast catching light, and that the ensuing fire caused the damage. If they are not sure about that, then they should acquit D.
- 1.105 If the jury is sure that D caused the damage, the verdict depends on whether, putting it in lay terms, the jury believes the defence is or may be true. If they do, they will return a verdict of “not criminally responsible by reason of recognised medical condition”. If they do not believe it and are sure that D was not sleepwalking at the time of the alleged offence and/or sure that D did not lack the capacity to control his actions, and that D deliberately or recklessly caused the damage, then they will convict. If they are not sure that D was not sleepwalking at the time of the alleged offence and/or not sure that D did not lack the capacity to control his actions, then again they will return the special verdict.

Disposal following the new special verdict

- 1.106 The Court of Appeal has recently emphasised the need for the powers of disposal following a special verdict to be examined critically, “so as to pay proper regard both to the interests of the individual defendant and to the public risk which he represents”.⁷⁷ Following the new special verdict of not criminally responsible by reason of recognised medical condition that we provisionally propose, the range of disposals for adults would be the same as that currently available following a verdict of not guilty by reason of insanity. A hospital order would continue to be possible if supported by evidence from two registered medical practitioners at least one of whom is approved under the 1983 Act as having special experience in the diagnosis or treatment of mental disorder, and if the conditions of section 37 of the 1983 Act are satisfied.⁷⁸
- 1.107 In addition, in respect of a person who was under 18, we provisionally propose that the court should be able to make a non-penal Youth Supervision Order, a form of Rehabilitation Order to which non-punitive requirements can be attached. The kinds of requirements which could be attached to such an order would be those such as a mental health treatment requirement, or a medical requirement.
- 1.108 It might be that the power of the courts to make supervision orders following a special verdict could usefully be amended. For example, the maximum period of a supervision order (currently two years) could be increased. Secondly, where a person has been the subject of a supervision order or a non-penal Youth Supervision Order but does not comply with the terms of the order, the question arises whether the person should face penal sanctions in all circumstances, or for all breaches except for refusal to consent to treatment, or whether penal sanctions are not appropriate at all. We discuss these possibilities in chapter 4.

⁷⁷ C [2013] EWCA Crim 223, [1] and [20], [2013] All ER (D) 06 (Apr).

⁷⁸ See s 37(2) of the 1983 Act. As to our provisional proposals for magistrates’ powers, see paras 1.22 and 1.23 below.

We propose to return to these difficult issues in more detail and in consultation with practitioners in the context of our work on unfitness to plead (where the disposal regime is the same).

Reformed defence of automatism

- 1.109 We propose reforming the defence of automatism and putting it into statutory form, as we describe in chapter 5.
- 1.110 We provisionally propose a defence of automatism where at the time of the alleged offence the accused suffered a total loss of capacity to control his or her actions which was not caused by a recognised medical condition. If the defence succeeds (which means if the accused adduces enough evidence to put it in issue and it is not disproved by the prosecution) then the accused will be simply acquitted.
- 1.111 Given that our proposed defence of recognised medical condition will apply to some cases which would currently fall within the automatism defence under the current law, we anticipate that the new automatism defence would apply in a narrower range of cases than the current automatism defence.
- 1.112 A small number of defendants who under the current law would be able to plead automatism and avoid any stigmatising verdict, would under our proposals fall instead within the recognised medical condition defence, and so be subject to the special verdict. In our view, that is the right outcome: if the loss of capacity is the result of a recognised medical condition such as sleep apnoea or diabetes causing sudden loss of consciousness, then the verdict should reflect that fact. As regards disposal, the court would have the power to order a disposal which offers the possibility of greater protection of the public, in contrast with a simple acquittal. Our proposed new verdict would not have the same negative connotations as a verdict of “not guilty by reason of insanity”.
- 1.113 Thus, for instance, where the accused is charged with causing death by dangerous driving and claims to have had no warning of a hypoglycaemic episode, the jury might convict if they are sure that the accused should have anticipated the medical emergency.⁷⁹ However if they accept he had a hypoglycaemic episode but are not sure he had warning of it, they will reach the new special verdict, and not acquit. The new special verdict would be apt for those who should bear “no moral blame”.⁸⁰
- 1.114 If a person’s defence is based on a recognised medical condition, then the automatism defence would not be available to him or her, irrespective of whether it is a qualifying recognised medical condition defence. So, for example, if D says that he lost all capacity to control his actions because of his acute intoxication, he

⁷⁹ As in *Rigby* [2013] EWCA Crim 34, [2013] Road Traffic Reports 23 where the accused was diabetic and the basis of his plea to causing death by dangerous driving was his failure to test his blood sugar levels before driving.

⁸⁰ See, eg, *Harrison* [2004] EWCA Crim 1527, [2004] All ER (D) 317 (May), in which D pleaded guilty to a charge of dangerous driving. He had suffered a hypoglycaemic attack which he could not have anticipated. His appeal against the period of disqualification from driving succeeded and the Court of Appeal held at [11] that “no moral blame attached to the appellant”.

or she will not be able to rely on the automatism defence or the recognised medical condition defence.

Prior fault and intoxication

- 1.115 Those who work in the criminal justice system will know that offenders with mental disorder will often also have a background of alcohol or drug abuse, and either or both of those factors may have played a part in the commission of an offence. It is therefore essential for us to consider how our proposals would work in practice alongside relevant common law rules governing those who commit crimes when voluntarily intoxicated or otherwise incapacitated.
- 1.116 The interaction of insanity, automatism and intoxication was considered in *C*. There is in the common law a supervening principle of prior fault: the accused is generally liable for any basic intent offence⁸¹ where he or she was culpable in inducing his or her loss of capacity. Lord Justice Hughes restated this principle as follows:
- In most, but not all, intoxication cases, the intoxication will be possibly relevant to a serious offence allegedly committed but will afford no defence to a lesser offence constituted by the same facts: for example causing grievous bodily harm with intent ... and causing grievous bodily harm without such intent ... , or of course murder and manslaughter. In the development of the common law, intoxication was historically regarded chiefly as an aggravation of offending, rather than as an excuse for it. For all the reasons explained in *Majewski*, the law refuses as a matter of policy to afford a general defence to an offender on the basis of his own voluntary intoxication. The pressing social reasons for maintaining this general policy of the law are certainly no less present in modern conditions of substance abuse than they were in the past.⁸²
- 1.117 The policy for this is readily understood: while it may be fair for a person to be acquitted where he or she completely lost control of his or her actions, it is not fair for there to be an acquittal where the accused may be blamed for whatever led to the loss of control. For example, a driver who loses control of the car when a stone comes through the windscreen is not to be held responsible, but a driver who knows he is on the verge of a hypoglycaemic coma but who drives anyway will fairly be held responsible.
- 1.118 This principle, and the case law, will continue to be relevant to the proposed new defence of recognised medical condition and to the proposed reformed defence of automatism. We spell out in chapter 6 how that principle can be applied to the new defences.
- 1.119 We discuss the relationship between the new defences and the existing law on intoxication in detail, including those instances of intoxication which are about taking medicines. Intoxication is not just about alcohol; it encompasses ingestion

⁸¹ Basic intent offences are all those for which the predominant mens rea is not intention, knowledge or dishonesty (this includes offences of recklessness, belief, negligence and strict liability).

⁸² *C* [2013] EWCA Crim 223 at [17], [2013] All ER (D) 06 (Apr).

of any intoxicating substance. This includes all drugs, whether prohibited, available on prescription or freely available.

- 1.120 In the course of chapter 6, we identify a potential anomaly in the current law which we need to address. A diabetic who, without fault, fails to take insulin and then commits an allegedly criminal act would be categorised as “insane” under the current law. In contrast, a diabetic who took insulin in accordance with a medical prescription, but who then had an unexpected reaction to it and committed an allegedly criminal act, would be acquitted. In our view, the appropriate verdict in both cases should be “not criminally responsible by reason of recognised medical condition” because in both cases it is the underlying condition which has given rise to the conduct constituting an offence. Achieving this result requires an amendment to the rules on intoxication, and so we propose that a person “D” shall be treated as pleading the recognised medical condition defence and not involuntary intoxication where:

D suffered from a recognised medical condition, and

D took a properly authorised or licensed medicine or drug for the treatment of that condition, and

D took the medicine or drug in accordance with a prescription, with advice given by a suitably qualified person, or in accordance with the instructions accompanying the medicine or drug in the case of over-the-counter medicines, or, if D did not take it in accordance with instructions, it was nevertheless reasonable for D to take it in the way he or she did in the circumstances, and

D had no reason to believe that he or she would have an adverse reaction to that medicine which would cause him or her to act in that way and

the taking of that medicine or drug caused D totally to lack the relevant criminal capacity.

Procedural issues

- 1.121 In chapter 7 we consider whether there is any reason that the defences should not be available in identical form in the magistrates’ courts as well as in the Crown Court and conclude there is not. This conclusion leads to the question of what disposal powers the magistrates should have. Magistrates can already make hospital orders under some circumstances under section 37 of the 1983 Act. They can also discharge an offender absolutely or make a supervision order following a conviction, but they cannot do either of those things if the accused has been acquitted, even if the reason for the acquittal was “insanity”.
- 1.122 We provisionally propose that magistrates should have the power to make a hospital order in respect of a person whom they have acquitted by reason of recognised medical condition but not the power to add a restriction order. They should therefore have the power to commit a case to the Crown Court if they think that a restriction order needs to be made. In addition, they should be able to make a supervision order, a non-penal Youth Supervision Order or an absolute discharge in the event of a special verdict of recognised medical condition.

Burden of proof

- 1.123 Under the current law, the burden of proving the defence of insanity falls on the accused. This is unusual for the criminal law, which usually requires the prosecution to prove all elements of an offence and to disprove any defence which the accused has put before the court.
- 1.124 We discuss this issue in relation to the proposed new defence and the reformed automatism defence in chapter 8. We conclude that the usual rules should apply to the new defence of “not criminally responsible by reason of recognised medical condition”, but that it is appropriate to require the accused to adduce substantial evidence supporting the defence before the prosecution can be required to disprove the defence. We therefore provisionally propose that if the accused seeks to plead the new defence he or she must adduce evidence from two experts.
- 1.125 As regards proof and the automatism defence, we do not propose any change: the accused would simply have to put enough evidence before the court to raise the defence.

Possible defence and special verdict of developmental immaturity

- 1.126 The principle of non-responsibility which underlies our proposed new defence of recognised medical condition also informs questions we raise about a possible new defence for a person who is not criminally responsible by reason of developmental immaturity. This might apply where, at the time of the alleged offence, the accused was under 18 and was *wholly* incapable of rationally forming a judgment, appreciating the wrongfulness of his or her acts, or controlling his or her physical actions, as a result of his or her developmental immaturity. If a person was wholly incapable of avoiding doing what he or she is alleged to have done because of a developmental immaturity, then it could be argued that he or she should not be held criminally responsible. It seems to us that this important question merits separate treatment, as we explain in chapter 9.

HOW OUR PROVISIONAL PROPOSALS WOULD IMPROVE THE LAW

- 1.127 A major advantage of the new defence we provisionally propose is the absence of any division between physical and mental disorders. That division is artificial in many situations, and misses the essential point, which is to focus on whether the accused had the relevant criminal capacity.
- 1.128 Our new defence avoids the stigmatising label of “insanity”.
- 1.129 Instead of a test defined in nineteenth century language and concepts, we would have a defence crafted in modern terms with the flexibility to accommodate developing medical knowledge.
- 1.130 The new defence would save legal and psychiatric practitioners from having to interpret the law somewhat creatively.
- 1.131 Our proposals achieve the right balance between, on the one hand, expert opinion as to a person’s medical condition and, on the other hand, judgment by the jury and magistrates as to whether it is fair to hold him or her criminally responsible.

- 1.132 Our proposals would make the law a great deal clearer than it is now. It is apparent from conversations with legal practitioners and responses to the Scoping Paper that the defences of insanity and automatism, and how they interact with the principle of prior fault and the rules on intoxication, are ill-understood.
- 1.133 That is not to suggest that the current law makes sense even if it is understood. As we say above, whether a person may plead insanity or automatism depends in part on whether there was an internal or external cause. Our proposals avoid this unhelpful distinction.
- 1.134 Our proposals will also allow the law to make orders for the protection of the public in circumstances where it is not currently possible or does not happen. For example, a person who operates machinery and who suffers from obstructive sleep apnoea⁸³ may cause harm to someone. Under the current law, if he or she succeeds in a defence of automatism, then a simple acquittal will follow, with no preventive measures being imposed by the court. Under our proposals, he or she would rely on the new defence and plead “not criminally responsible by reason of recognised medical condition”. If that plea succeeded, the court could require him or her to obtain the necessary medical treatment or supervision.
- 1.135 Our proposals put the burden of proof in the right place.
- 1.136 Getting the defence right is in tune with government objectives of diverting people from the penal system appropriately, and of reducing reoffending.
- 1.137 The legal tests are, as we acknowledge at paragraph 1.17 above, only one part of the jigsaw. Comprehensive reform of the management of mentally disordered suspects in the criminal justice system is likely to require change in:
- (1) procedures (not necessarily in legal procedures),
 - (2) in resources (for example, in ensuring adequate facilities for mental health care and adequate numbers of trained professionals being available),
 - (3) and in attitudes (particularly regarding the provision of healthcare).⁸⁴
- 1.138 The overarching aim of our proposals is to balance protection of the public with fair treatment of mentally disordered offenders.

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⁸³ Obstructive sleep apnoea is a medical condition that causes interrupted breathing during sleep. It can make the person very tired, and prone to fall asleep in the daytime.

⁸⁴ There is a legal principle of equivalence of care, which means that a person who is in custody is entitled to the same health treatment as a person who is not in custody: *Qazi* [2010] EWCA Crim 2579, [2011] 2 Cr App R (S) 8 at [23].

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CHAPTER 2

SHOULD THERE BE AN “INSANITY DEFENCE” AT ALL?

- 2.1 Our task in this chapter is to tackle the question of whether there should be a special “defence” based on “insanity”, or in modern terms, mental disorder, at all. Paragraphs 2.2 to 2.34 lead up to that question. As we explain in Appendix A, our view is that the foundation of criminal responsibility is the person’s capacity not to do the act which would amount to an offence. From that it follows that there should be a special defence based on the accused’s lack of capacity at the time of the offence. (We outline a mental disorder defence at paragraph 2.35 below.) However, in our view there are significant drawbacks to a special defence which is *confined* to mental disorders, and there is good reason not to restrict it in this way. We therefore go on to explain why it would be preferable for the reformed defence to include physical as well as mental medical conditions, provided they lead to a relevant loss of capacity and are subject to other limiting factors.

NO SPECIAL DEFENCE

- 2.2 Some academics have argued that there should be no “insanity” defence at all in criminal law. On this view, evidence of mental disorder should be relevant at trial to negate the mens rea required for the particular offence (such as intent) and, if the mens rea cannot be proved, then the defendant should simply be acquitted, in accordance with general legal principle. If mens rea can be proved, the accused may be convicted. We refer to this idea as “the abolition proposal”.
- 2.3 Under this proposal, an offender’s mental condition would be taken into account at sentencing but not when deciding whether that person was responsible for what he or she did except insofar as it was relevant to mens rea. If mens rea does not have to be proved in respect of any element of the offence charged (in other words, it was a strict liability offence or an offence of negligence) then the accused’s mental condition would be irrelevant, and if he or she had performed the conduct which constituted the offence, then a conviction would result.

The arguments against a special defence based on mental disorder

- 2.4 The abolition proposal has been put most strongly by academics in the United States.¹ These academics draw support from the fact that this scheme represents

¹ For example, J Goldstein and J Katz, “Abolish the ‘Insanity Defense’ – Why Not?” (1963) 72(5) *Yale Law Journal* 853; R J Gerber, “Is the Insanity Test Insane?” (1975) 20 *American Journal of Jurisprudence* 111. Leading commentators in this jurisdiction take the view that, outside the categories of severe psychosis or profound learning disability, the argument for abolition of a defence of insanity “has considerable force, since there is less diagnostic precision and more scope for debate concerning culpability”: *Simester and Sullivan’s Criminal Law* p 714 with reference to the partial abolition argument made by Morris: N Morris, “The Criminal Responsibility of the Mentally Ill” (1982) 33 *Syracuse Law Review* 477.

the current law in Idaho, Kansas, Montana and Utah² where a special defence of mental disorder has been removed so that a plea based on such a disorder can only be one of denial of mens rea.³ In Montana, this step led to a decrease in the proportion of not guilty verdicts based on the accused's mental disorder. Additionally, defendants who are convicted following an unsuccessful plea based on their mental state are more likely to receive probation than to be sent to prison.⁴ At the same time, the number of people who were found unfit to be tried increased. One interpretation of these data is that the courts were trying to compensate for not being able to acquit an accused by diverting him or her from the criminal trial by a procedural mechanism.⁵

No special defence is necessary or justifiable

- 2.5 Some would argue that abolition of the insanity defence is more consistent with general principles of criminal law: if the prosecution can prove the elements constituting the offence, the charge is made out, and if it cannot, then the accused must be acquitted; no special defence is necessary.
- 2.6 For example, Slobogin has argued that "mental disorder should be relevant to criminal culpability only if it supports an excusing condition that, under the subjective approach to criminal liability increasingly accepted today, would be

² See further Idaho Code s 181-207 (1997), Kansas Statute Annotated s 22-3220 (1995), Montana Code Annotated s 46-14-214 (2001) and the Utah Code Annotated s 76-2-305 (1999) as referenced in: C Slobogin, "The Integrationist Alternative to the Insanity Defense: Reflections on the Exculpatory Scope of Mental Illness in the Wake of the Andrea Yates Trial" (2003) 30 *American Journal of Criminal Law* 315, 339. We also note that the Law Reform Commissioner of Tasmania recommended the abolition of the insanity defence, but the recommendation was not implemented: Tasmanian Office of Law Reform, *Insanity, Intoxication and Automatism*, Report 61 (1989).

³ This is discussed in detail in C Slobogin, "The Integrationist Alternative to the Insanity Defense: Reflections on the Exculpatory Scope of Mental Illness in the Wake of the Andrea Yates Trial" (2003) 30 *American Journal of Criminal Law* 315. For an early account of the experience in the USA, see ch 2 of Mackay (1995) and p 128 on considerations of the constitutionality of abolition of the defence in Montana and Idaho. Further information on the law in other jurisdictions can be found in Appx C.

⁴ From 23% to 2.3%: "After the adoption of the Mens Rea Alternative in Montana, only 2.3% of those who asserted mental state defenses prevailed": C Slobogin, "The Integrationist Alternative to the Insanity Defense: Reflections on the Exculpatory Scope of Mental Illness in the Wake of the Andrea Yates Trial" (2003) 30 *American Journal of Criminal Law* 315, 339.

⁵ For data see: C Slobogin, "The Integrationist Alternative to the Insanity Defense: Reflections on the Exculpatory Scope of Mental Illness in the Wake of the Andrea Yates Trial" (2003) 30 *American Journal of Criminal Law* 315, 339. Note that "Appelbaum describes how, in the years after abolition in Montana, defendants were instead found unfit to stand trial, ultimately having their charges dismissed, in the same numbers (and with the same demographics) as would have been previously found not guilty by reason of insanity": New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 3.8 citing P Appelbaum, *Almost A Revolution: Mental Health Law and the Limits of Change* (2004) pp 173 to 175 and 181 to 183, citing Steadman and others, *Before and After Hinckley: Evaluating Insanity Defense Reform* (1993).

available to a person who is not mentally ill”.⁶ In other words the mental disorder would be relevant if it supported pleas of excuse such as mistaken belief or absence of intent. His proposal “would treat people with mental disorder no differently from people who are not mentally ill, assuming ... a modern criminal justice system that adopts a subjective approach to culpability”. He says, rather, that “the universe of excuses has expanded to the point where many of those who would be acquitted under an insanity defense could also succeed under another doctrine” and if general ignorance of the law were added to those excuses, then there would be no moral need for a separate defence of mental disorder.⁷

- 2.7 To illustrate Slobogin’s position, we can assess his analysis of the responsibility of a person who killed another. He takes the example given by Schopp⁸ of a woman (“Mary”) who killed a stranger as the victim came out of church. Mary acted in response to commands she had heard as she walked under telephone wires and because some people had been watching her on the subway. Those commands came from “bad people” who would kill her unless she convinced them that she too was bad. She picked someone leaving church because she had found a dollar note with “In God We Trust” printed on it, and the victim had just left church when Mary saw her, which told her that God wanted her to do it. Slobogin accepts that Mary’s “cognitive focus, reasoning and concept formation capacities are severely disturbed”, but argues that the key question is whether those mental disturbances made it impossible or more difficult for her to “assess the good reasons for not killing”.
- 2.8 He thinks it improbable that Mary did not consider the moral thought that she ought not to kill an innocent person but even allowing that she did, he concludes that there is no way of telling whether she could not think rationally about the issue at the time or just did not. He takes the case to be one of irresistible impulse. He concludes that if she is to be excused, it should be on the basis of duress, “not on the unprovable judgment that it was harder for her than for a non-mentally ill person to act for, or be guided by, good reasons”.⁹
- 2.9 We cannot agree with this analysis. It is not obvious that Mary could have reasoned from that thought to her own situation. It seems much more reasonable to treat the case as one of inability to reach a judgment in a rational way. Morse

⁶ C Slobogin, “An End to Insanity: Recasting the Role of Mental Illness in Criminal Cases” (2000) 86 *Virginia Law Review* 1199, 1202. For example, N Morris, *Madness and the Criminal Law* (1982) and N Morris, “The Criminal Responsibility of the Mentally Ill” (1982) 33 *Syracuse Law Review* 477, 501. See also J Goldstein and J Katz, “Abolish the ‘Insanity Defense’ – Why Not?” (1963) 72(5) *Yale Law Journal* 853, 872.

⁷ C Slobogin, “An End to Insanity: Recasting the Role of Mental Illness in Criminal Cases” (2000) 86 *Virginia Law Review* 1199, 1207. He gives a number of reasons for abolition of an insanity defence. We mention only one here.

⁸ For the example given by Schopp see: R Schopp, *Automatism, Insanity and the Psychology of Criminal Responsibility* (1991) pp 160 to 164. Schopp does not share Slobogin’s abolition approach. He supports the principle of a defence which provides that a person is not responsible for criminal conduct “while suffering major distortion of his cognitive capacities that substantially impaired his ability to decide whether or not to perform that conduct through the process of practical reasoning that is ordinarily available to an adult who does not suffer major cognitive disorder”: R Schopp, above, p 215.

⁹ C Slobogin, “An End to Insanity: Recasting the Role of Mental Illness in Criminal Cases” (2000) 86 *Virginia Law Review* 1199, 1233 to 1234.

and Hoffman criticise Slobogin's analysis on the basis, amongst other things, that it relies on a limited notion of rationality if it requires an ill person who delusionally believes that he is at imminent risk of death to consider rationally whether he should act in self-defence.¹⁰ The important feature – morally speaking – about such a person is that she is incapable of making a rational judgment about how to respond to the real world. And if it is accepted, as we argue in Appendix A, that it is not justifiable to hold someone criminally responsible for conduct amounting to a criminal offence if she or he lacked the capacity to avoid doing it, then a person like Mary should be able to rely on a special defence because of her mental disorder.

Wrong in principle

- 2.10 A second plank in the argument advanced by those opposed to an insanity defence is that:

It is wrong in principle to use coercion through the criminal justice system where the elements of guilt are not made out. Civil commitment on the basis of dangerousness is preferable, subject to reliable indicators of that condition.¹¹

- 2.11 Goldstein and Katz argued in 1963 that the real purpose of the special verdict was to allow the state to detain a person not convicted of any crime. In their eyes, as no other justification of the special verdict was satisfactory, this purpose was invalid. Similarly, Morris argued that an unacknowledged purpose of the special verdict was detention of those who, though acquitted, were perceived to pose a risk of harm.¹²

- 2.12 We consider that this argument has considerable force. It describes the operation of English law and the law in several other jurisdictions.¹³ Brudner describes the link in the insanity test in the Canadian Criminal Code to be:

best viewed as providing eligibility criteria for determining which innocents will be vulnerable to state coercion for reasons of dangerousness rather than as themselves providing indicia of dangerousness.¹⁴

- 2.13 This seems to us to be an accurate description, and a useful encapsulation of the link between verdict and disposal. The defence of insanity and the issue of disposal are nevertheless distinct. When a defendant pleads insanity, then his or her mental state at the time of the offence will be in issue; if found not guilty by reason of insanity, then the issue of disposal will focus on the accused's mental

¹⁰ S Morse and M Hoffman, "The Uneasy Entente Between Insanity and Mens Rea: Beyond *Clark v Arizona*" (2007) *Scholarship at Penn Law*, Paper 143, p 62.

¹¹ *Simester and Sullivan's Criminal Law* p 714, n 83.

¹² He meant this as a criticism of the law.

¹³ In New Zealand, liability is established under s 23 of the Crimes Act 1961, and disposal is then considered under ss 23 to 25 of the Criminal Procedure (Mentally Impaired Persons) Act 2003. Similarly in Canada, liability is established under s 16 of the Criminal Code, and the court then moves to a disposition hearing.

state at the time of disposal. The question for the court in relation to the verdict looks to the past, whereas the question for the court at the time of the disposal looks to the future and is partly about whether the individual will pose a risk of harm. The purpose of the special verdict is to reflect criminal responsibility, and thus partly to protect mentally disordered people from conviction (not just from detention).

- 2.14 We do not think it follows from this that it is wrong to use specifically provided statutory powers to detain a person who has been found not guilty by reason of insanity. A person with mental disorder who has done what would amount to a criminal offence is not, it seems to us, in the same position as a person who has been acquitted without any reliance on a mental disorder defence. It is justifiable, on the grounds of public protection, to detain a person who has been found to have committed what would have been a criminal offence but for his or her medical condition (whether physical or mental).

No reason for distinguishing between different causes of non-responsibility

- 2.15 A third argument that has been advanced by those favouring abolition is that the insanity defence distinguishes unfairly between the person who is excused by reason of their mental state and the person who is not excused having been driven into criminal behaviour by other circumstances beyond their control. This is one of the arguments developed by Morris. His argument has been summarised as follows:

Morris contended that the special defense of insanity, taken on its own terms, was morally bankrupt because, in practice, it was hopelessly underinclusive. The defense was premised on the idea that persons who lacked the power to make a meaningful choice could not be considered morally blameworthy. Yet various conditions other than mental illness that limited the power to choose, such as social deprivation, were excluded from consideration by the law. And even within the permitted exception, many persons who might qualify for exculpation as insane never had a chance to raise the insanity plea, because they lacked the resources to pay competent lawyers and expensive experts The only morally consistent course was to reject a special defense of insanity altogether.¹⁵

- 2.16 We accept, subject to important qualification, the objection that there may be no good reason for distinguishing between mental illness and other conditions which remove a person's ability not to do what they do (or to choose what they do). We address this argument below where we explain why we think the defence should extend to physical conditions as well as mental conditions.
- 2.17 We cannot, however, go as far as Morris in accepting that other circumstances outside the individual's control can be accepted as a legal basis for non-responsibility. It may be that, for example, an accused person suffered brain

¹⁴ A Brudner, "Insane Automatism: A Proposal for Reform" (2000) 45 *McGill Law Journal* 65, 76.

¹⁵ P Appelbaum, *Almost a Revolution* (1994) p 175.

damage due to his mother's alcoholism while pregnant. If that brain damage is severe enough then it may affect his ability to understand the consequences of his actions to the point where it is not just to hold him responsible. However, in such a case the reason for a defence based on his non-responsibility would be the lack of capacity. The background causes of that lack of capacity are not legally relevant (save where they amount to prior fault of the accused).¹⁶

The arguments for a special defence

1: That if a person is non-culpable because of mental disorder, then that should be the true ground for the verdict, not the presence or absence of mens rea

- 2.18 We consider that the analysis which depends purely on whether the elements of an offence (the actus reus and mens rea) are satisfied can lead to unwelcome results, as described below, and also that it fails to reflect what a mental disorder defence is about. Our analysis of the foundations of an insanity defence led us to conclude that it is essentially a denial of criminal responsibility due to a person's lack of capacity. That effectively amounts to a plea: "I, the defendant, deny responsibility for what it is I have done. I do so on the basis of my medical condition at the time, irrespective of whether I could be said to have had any particular mens rea at the time". If the accused's medical condition explains why he or she either did *or did not* have the relevant mens rea for the offence, then the defence should apply. Similarly, if his or her medical condition was such that he or she did not have the capacity to avoid performing the proscribed conduct, then it does not matter whether the offence required any particular mens rea or not.
- 2.19 Howard has described the abolition proposal as "difficult to justify":
- If we are able to say that an individual who suffers from a mental disorder is not responsible and therefore is not a moral agent, it is inaccurate and artificial to describe such an individual as lacking *mens rea*. An absence of responsibility ought to precede consideration of any of the elements of an offence.¹⁷
- 2.20 Or, as Moore puts it: "Crazy people are not responsible because they are crazy, not because they always lack intentions, are ignorant, or are compelled".¹⁸
- 2.21 The argument against having a simple acquittal where a person lacks the mens rea because of his or her mental condition can be illustrated by the case of *Ratnasabapathy*.¹⁹ This tragic case concerned an accused with a diagnosis of autistic spectrum disorder ("ASD"). He was charged with causing grievous bodily harm with intent to do so contrary to section 18 of the Offences Against the Person Act 1861, and child cruelty contrary to section 1(1) of the Children and Young Persons Act 1933. The issue on appeal was whether the jury had been

¹⁶ See S H Kadish, "Excusing Crime" (1987) 75(1) *California Law Review* 257, 284.

¹⁷ H Howard "Reform of the Insanity Defence: Theoretical Issues" (2003) 67(1) *Journal of Criminal Law* 51.

¹⁸ M S Moore, *Law and Psychiatry* (1984) p 223.

¹⁹ [2009] EWCA Crim 1514 (the substantive appeal).

correctly directed on how the defendant's mental condition affected proof of the mens rea for the charges.²⁰ In respect of the section 18 charge, the mens rea required was intent to cause really serious harm. The child cruelty charge required proof of wilful neglect in a manner likely to cause unnecessary suffering or pain to the child.²¹ The allegations were that the appellant, the victim's father, had failed to seek medical help for fractures suffered by the baby, and that he had tried to force feed her with a pipette in such a way as to cause brain damage and cardiac arrest. The defence relied on the appellant's ASD to explain his failure to respond appropriately, and his force-feeding of the baby. The defence said that, by reason of his condition he was less likely than a person without that condition to realise that the baby was in pain, and that his rigidity of thought, together with other features of his thinking patterns, meant that he would not realise that he was harming the baby.

- 2.22 Following his conviction, the accused killed himself.²² The appeal was pursued following his death. In the event, the appeal failed.²³ We use the case as an illustration because if mens rea had not been proved in this case, a simple acquittal would not seem to reflect the reality of what had happened. If this accused was not guilty of the very serious charges, it would be more accurate to say that he was not guilty (or not criminally responsible) *because of* his mental condition.

2: Public protection requires the court to have special powers

- 2.23 If there were no specific defence of insanity, then if a defendant with a mental illness was acquitted, a potentially dangerous person could be released without any criminal order for his or her treatment, for the protection of the public or of specified members of the public.²⁴

²⁰ See *Ratnasabapathy* [2009] EWCA Crim 695 at [32] and [33] in which leave to appeal was given.

²¹ This includes deliberately refraining from obtaining medical help, or failing to obtain it because the parent does not care whether help is obtained or not. It does not include the case where the parent genuinely does not realise (perhaps due to his or her mental state) that medical help is needed: *Sheppard* [1981] AC 394; *W (Emma)* [2006] EWCA Crim 2723; and *Blackstone's* B2.140.

²² The insanity defence was not raised. It is a matter for speculation whether the jury convicted because, being unaware of the alternative special verdict since it was not available to them, they found conviction to be less unpalatable than a simple acquittal where the child had been so severely harmed. It may of course be that the jury was sure that the accused really did intend the harm.

²³ It failed because the verdict was not unsafe, despite defects in the trial judge's direction. There was "plenty of evidence that demonstrated that R had shown consequential understanding" and although he clearly had a mental disorder, "it did not create a complete lack of capability": [2009] EWCA Crim 1514.

²⁴ The Court of Appeal has recently held that a restraining order following an acquittal must identify a person or group of persons whom it is designed to protect: *Smith (Mark John)* [2012] EWCA Crim 2566, [2013] Criminal Law Review 250 (see n 24 in ch 7 below). It is not therefore an appropriate vehicle for protection of the public generally. In *AR* [2013] EWCA Crim 591 the Court of Appeal held that, even if it is feared that the individual's mental state will deteriorate and that specified people will be at risk of harm, a restraining order will not be appropriate if the court is not satisfied that the individual is likely to pursue a "course of conduct" within the meaning of s 1 of the Protection from Harassment Act 1997.

- 2.24 Consider the example of the *Attorney General's Reference (No 3 of 1998)*.²⁵ In that case, the defendant was charged with aggravated burglary, with a count of affray added subsequently. He smashed his way into someone's home with a snooker cue and tried to strike the householder. It took five police officers to restrain him. It was agreed by the prosecution and the defence that he was legally insane at the time of the offence. There was psychiatric evidence that the accused was unable to form a criminal intent at the time of the offence and at first instance the jury was directed to acquit. In the words of Lord Hutton, "a man who had committed very violent acts at a time when he was insane and did not realise that his acts were wrong was set at liberty".²⁶ If there were no special defence, then, because mens rea could not be proved in such a case, that accused would go free.²⁷
- 2.25 If there were no specific defence of mental disorder and no special verdict, then the defendant may be acquitted or convicted. In the event of acquittal the court would need the power to detain the acquitted person in order to impose some kind of civil treatment or detention order. This is because the criminal proceedings would have ended, and so the court would have no power to make any order directed at treatment or detention of the acquitted person. If detention were thought necessary on mental health grounds then the appropriate civil proceedings would have to be started.
- 2.26 There are, however, specific reasons why reliance on existing civil powers of detention for public protection would be inadequate. First, if only those powers were available, a short but dangerous time gap would arise between the moment of acquittal and the making of a civil order for admission. There would need to be an additional power to detain the acquitted person immediately so that the application to detain him or her as a civil patient could be made.
- 2.27 More importantly, a significant feature of detention as a criminal patient lies in the Secretary of State or tribunal having oversight when a restriction order has been imposed. If a restriction order has been attached in a criminal case then the patient may only be discharged from hospital by the responsible clinician or hospital managers if the Secretary of State consents, or by the Secretary of State, or by a tribunal.²⁸ In contrast, a civil patient may be discharged by a responsible clinician or hospital manager without reference to the Secretary of State. In cases of criminal detention with a restriction order where the clinician recommends that the patient be released, the consent of the Secretary of State will not automatically be given. Each case is considered individually, and the Secretary of State will consider the need to protect the public.

²⁵ [2000] QB 401. On this case, see case note: J R Spencer, *A-G's Reference No 3 of 1998*, 2000 (2000) *Cambridge Law Journal* 9.

²⁶ *Antoine* [2001] 1 AC 340, 371.

²⁷ As in fact occurred in the case, because of the ruling at first instance that the prosecution had to prove all elements of the offence, including mens rea. On appeal it was held that the trial judge had been wrong, and the prosecution did not have to prove that the accused had the mens rea: [2000] QB 401.

²⁸ Namely, the First Tier Tribunal (Mental Health), the Upper Tribunal for England and the Mental Health Review Tribunal for Wales.

- 2.28 The difference in duty between the role of the Secretary of State and the role of the Tribunal is also significant. The Tribunal has a duty to release the individual if the conditions for detention under the 1983 Act are not met. The Secretary of State has a broader discretion, and may discharge the patient if he or she sees fit.
- 2.29 For all these reasons, we conclude that civil powers of detention are not adequate to protect the public in cases where a person has been acquitted.

3: What of cases where the mens rea existed, but resulted from a mental disorder?

- 2.30 The more problematic case for those who support the abolition proposal is the one where the defendant is proved to have had the relevant intent for the crime charged – to cause grievous bodily harm, for example – but was suffering from delusions at the time which affected the formation of the intent. If there were no special mental disorder defence then the actus reus and the mens rea could both be proved against such a person and he or she would be convicted and held criminally responsible despite his or her mental state. Proponents for the abolition of the special defence would accept this as a just result.²⁹
- 2.31 If the defendant is confined simply to denying mens rea, then it is strongly arguable that some of the most ill people will be unfairly at risk of conviction (such as the accused in *Ratnasabapathy* described above). The point is put by commentators criticising the law in States in the USA where there is no defence of insanity:

No matter how limited an insanity defense may be, some defendants will have been so grossly out of touch with reality at the time of the crime that an excuse is warranted because their mental disorder ... interferes with their rationality even if it does not interfere with their formation of *mens rea*. It is precisely because of this category of defendants that *mens rea* alone cannot do the work necessary for a morally coherent system of criminal responsibility.³⁰

This strikes us as a very persuasive point.

4: The proposal must take account of defences

- 2.32 Finally, there is the less powerful argument that proof of actus reus and mens rea is not all that matters in a criminal trial: the law allows for defences which justify

²⁹ As described by Mackay: "Thus Morris maintains that 'there would be no greater injustice involved in convicting such [cases] and applying the psychological diagnosis to the decision how to treat the offender than in convicting in any of the other thousands of cases that daily flow through our criminal courts'". Mackay (1995) p 126 quoting N Morris and G Hawkins, *The Honest Politician's Guide to Crime Control* (1969) p 80. Morse comments, "Those who believe that the insanity defense should be abolished must claim either that no defendant is extremely crazy at the time of the offense or that it is morally proper to convict and punish such people": S Morse, "Excusing the Crazy: the Insanity Defense Reconsidered" [1985] 58 *Southern California Law Review* 779, 780. See also N Morris, "The Criminal Responsibility of the Mentally Ill" (1982) 33 *Syracuse Law Review* 477.

³⁰ S Morse and M B Hoffman, "The Uneasy Entente Between Insanity and Mens Rea: Beyond *Clark v Arizona*" (2007) *Scholarship at Penn Law*, Paper 143, p 64.

or excuse what would otherwise be a crime, such as self-defence, duress and necessity.³¹ Unless this is taken into account, people whose perception of reality is affected by their mental disorder will be treated differently in law, depending on whether their perception relates to a matter of mens rea, or a matter of defence.³² For example, the person who believes he is strangling a snake not a person would lack mens rea for an offence against the person, but the person who mistakenly believes he is being attacked by a person when he is not, would have mens rea for the assault but would qualify for a defence if his response to the threat and danger as he perceived it was reasonable. Even worse, some defences have a mental element, such as where the accused must hold a particular belief for a defence to be made out.³³

Conclusion

- 2.33 The abolition of a special defence for the mentally disordered would result in conviction of people who could not, due to their mental disorder, have avoided committing the crime, and in our view that result is not just. We respectfully agree with McAuley:

If the [M’Naghten] Rules did not exist, it would be necessary to invent something very like them. This follows from the inescapable fact that serious mental illness is a cognitive failing that radically affects an agent’s capacity to act rationally, and that there is a strong moral impulse to exempt those who ... are manifestly incapable of acting rationally from criminal responsibility. The problem is therefore to fashion a criterion of insanity that accords with the common perception of mental illness as a pervasive defect of reason, and that enables juries to acquit where it seems morally appropriate to do so.³⁴

- 2.34 **Conclusion 1: We therefore conclude that there should be a defence which allows for a special verdict where the case is not proved against the accused because of his or her mental disorder as well as where it is proved because of the mental disorder.**

³¹ This was one of the reasons for the New Zealand Law Commission’s rejection of this option: New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 3.6.

³² For the ambiguities as to the division between elements of an offence and defence, see A Simester, “Mistakes in Defence” (1992) 12 *Oxford Journal of Legal Studies* 295.

³³ Such as a belief as to the age of a particular person.

³⁴ McAuley pp 25 to 26. He then goes on to say he thinks this is best done within the framework of the M’Naghten Rules. See also the Scottish Law Commission which rejected the option of having no defence of insanity principally on the ground that it did not give effect to the “basic principle” that it is unfair to hold a person responsible where he or she suffers from a severe mental disorder: Scot Law Com 195, para 2.17.

A MENTAL DISORDER DEFENCE?

2.35 A mental disorder defence might look something like this:

Where an accused would be convicted of the offence charged but there is sufficient evidence that at the time of the alleged offence he or she had a mental disorder and, as a result of that disorder, he or she wholly lacked one or more of the relevant criminal capacities, then the jury or magistrates shall return a special verdict of “not criminally responsible by reason of mental disorder”.

“Mental disorder” would include any disorder or disability of the mind, learning disability or learning difficulty, but not acute intoxication or a disorder characterised solely or principally by abnormally aggressive or seriously irresponsible behaviour.

The relevant criminal capacities would be the accused’s ability, in relation to what he or she is alleged to have done, to form a rational judgment, to appreciate wrongfulness, and to control his or her physical acts. (We discuss these capacities at paragraphs 4.4 and following below.)

The defence would not be available where the accused had culpably brought about the loss of capacity.

The connection with the defence of automatism

2.36 The question arises, if a statutory mental disorder defence were created in England, what would be the position of the automatism defence.

2.37 The evolution of the defence of (sane) automatism has a particular history in English law:

As a distinct defence, in English and Australian law automatism dates from the early 1950s.³⁵ The impetus to develop automatism or a defence akin to automatism had its origin in the combination of two pressures. The first pressure arose from the limitations of the M’Naghten formulation of insanity. Notwithstanding development and refinement of the M’Naghten rules, it remained the case that if the potentially exculpatory mental state of the accused did not proceed from a disease of the mind, the defence of insanity would not be available. The second pressure derived from an appreciation that a verdict of insanity, even if available, carried the consequence of indefinite confinement which was, in some cases, clearly not a just outcome.³⁶

2.38 As we have explained in chapter 1, the case law in England has, on consideration of “insane automatism” and “sane automatism”, relied on the “fundamentally flawed”³⁷ distinction between “internal” and “external” causes to

³⁵ The earliest reported case in which the term “automatism” is used in its modern sense is *Harrison-Owen* [1951] 2 All ER 726 (footnote in original).

³⁶ C R Williams, “Development and Change in Insanity and Related Defences” (2000) 24 *Melbourne University Law Review* 711.

³⁷ C M V Clarkson and H M Keating, *Criminal Law: Text and Materials* (7th ed 2010) p 382.

differentiate the two, leading to the unreasonable classification of epilepsy and a hyperglycaemic state as falling within “insane automatism”.

- 2.39 Reform of the defence of insanity entails reform of the defence of automatism for the following reason. If the insanity defence were to be reformed by introducing a statutory mental disorder defence, inevitably, the existing common law rules on insane and non-insane automatism would be abolished. The result would be that, unless the automatism defence was also reformed and put into statutory form, there would be unanswered questions for the courts to resolve. For example, a defendant whose not guilty plea rested purely on the fact that at the time he or she was suffering from an epileptic fit would, under the current law, be classified as an “insane automatism” case. Under a reformed mental disorder defence he or she would not seek to rely on the proposed defence of mental disorder, and yet he or she would seek to plead “not guilty” on the basis that his or her actions were involuntary. The preceding common law would have classified the defendant as “insane”, but how would the judges deal with the basis of plea? We do not think it would be appropriate simply to leave such a question to be resolved somehow by the courts through the operation of case law. A reformed automatism defence would need to be put on a statutory footing alongside a mental disorder defence.
- 2.40 A reformed automatism defence, to complement a mental disorder defence, could be formulated along the following lines:

The accused shall not be convicted if he or she may have been incapable of effective control of his or her actions at the time of the alleged offence, other than as a result of mental disorder or voluntary intoxication.

- 2.41 An essential difference between a mental disorder defence and an automatism defence is that the former would lead to a special verdict and the latter to a simple acquittal. The court would continue to have special powers of disposal following a special verdict, but no special powers of disposal following an acquittal (with the exception of the power to make a restraining order which arises in some limited circumstances).³⁸
- 2.42 If, therefore, there were a mental disorder defence, the result would be that the public may be protected from a recurrence if the accused suffered from a mental disorder, but not if the accused suffered from a physical disorder.³⁹ In our view, this is a strong reason not to limit a special defence to mental disorder.

Uncertainty about the definition of “mental disorder”

- 2.43 Another strong reason for not limiting the special defence to mental conditions is the difficulty of finding the right terminology for describing mental disorders in this context. There is not even a settled definition of mental disorder in the central medical reference texts, as the introduction to DSM-IV notes: “The concept of

³⁸ Protection from Harassment Act 1997, s 5A, inserted by s 12 of the Domestic Violence, Crime and Victims Act 2004.

³⁹ We have considered the possibility of adapting the automatism defence to allow a different kind of special verdict for some categories of defendant suffering from a physical disorder but concluded that the result would be unnecessarily complicated.

mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations”.⁴⁰

- 2.44 We do not think it would be helpful to cast the defence in terms of persons being of “unsound mind”. To do so might appear useful because it would align the English defence and the description in the ECHR of a condition justifying detention under article 5(1)(e).⁴¹ This return to language of the 1930s⁴² does not, however, seem to us to be viable because it is not obvious what “unsound mind” means; it is not defined in the case law; nor is it consistent with our policy aim of avoiding language that is out of step with modern psychiatric thinking.
- 2.45 An obvious possibility would be to refer simply to “mental disorder”, building on the definition in the 1983 Act, but this is not necessarily a simple solution. In the criminal law, the definition of “mental disorder” in section 1 of the 1983 Act is often relied upon,⁴³ but while it may work in those contexts, it would not do so for the purposes of a general defence without modification.
- 2.46 We have seen that although the 1983 Act opens with a definition of “mental disorder” (“any disorder or disability of the mind”)⁴⁴ it is not in fact a fixed definition: it is modified in the Act according to its purpose. Thus, in some situations it includes learning disabilities, but a person with a learning disability is specifically excluded from the definition of person suffering from mental disorder for the purposes of specific provisions in the 1983 Act, “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”. The function and purpose of the definition in section 1(2) of the 1983 Act is to feed into lawful decisions as to treatment and containment in the civil sphere. It is not surprising, therefore, that it would need adaptation in order to serve the quite different function of exempting a person from criminal responsibility.⁴⁵ A simple reference to the definition in the 1983 Act would not, therefore, be appropriate.
- 2.47 If we were to propose a defence based only on mental disorder it would be vital to have a clear definition of “mental disorder”. Reliance on the 1983 Act would not do. It then becomes a very difficult exercise to identify what types of mental illness would qualify. It is obvious that conditions such as diabetes and epilepsy are not “mental disorders”, but what about sleep disorders? Would the mind have to be distinguished from the brain, in order not to bring disorders such as epilepsy

⁴⁰ See under Definition of Mental Illness: American Psychological Association, *Diagnostic and Statistic Manual for Mental Disorders*, - DSM IV (4th ed 1997). See also the revised edition: DSM IV-TR (2000) and, in 2013, DSM-5.

⁴¹ On art 5(1)(e) see paras 4.146 to 4.148 below.

⁴² The phrase was used in the Mental Treatment Act 1930, s 20, which has since been repealed.

⁴³ For example, in the Sexual Offences Act 2003, s 79(6), for the purpose of identifying a potentially vulnerable person who could be a victim of a sexual offence under s 30.

⁴⁴ See s 1(2) of the 1983 Act, as amended by s 1 of the 2007 Act.

within it? And what about those disorders which have an organic origin – are not psychiatric in nature – but which lead to an alteration in a person’s psychological make-up? For example, if a person has suffered brain damage, that can in some cases lead to a greater risk of loss of self-control. Is brain damage then to be classified as mental disorder? The alternative would be for the brain-damaged person to plead automatism, and, if successful, to be simply acquitted.

2.48 To take another example, what of the person who suffers shock and commits an offence, such as the person who, following a “road rage” incident, is assaulted by another driver and immediately thereafter drives straight into the back of the car in front? If shock is a mental disorder, then there would be a special verdict, but it could be argued that shock is not a disorder but merely a normal reaction.

2.49 We conclude on this point that a specific definition of mental disorder would be required, but that it could be problematic and risk creating arbitrary distinctions as found in the present law.

The alternative

2.50 The alternative possibility, which we present as our preferred option in this paper, is that the defence should be expanded to include physical as well as mental conditions. At first sight it might appear that an extremely large number of defendants might be able to rely on such a defence if it was not restricted to mental disorder. This would not in fact be the case because the crucial question would always remain: did the accused wholly lack one or more of the relevant criminal capacities at the time of the alleged offence? Provided that we have identified the right capacities (on which, see paragraphs 4.4 and following below) then the kind of disorder or condition is not the most significant feature of the defence.

2.51 As with a mental disorder defence, the defence of automatism would also have to be reformed.

The shortcomings of a mental disorder defence

2.52 We prefer the recognised medical condition defence because in our view there are significant difficulties with restricting the special defence based on a lack of capacity to cases of mental disorder. In addition to the unsatisfactory outcomes in the practical application of the defence as we explained above, there are more principled objections.

No reason to treat mental disorders differently from physical disorders

2.53 As a matter of principle, there is no reason to restrict a defence of non-responsibility to those people with mental disorders. We can see no reason to distinguish here between physical and mental conditions: if, at the time of an alleged offence, a person did not have the capacity to avoid performing the

⁴⁵ Another possibility we have discounted was to include a reference to symptoms and diagnostic criteria: see the draft Criminal Code of 1989, and the proposals in P Shea, “M’Naghten Revisited – Back to the Future?” (2000) 12(3) *Current Issues in Criminal Justice* 347, 360. The risk of having a defence cast in terms of symptoms is that it will not be clear enough, and a great deal of court time could be spent inquiring into the presence or absence of symptoms.

conduct which would amount to a criminal offence, then he or she should not be held legally responsible whether that inability was physical or mental. It should not matter whether that lack of capacity is due to mental disorder (by which we mean mental illness, learning disability or learning difficulty) or to a physical condition so long as the other criteria of the defence are met.

- 2.54 It is notable that the present law already recognises that some physical conditions which result in a relevant lack of capacity fall within the special defence. Examples of cases in which purely physical conditions have given rise to insanity pleas include *Sullivan* (epilepsy) and *Quick* (diabetes).⁴⁶
- 2.55 Relevant incapacities may result from mental illness, from what may be called a disease of the brain (epilepsy), or from a mental disorder which, though organic in nature, shares features with mental illness (such as dementia). The mind/body distinction is not helpful in this context.⁴⁷ Where it is hard to disentangle whether a person acted as a result of mental illness or some physical condition, the effect of our new defence would be that, so long as the accused lacked the relevant capacity as a result of a recognised medical condition, the jury need not specify which of various medical causes was determinative.

Reduced stigma

- 2.56 Although a verdict of “not criminally responsible by reason of mental disorder” would be less stigmatising than the current special verdict of “not guilty by reason of insanity”, we think a verdict of “not criminally responsible by reason of recognised medical condition” would go further in removing stigma from the verdict.⁴⁸ It would also remove any distinction between physical and mental illness, and in doing so help reduce the stigma attaching to mental illness.

More appropriate labelling

- 2.57 Consider the example where a person is charged with causing death by dangerous driving. She suffers from diabetes and says it was committed as a result of falling into a hypoglycaemic coma which she could not have anticipated. She had been following medical advice as to insulin, eating and monitoring her blood sugar levels. At present she would be acquitted outright. We would argue that her situation more appropriately fits within a defence of not criminally responsible by reason of medical condition. This is an accurate description and indicates that she was not to blame.

⁴⁶ *Sullivan* [1984] AC 156 and *Quick* [1973] QB 910. See n 21 in ch 1 and para 1.42 above respectively.

⁴⁷ The overlap between physical and mental harm is already recognised in the law: for the purposes of proving “bodily harm” as a component of an offence against the person, “bodily harm” may include psychiatric injury: “the phrase ‘actual bodily harm’ is capable of including psychiatric injury. But it does not include mere emotions ... nor does it include, as such, states of mind that are not themselves evidence of some identifiable clinical condition”: *Chan-Fook* (1994) 99 Cr App R 147, 152, by Hobhouse LJ. Psychological injury which does not amount to a recognisable psychiatric illness does not amount to “bodily harm”: *Dhaliwal* [2006] EWCA Crim 1139, [2006] 2 Cr App R 24.

- 2.58 A special verdict of “not criminally responsible by reason of recognised medical condition” would attach to a person who had lost capacity as a result of mental illness at the time of the offence. He too would not be to blame, and the verdict would reflect that. The special verdict would, however, make an order for public protection possible.
- 2.59 We would argue that public protection justifies the court having special powers in the event of a special verdict in both these cases, and a new special defence for recognised medical condition leading to a new special verdict would allow this. The particular disposal might be very different in one case from the other: the person with mental illness might be made the subject of a hospital order whereas the person with diabetes would receive a supervision order or an absolute discharge, but some kind of special disposal may be needed.

Appropriate outcomes

- 2.60 The advantages of a recognised medical condition defence over a mental disorder defence are also apparent when considering the effect on cases which might be classified as “automatism”. Those conditions which may be clearly classified as physical disorders and not mental disorders would lead to acquittal if the special defence were confined to mental disorders. This would include people with epilepsy, diabetes, those who suffered from hypoglycaemia for some other reason, those who had suffered a stroke, or from arteriosclerosis. It might include those who suffer from sleep disorders, but that is not clear. The court would have no powers to deal with a person even if it thought that the risk of recurrence meant that harm might well result in the future. If, by contrast, the special defence (with special disposal powers for the court) extended to all recognised medical conditions, then the court would have power to make, say, a supervision order with a medical treatment requirement, where it thought such an order was necessary and desirable.
- 2.61 The automatism defence which would complement the wider “recognised medical condition” special defence would be narrower than the automatism defence which goes with a mental disorder defence. It would be restricted, broadly speaking, to cases of reflex and one-off causes of total loss of control.

Problem to be addressed with the recognised medical condition defence as well as with the mental disorder defence

- 2.62 In the mental disorder defence outlined above, we have excluded acute intoxication and disorders which are characterised solely or principally by abnormally aggressive or seriously irresponsible behaviour. These conditions would also not qualify for the wider “recognised medical condition” defence, and so they are explained in chapter 4 below.

⁴⁸ The definition of “incapacitated person” in s 118 Taxes Management Act 1970 (“any infant, person of unsound mind, lunatic, idiot or insane person”) was removed by s 222(4)(a) of the Finance Act 2012. The Government suggested deleting the definition because these phrases are “offensive and anachronistic”: Summary of responses to a Government consultation on *Incapacitated Person – a Modern Definition* (Dec 2011) p 10.

Conclusion

- 2.63 **Conclusion 2: Our provisional conclusion is that there should be a special verdict in those cases of total lack of criminal capacity resulting from a recognised medical condition (provided the other criteria of the defence are met) without limiting it to mental disorders.**⁴⁹
- 2.64 In the next chapter we describe the main features of the new special defence which we propose; we go into it in detail in chapter 4.

⁴⁹ We have considered also whether it would be beneficial to have different verdicts available for different disorders (eg, “not guilty by reason of sleep disorder”, “not guilty by reason of epilepsy” and so on, as suggested in I Ebrahim, P Fenwick, R Marks and K Peacock, “Violence, Sleepwalking and the Criminal Law: The Medical Aspect” [2005] *Criminal Law Review* 601, 612). We have concluded that, as with any finite list, there would have to be a “sweep-up” clause, which would undermine the usefulness of specific verdicts. Further, there could be considerable legal argument about which of the specific verdicts was applicable, especially in cases where several factors had contributed to the defendant’s act or omission. Accordingly, we have not pursued that possibility.

CHAPTER 3

A NEW DEFENCE OF “NOT CRIMINALLY RESPONSIBLE BY REASON OF RECOGNISED MEDICAL CONDITION” (I): OVERVIEW

INTRODUCTION

- 3.1 We provisionally propose that an accused should not be held criminally responsible where he or she completely lacked the ability to conform to the law, due to a recognised medical condition. This chapter gives an overview of this provisional new defence, and the detail follows in the next chapter. Reforms to the defence of automatism, which would complement the proposed new defence, are set out in chapter 5. The account of this new defence is completed by a discussion in chapter 6 of how it fits with the law on prior fault and on intoxication.¹

TOTAL LACK OF CRIMINAL CAPACITY

- 3.2 The defendant’s lack of capacity is at the heart of our main proposal and this is its principal strength. We think the new defence will be comprehensible to the non-lawyer partly because the concept of lack of capacity is one which is employed in other contexts in the civil law and so is one with which some people are familiar.² The idea of a lack of capacity leading to specific legal consequences is not new. We discuss the relevant capacities in detail in chapter 4.
- 3.3 It is central to the defence that the accused was *incapable* of complying with the relevant law. In other words, the defence is only to be available where the accused totally lacked capacity rather than where he or she partially lacked capacity or lacked effective capacity. This limitation is justified in theoretical terms because this is not a defence of reduced responsibility but of no responsibility. It is also justifiable in policy terms because it will help to exclude from the defence those with, for example, a personality disorder which makes it hard but not impossible to control antisocial impulses.³

Relevant criminal capacities

- 3.4 The relevant criminal capacities in the proposed defence are: the ability rationally to form a judgment, the ability to understand wrongfulness, and the ability to control one’s physical actions. We explain why we have provisionally settled on these capacities as those underpinning criminal responsibility at paragraphs 4.4 and following below. The defence depends on a recognised medical condition

¹ We have considered whether there might beneficially be a single defence of lack of capacity/non-responsibility, which then has categories within it of, eg, being under the age of responsibility, automatism, medical condition, but it seems unnecessarily complicated and inappropriate, given that some of these defences would lead to a special verdict and some would not. We can see, however, that if the criminal law were codified, it might be appropriate to group defences founded on lack of responsibility together.

² The concept of “capacity” is employed in the civil law. See eg ss 2(1) and 3 of the 2005 Act.

³ We discuss how personality disorders relate to the new defence we propose in detail at paras 4.93 and following below.

causing a total lack of one (or more) of these capacities in relation to what the accused is charged with having done.

- 3.5 It is worth noting that “capacity” here is issue and time specific. The question is whether the accused lacked a specified capacity – to form a judgment rationally, for example – and also a specified capacity *in relation to the charge* that the accused is facing. So for instance, a court would not need to inquire into the accused’s ability to think rationally in general terms but would ask, rather: at the point where the accused did what is alleged, could he or she reach a decision rationally about what to do?
- 3.6 As it is the accused’s capacity at the time of the alleged offence which is pertinent, so there is no “passport” to exemption from criminal liability that comes with a diagnosis of, for example,⁴ a mental illness. A person with, say, schizophrenia will not necessarily have lost all capacity to form a rational judgment, and loss of capacity will not be assumed by the court just because a person had a recognised medical condition at the time.

Applicable to all offences

- 3.7 In our view it follows from this foundation for the defence that the defence should be available in respect of offences of strict liability as well as offences which require proof of mens rea.⁵ In other words, the new defence would be available in relation to any kind of offence.
- 3.8 An example may be found in the facts of *DPP v Harper*.⁶ The accused was charged with driving with excess alcohol.⁷ He had been diagnosed with manic depressive psychosis in 1992, had been under treatment for it since 1995, and at the time of the alleged offence was suffering from that condition. His friend thought he was behaving abnormally (for example, throwing chicken feed around at 4am) and was concerned enough to call the police. When arrested, the accused was speaking and acting irrationally. Such a person should, we would argue, be found not criminally responsible by reason of recognised medical condition rather than either being convicted or simply acquitted of the drink driving offence. The fact that mens rea need not be proved in that offence is rather beside the point.

Retaining the possibility of a simple acquittal

- 3.9 The new defence that we propose would not lead to a simple acquittal but to a special verdict with associated disposal powers for the court. Evidently, therefore, the special verdict is not appropriate for a person who ought to be acquitted even if he or she had had the condition at the time of the alleged offence. For example, if the accused is charged with arson but has an alibi for the time of the arson, then a simple acquittal is the right outcome. Under the current law the accused is protected from an unwarranted special verdict of insanity by the requirement on

⁴ We explain why we do not think there should be a general exemption in Appx A at paras A.94 to A.101.

⁵ See para 1.21 above.

⁶ [1997] 1 WLR 1406.

⁷ Contrary to s 5(1)(a) of the Road Traffic Act 1988.

the prosecution to prove that the accused “did the act or made the omission”.⁸ There are inherent difficulties in separating the act or omission from the mental element.⁹ Requiring the prosecution to prove that the accused had done something which would lead to his or her conviction if not for his or her medical condition is, however, important, and our provisional new defence will provide for this.¹⁰

Burden of proof

- 3.10 We discuss the issue of which party should have the burden of proving or disproving the defence in full in chapter 8 below. We conclude that an elevated evidential burden should lie on the accused to raise the elements of the defence but that, once that is satisfied, it should be for the prosecution to disprove the defence.

The role of expert evidence

- 3.11 The accused who raised the new special defence would be required to adduce evidence from two expert witnesses. The expert evidence would not, however, determine the verdict. The ultimate issue of criminal responsibility remains one for the tribunal of fact even if the expert evidence is agreed as to the presence of a recognised medical condition and total loss of capacity.¹¹ A jury is not bound by expert opinion even if it is uncontradicted.¹²

“RECOGNISED MEDICAL CONDITION”

- 3.12 At the core of the proposed test for a new defence would be whether the accused had a recognised medical condition which caused a total lack of capacity to reason rationally or an inability to control his or her actions. We discuss in detail what we mean by “recognised medical condition” and lack of criminal capacity at paragraphs 4.55 and 4.4 below respectively.
- 3.13 A wide pool of people would potentially satisfy this element of recognised medical condition, but that is merely one element of the defence. The defence itself will be a narrow one because of the prior requirement for total lack of capacity, and because not all medical conditions will qualify as “recognised medical conditions” for the purposes of this defence.

Non-qualifying conditions

- 3.14 Whether a medical condition is a “recognised medical condition” for the purposes of the defence will be a question of law. Medical reference texts and expert opinion will guide the judge, but they will not be conclusive as to whether a condition is a “recognised medical condition” as a matter of law. The essence of the defence is that a person is not to be held criminally responsible where he or she lacked capacity not to commit the alleged offence, and was not culpably

⁸ See para 1.31 above.

⁹ See para 1.32 above.

¹⁰ See para 4.6 below.

¹¹ The only possible exception would be in the circumstances described at paras 7.54 to 7.87 below, where no purpose is served by leaving the case to the jury.

¹² *Walton v The Queen* [1978] AC 788; *Khan* [2009] EWCA Crim 1569, [2010] 1 Cr App R 4.

responsible for that lack of capacity. It therefore follows that conditions which necessarily conflict with that underlying principle will not qualify as recognised medical conditions for the defence.

Acute intoxication exclusion

- 3.15 For example, acute intoxication would not be a condition which would qualify for the defence. This is because an acutely intoxicated defendant is directly at fault for becoming intoxicated and thereby for inducing the incapacitated state. This is quite unlike for example alcohol dependence syndrome in which some of a sufferer's drinking may be involuntary. As a matter of policy, an acutely intoxicated defendant should not be exempt from criminal responsibility on the basis that he or she lacked capacity. We do not see why such a person should be entitled to the defence while a person who was drunk to a lesser extent is excluded, given that both of these people are at fault. We explain this in more detail in chapter 4.

Anti-social personality disorders

- 3.16 We anticipate that recognised medical conditions which are characterised solely or principally by abnormally aggressive or seriously irresponsible behaviour – which are manifested by criminal behaviour – would also not qualify for the defence. Such a limitation would take out of the scope of the defence those defendants whose lack of capacity stems from a particular kind of personality disorder. We discuss personality disorders more fully in chapter 4 below.

THE RELATIONSHIP BETWEEN THE NEW DEFENCE AND AUTOMATISM

- 3.17 At present the relationship between insane and sane automatism gives rise to difficulties.¹³ With the introduction of the new defence of “not criminally responsible by reason of recognised medical condition”, the relationship between it and the defence of automatism will inevitably be different.
- 3.18 The new defence accommodates not only those with mental disorder but also those with physical conditions, so the scope of the automatism plea would be narrowed correspondingly. The reformed defence of automatism would be available only where there is a total loss of capacity to control one's actions which is not caused by a recognised medical condition and for which the accused was not culpably responsible. The defence of automatism would apply in the case of a person acting in response to a reflex, but, for example, would not be available to people with diabetes, epilepsy or sleep disorders. Defendants with such conditions would fall within the defence of “not criminally responsible by reason of recognised medical condition”. The proposed defence of automatism is fully described in chapter 5 below. A person who successfully pleaded automatism would be simply acquitted.

THE RELATIONSHIP WITH THE LAW ON PRIOR FAULT AND INTOXICATION

- 3.19 If the accused's lack of capacity is due to something the accused culpably did or failed to do, then the new defence should not be available to him or her. We propose to frame the new defence and reformed automatism defence in accordance with this principle.

¹³ See paras 5.38 to 5.64 below.

- 3.20 We propose an adjustment of the rules on intoxication, in order to avoid generating an anomaly in respect of the person whose loss of capacity, due to a recognised medical condition, arose from an unexpected reaction to a prescribed medicine. We discuss this fully in chapter 6.

A NEW SPECIAL VERDICT

- 3.21 Under the current law, a successful plea of insanity leads to a special verdict, namely not guilty by reason of insanity, with particular disposal powers. The proposed new defence would replace the defence of insanity and lead to a new special verdict – not criminally responsible by reason of a recognised medical condition – with special disposal powers.

DISPOSALS FOLLOWING THE NEW SPECIAL VERDICT

- 3.22 Whether the new defence and special verdict should be available in the magistrates' court as well as in the Crown Court is an issue we discuss in chapter 7 below. We conclude that the new defence and new special verdict should be available at both levels of court. We also discuss there what powers of disposal the magistrates should have following the (new) special verdict. Here we are concerned only with powers of disposal in the Crown Court.
- 3.23 We do not propose any change to the court's powers of disposal as regards adults. Those powers which apply when a defendant is found not guilty by reason of insanity, namely a hospital order with or without a restriction, a supervision order or an absolute discharge, would apply following the new special verdict.
- 3.24 As regards children and young people, we think, provisionally, that the court should also have the option of making a non-penal Youth Supervision Order, which we describe at paragraph 4.153 below.
- 3.25 In the event of breach of a supervision order or a non-penal Youth Supervision Order made following the new special verdict, the question arises whether there should be the possibility of penal sanctions. We expand on this at paragraphs 4.154 and following below.

NAMING THE NEW DEFENCE

- 3.26 We need a label that is accurate, comprehensible, and non-stigmatising (insofar as that is possible). Mackay has written that:

It becomes imperative that a more neutral term be found so that defendants who are mildly depressed or diabetic or who suffer from isolated epileptic fits should not be reluctant to seek a special verdict because of some psychiatric label attached to it, such as "mental disorder".¹⁴

We agree.

- 3.27 We think there is merit in the verdict being "not criminally responsible by reason of ..." instead of "not guilty by reason of ...", because the essence of the plea is

¹⁴ Mackay (1995) p 138.

that the defendant claims not to be criminally responsible.¹⁵ In this respect we would be following the Canadian Criminal Code¹⁶ and recent legislative reform in Scotland.¹⁷

- 3.28 As noted, the basis of the new defence that we are proposing is that the accused wholly lacked the capacity not to do what he or she did which would otherwise constitute an offence. We do not think, however, that it would be helpful to label the defence the “lack of capacity” defence. “Capacity” is used in the civil law to refer to a different test of capacity, and we think that to use the same label for a verdict in respect of a different set of abilities would be confusing.
- 3.29 The basis of the defence is the total lack of capacity due to a medical condition. It would not therefore be appropriate to call it the “mental disorder defence”.¹⁸ We provisionally propose that the new defence be called the “recognised medical condition defence”. The accused would plead “not criminally responsible by reason of a recognised medical condition”, and the special verdict would be in those terms.

¹⁵ See paras 2.18 and following below.

¹⁶ Canadian Criminal Code, s 16. See para C.26 in Appx C to the Supplementary Material to the Scoping Paper.

¹⁷ See s 51A of the Criminal Procedure (Scotland) Act 1995 which states that “A person is not criminally responsible for conduct constituting an offence ...” inserted by s 168 of the Criminal Justice and Licensing (Scotland) Act 2010. See para C.60 in Appx C to the Supplementary Material to the Scoping Paper.

¹⁸ Such a label would also be too wide, because the partial defence of diminished responsibility could also fall into the category of “mental disorder defence”, as Professor Maher noted in relation to the recommendations by the Scottish Law Commission: G Maher, “The New Mental Disorder Defences: Some Comments” [2013] *Scots Law Times* 1.

CHAPTER 4

A NEW DEFENCE OF “NOT CRIMINALLY RESPONSIBLE BY REASON OF RECOGNISED MEDICAL CONDITION” (II): THE DETAIL

- 4.1 In the previous chapter we outlined the main features of the proposed new defence of “not criminally responsible by reason of recognised medical condition”. An accused would be entitled to the new special verdict of “not criminally responsible by reason of recognised medical condition” where he or she wholly lacked a relevant criminal capacity at the time of the alleged offence because of a qualifying condition. The existing prior fault principles would apply to the defence, with the effect that it would not be available in some circumstances where the accused had culpably caused the lack of capacity.¹
- 4.2 In this chapter we explore these elements of the proposed new defence in detail:
- (1) the relevant capacities, namely, to form a judgment rationally, to appreciate the wrongfulness of the act or omission, or to control his or her physical acts in relation to what he or she is charged with having done;
 - (2) what is meant by a “recognised medical condition”;
 - (3) what is meant by a “qualifying” recognised medical condition; and
 - (4) the respective roles of expert witnesses, of the judge, and of the tribunal of fact.
- 4.3 The proposed defence is described fully from paragraph 4.4 below. The provisional proposal is to be found at paragraphs 4.158 and following. At the end of this chapter is a table comparing the outcome of leading cases under the present law with the outcome under our proposed defence. This chapter concludes with a diagram showing the steps the court would take in considering the proposed new defence, and how it relates to the reformed defence of automatism which we discuss in chapter 5.

THE RELEVANT CAPACITIES

- 4.4 The first issue is the loss of a relevant capacity and it is worth noting that the proposed new defence requires that the accused suffered a *total* loss of a relevant capacity. If the accused retained the relevant capacity in some degree, then the defence will not be available.
- 4.5 It is also worth noting that a person may have a diagnosis of a mental illness but it will not automatically follow that he or she totally lacks a relevant capacity. For example, in the Australian case of *Adam*, the accused suffered from bipolar disorder. He had gone walking in the bush and become lost. He tried to light a signal fire in order to be rescued, but the fire rapidly spread out of control. He was charged with causing a bushfire, being recklessly indifferent as to whether his conduct caused the fire. The facts of his diagnosis and his mental distress at the

¹ The interaction with the principle of prior fault is explained fully in ch 6.

time of the offence did not completely negate his reasoning capacities. He was still able to appreciate the risk of starting a bushfire from his act of lighting a signal fire.²

- 4.6 When we considered the partial defence of diminished responsibility in 2006, we examined the definition in section 2 of the Homicide Act 1957 as it then was. We emphasised that the law should make clear the impact of the abnormality of mental functioning on capacity.³ The same point can be made of a defence based on incapacity due to a recognised medical condition: the range of accused people who may rely on the defence of non-responsibility should be defined not just by the existence of a recognised medical condition but also by the effect of that condition. The crucial effect, for the purposes of identifying whether someone has criminal responsibility, is the impact of that condition on the relevant capacities, namely that as a result of the medical condition the accused is incapable in specified ways. The capacity itself cannot exist in the abstract: it must be incapacity in relation to a particular act or omission. The act or omission in question is, of course, the act or omission which the accused is charged with having done, and which would otherwise constitute a criminal offence.
- 4.7 We conclude in Appendix A that the essential capacities, for a person to bear criminal responsibility, are rationality (practical reasoning) and ability to control physical actions. In light of that conclusion we now consider what kinds of capacity must be affected for the defence to apply.

Practical reasoning/ rationally forming a judgment

- 4.8 One of the criticisms made of the cognitive limb of the M’Naghten Rules has been that its focus on cognitive abilities is too narrow. Some reform agencies have proposed broader-based defences where the accused was unable, as a result of mental disorder, to “appreciate” what he or she was doing.⁴ In jurisdictions where an “appreciation” test is applied, there is often case law defining what “appreciate” means.
- 4.9 The Scottish Law Commission in its report⁵ said that “in our view the particular value of the concept of appreciation is that it connotes something wider than simple knowledge and includes a level of (rational) understanding. It therefore avoids the narrowness of the M’Naghten Rules, as they have been traditionally interpreted”. It seems to us that the test ought to extend at least to understanding the circumstances and consequences of the defendant’s act or omission.
- 4.10 Some jurisdictions, such as South Africa, have dispensed with the cognitive limb of the M’Naghten Rules altogether. The South African legislation states that the accused must have been incapable of appreciating the wrongfulness of his act or omission, or of acting in accordance with that appreciation. It has been suggested

² *Adam* [2012] SADC 119 (District Court of South Australia).

³ Law Com 304, para 5.110.

⁴ As in the Federal defence and the American Law Institute Model Penal Code in the US, the Canadian Criminal Code, and in the Scottish and South African legislation. See paras C.50, C.27, C.60 and C.75 respectively in Appx C to the Supplementary Material to the Scoping Paper.

⁵ Scot Law Com 195, para 2.47.

however that this would be interpreted as entailing an appreciation of the nature of the act or omission (because a person must know the nature of the act in order to be able to see it as wrongful or not wrongful).⁶ We take the view that if the appreciation of the nature of the act would be implied even if this cognitive limb were to be left out, then it is better for legislation to be explicit in including it.

- 4.11 Moreover, as the lack of capacity for rational thought underlies the defence, it is clear that the relevant capacities should reflect this. Schopp identifies at least three types of “cognitive competency” that he sees as necessary for practical reasoning: the ability to form accurate beliefs, an ability to draw on existing wants and beliefs that the actor has, and “an accurate reasoning process that allows him to draw warranted conclusions about the probable relationships among various wants, acts, and consequences”.⁷ We can sum this up as an ability rationally to form a judgment. We have considered whether this is best expressed in terms of appreciation or understanding circumstances and consequences, but think that it would in practice be hard to pin down what kinds of consequences a person might be expected to be able to appreciate, and that would not quite capture the connection between reasoning and action.
- 4.12 The comparable position in civil law is instructive here. For the purposes of a test in the civil law we recommended⁸ the functional approach: this asked whether, at the time the decision had to be made, the person could understand its nature and effects. However, we also thought that understanding might not be enough. There were cases where people could *understand* the nature and effects of the decision to be made but the effects of their mental disability prevented them from *using* that information in the decision-making process. The examples given were those of a person suffering from anorexia who always decides not to eat, and a person whose mental disability meant that he or she was “unable to exert their will against some stronger person who wishes to influence their decisions or against some force majeure of circumstances”.⁹ Similarly, in the criminal context, in our report on what “consent” should mean in the context of sex offences,¹⁰ we took the view that the same two elements were crucial: was the person in question unable either to *understand* or to *decide*, and this approach has been followed by the House of Lords in their interpretation of section 30 of the Sexual Offences Act 2003.¹¹
- 4.13 In our work on diminished responsibility we proposed that one of the capacities in question there was whether the defendant was able to form a rational judgment.¹² This was suggested to us by the Royal College of Psychiatrists, and we therefore

⁶ C R Snyman, *Criminal Law* (4th ed 2002) p 170 cited at S Yeo, “The Insanity Defence in the Criminal Laws of the Commonwealth of Nations” [2008] *Singapore Journal of Legal Studies* 241, 250.

⁷ R Schopp, *Automatism, Insanity and the Psychology of Criminal Responsibility* (1991) p 189.

⁸ In Mental Incapacity (1995) Law Com No 231. This resulted in the test in s 3 of the 2005 Act.

⁹ Mental Incapacity (1995) Law Com No 231, para 3.17.

¹⁰ Published as an annex to the Home Office report *Setting the Boundaries* (2000) para 4.84.

¹¹ In *Cooper* [2009] UKHL 42, [2009] 1 WLR 1786.

¹² Law Com 304, para 5.112, n 85.

assume that it would be practicable for a psychiatrist (or psychologist) to assess whether a person had this capacity. On closer consideration, and as we explain in Appendix A,¹³ the capacity in issue here is about *how* a person reaches a decision, not whether the decision itself may be judged to be rational.¹⁴ In practice, a judgment which is irrational (eg that a baby is a log) may lead to the inference that the accused was wholly unable to reason rationally, but the question should nevertheless focus on capacity rather than on the judgment.

Conclusion

- 4.14 **Conclusion 3: We take from the civil law, and from our previous examinations of the issue, that one of the relevant capacities is the capacity for practical reasoning, and for the purposes of the new defence this is best expressed as the capacity rationally to form a judgment about the relevant conduct or circumstances.**
- 4.15 This criterion would deal, for example, with a case where the accused killed someone he believed to be the reincarnation of Napoleon. The accused might realise that it is morally and legally wrong to take the law into one's own hands by killing, and yet be unable to think rationally about what he was doing so that he should not be held criminally responsible.
- 4.16 Another example might be the case of a parent who was clinically depressed to the point of being suicidal, and who jumped off a motorway bridge with her child. The child died, but the mother survived and is prosecuted for murder. If the jury was satisfied that her depression deprived her of the capacity rationally to make a judgment about taking the steps which resulted in the child's death, then the appropriate verdict would be not criminally responsible by reason of recognised medical condition.
- 4.17 That case may be contrasted with that of the mother who is depressed and kills her child as a vindictive act against the child's father. It might be that the fact of being depressed distorts her thinking, but it seems to us that where the jury perceives that she acted out of vindictiveness (say, because of the degree and nature of planning), it would not be satisfied that her depression prevented her making a judgment in a rational way.¹⁵
- 4.18 As regards the effect of the requirement for a total loss of capacity, we do not think that would cause significant difficulty for a jury. For example, even if there was evidence that the accused had severe depression, but that an antagonistic relationship with the child's father was part of the background to that condition, we believe that a jury might still conclude that the accused had not been capable of thinking rationally.

¹³ See paras E.68 to E.73 in Appx E.

¹⁴ This point was made to us by Dr Jillian Craigie in her response to CP 197.

¹⁵ Similarly, even where an accused holds delusional beliefs about sexual intercourse and is motivated by them, if D was nevertheless able to understand that V was not consenting to intercourse, D will not be wholly lacking in a capacity rationally to form a judgment. See, eg, *OV* (2013) British Columbia Supreme Court 52.

Capacity to appreciate wrongfulness

- 4.19 While it is clear that the effect of a recognised medical condition on a person's capacity for rational thought is an important feature if he or she is to be exempted from criminal liability, it is less clear that his or her capacity to make moral judgments about conduct is relevant.¹⁶

What kind of "wrongfulness" is in issue?

- 4.20 In the English jurisdiction, criticism of the "wrongfulness" limb of the M'Naghten Rules has focused on the fact that it is restricted to those who lack awareness that what they are doing is *legally* wrong. This is unwarrantedly narrow, and does not reflect the reality of the psychiatric assessments. Assessing whether a person knew what they were doing was wrong is part of the test which psychiatrists currently apply. Empirical studies show that psychiatrists are more likely to refer to this capacity than to the cognitive limb when providing evidence in insanity cases. The studies also reveal that the psychiatrists interpret this limb of M'Naghten as referring to the accused's awareness of his or her act as morally wrong, not just legally wrong.¹⁷
- 4.21 If "wrongfulness" is to be interpreted as "morally wrong" rather than legally wrong, that begs the question whose morality is to be used as the standard by which the accused's appreciation is judged. It would obviously not be desirable for a court to have to conduct an inquiry into what was generally regarded as morally wrong; on the other hand, the standard cannot be wholly subjective to the accused.
- 4.22 In Canadian case law, the accused need only appreciate that the act was something he or she ought not to do.¹⁸ This approach leaves it open to show that the accused knew the act was against the law, which signals that it is generally thought of as wrong, but does not limit awareness of wrongfulness to awareness of illegality (as English case law does). We think this is an approach we should follow.

Why have a "wrongfulness" limb at all?

- 4.23 Some jurisdictions do not include this limb in their mental disorder defence. Others, by contrast, would put the ability to know right from wrong at the heart of a mental disorder defence.¹⁹

¹⁶ There are conflicting possible approaches. One line of thought is that "procedural rationality is all that is required for the capacity to recognize moral norms", but others would argue that "moral knowledge ... seems to require psychological functions beyond those that underpin procedural rationality": J Craigie and A Coram, "Irrationality, Mental Capacities and Neuroscience" in N Vincent (ed), *Legal Responsibility and Neuroscience* (forthcoming).

¹⁷ See paras 3.33 to 3.38 in the Supplementary Material to the Scoping Paper.

¹⁸ See also s 27 of the Criminal Code of Queensland.

¹⁹ For example, the South African legislation: see para 4.10 above. Bonnie would found the insanity defence *solely* on an inability to appreciate wrongfulness, which he thinks is both necessary and sufficient. R Bonnie, "The Moral Basis of the Insanity Defense" (1983) 69(2) *American Bar Association Journal* 194, 197.

- 4.24 The Scottish Law Commission initially took the view that this “wrongfulness” limb was superfluous, but consultation revealed that this was thought to be inadequate and something to that effect should be part of the defence.²⁰
- 4.25 We think it is instructive that in jurisdictions where the “wrongfulness” limb is not explicitly made part of the defence, in practice it nevertheless seems to work its way back in. For example, in Alaska, the insanity defence is available where “the defendant was unable, as a result of mental disease or defect, to appreciate the nature and quality of the conduct”.²¹ On the face of it there is no basis for the accused to plead the defence on the ground that he or she could not appreciate the wrongfulness of the conduct, but as Mackay has noted,²² this has been interpreted to mean not only “the defendant’s bare awareness of the physical acts he or she is performing” but also his or her “appreciation of the nature and quality of that conduct and its consequences”.²³ Appreciation of the nature of an act surely includes appreciation of its moral qualities.
- 4.26 In some cases, it is precisely because the accused appreciates that what he or she is doing is generally considered morally wrong that it seems fair to hold him or her responsible.
- 4.27 Tadros writes that “failing to understand that what one has done is wrong often merely manifests an ethical failure on the part of the defendant ...”.²⁴ He gives the examples “of those who enslave others because they do not see those others as fully human, or who bind the feet of children because they do not see that it is cruel to do so, or who forcibly have intercourse with women because they do not see that sexual autonomy of women is important”. It is true that part of the culpability of the people in these examples lies precisely in their failure to see that what they are doing is wrong. The same may be said of a person with a personality disorder who may well not personally appreciate the wrongfulness of a crime in the sense of having any moral or emotional understanding. It would not, however, be acceptable to say that the perpetrators in these examples should be exempted from criminal responsibility because they genuinely do not see the moral difficulty in behaving in these ways (and we do not suggest Tadros would exempt them). It is for that failure that they are held responsible.

²⁰ The Commission wrote, “We now consider that a mere reference to lack of ‘appreciation of conduct’ would leave the test incomplete, and in particular would fail to bring out how the mental disorder has an effect on the accused’s conduct”. Scot Law Com 195, para 2.49.

²¹ Alaska Statutes, s 12.47.010 (Supp 1986).

²² Mackay (1995) p 114.

²³ *Patterson v State* (1985) 708 P 2d 712, 717.

²⁴ He gives the example of “Kathy, who makes a racist joke. Bill is (rightly) offended. Kathy responds (honestly) that she sees nothing wrong with the joke. That Kathy does not see that it is wrong to make the racist joke does not establish that she is not morally responsible for making the joke. On the contrary, part of the very criticism that is properly directed at Kathy is that she does not see the joke as offensive when in fact it is”.
V Tadros, *Criminal Responsibility* (2009) pp 324 to 326.

- 4.28 Some²⁵ might say that the ability to make a judgment rationally incorporates an ability to appreciate what is right and what is wrong and therefore there is no need for a separate “wrongfulness” capacity to be part of the test in the new defence.²⁶ It is true that a decision about how to act which took no account of the moral nature of the act might not be the result of a fully rational process, but we consider that this distinct feature ought to be made an explicit part of the capacity test if it is to be part of it at all.
- 4.29 We have considered whether, if this limb is included in the new defence, a person who can recognise the wrongfulness of what he or she is going to do will in some circumstances be unfairly vulnerable to conviction. We have in mind for example a person who tries to kill someone in the sincerely-held belief, arising out of her depression, that it would be better for that victim to be dead, even though she “knows” that murder is against the law. We have concluded that such a person would be entitled to the defence under a different limb – because she would be incapable of rationally forming a judgment due to the distortion of her thinking (as in the example at paragraph 4.16 above).
- 4.30 This “wrongfulness” capacity limb of the defence might, however, be relevant in the following kind of case. If the accused suffered from a mental illness involving paranoia which led to his belief that his child was possessed by evil spirits, he might see no wrong in an “exorcism” which entailed assaults on the child.²⁷ In most such cases, the individual’s capacity is likely to be substantially impaired, not negated. A diminished responsibility plea might succeed on a murder charge. This limb of the proposed new defence could however be significant if there was a total loss of capacity.
- 4.31 Inclusion of a “wrongfulness” capacity limb on which the accused could rely if he was incapable of understanding that his or her act was generally regarded as wrong would not automatically open the defence to those with antisocial personality disorders. Such a disordered person will not be able to rely on the defence if the evidence supports a view that he or she had not lost the ability to appreciate rationally whether an act was right or wrong.²⁸

²⁵ See, eg, Dixon J in *Porter* (1936) 55 CLR 182, 189 to 190, and see the discussion at para 2.45 of Scot Law Com 195.

²⁶ We note, however, that the research shows that psychiatrists do rely on the wrongfulness limb in their assessments, either on its own or in conjunction with the cognitive limb. See para 4.20 above.

²⁷ This is distinct from the case where the accused has such a belief but not as a result of any medical condition: see, eg, *Sogunro* 3 Oct 1996 9507833 Y4. It is also distinct from the case where the accused had delusional beliefs arising from a mental disorder but retained the capacity to know what he or she was doing and that it was wrong: see *B* [2013] EWCA Crim 3.

²⁸ This was the view taken by the Canadian Supreme Court: see *Oommen* [1994] 2 SCR 507, discussed at para 4.101 below. See also *Chaulk* [1990] 3 SCR 1303.

- 4.32 This limb of the defence would not be of any help to a person who, for a reason other than a recognised medical condition, did not know that what they were doing was generally regarded as wrong. For example, an accused who had been indoctrinated but had no recognised medical condition would not qualify for the new defence. If the accused knew that his or her act was something that others would say he ought not to do, though personally thinking he ought to do it, the accused would not be able to plead the defence unless he lacked capacity in one of the other relevant ways as a result of a recognised medical condition. The defence would not, on this basis, be available to a person acting to “avenge” a perceived dishonour or disrespect, for example.

Conclusion

- 4.33 **Conclusion 4: We conclude that if a person did not have the ability to conform to the law because he or she could not understand that the conduct was something he or she ought not to do, and that incapacity was because of a qualifying recognised medical condition, then that person should not be held criminally responsible. Therefore, one aspect of capacity to conform to the law should be the capacity to understand the wrongfulness of the act or omission, and that wrongfulness should not be limited to illegality.**

Capacity to control physical actions

- 4.34 In chapter 1, we refer to one of the criticisms that some have made of the M’Naghten test, namely that it does not encompass mental disorders which affect a person’s ability to control him or herself. This issue is not about abnormal desires, nor even about abnormally strong desires which are the reason for a person’s actions. Impulsivity in itself is not what is in view, and nor even is impulsivity in combination with a recognised medical condition. This “capacity to control” limb of the defence would be relevant when a recognised medical condition gave rise to the complete inability of the accused to control his or her actions at the time of the alleged offence.²⁹ This issue is about a genuine loss of capacity for physical control arising out of a recognised medical condition.
- 4.35 The problem is sometimes referred to as one of “volition”. We avoid the term “volition” because it is not one in everyday use, even by lawyers. We also avoid the term “irresistible impulse” because that suggests that we are dealing with a spontaneous one-off reaction, whereas the action in question might not be in response to an external impulse at all. We also take the practical view that whether a person is able to will not to do something is not the focus; rather, it is whether it is possible for him or her to make a choice. A person with no possibility of making any choice – whose action is in that sense “automatic” – does not have the capacity to control his or her actions. What is in view is “involuntary” actions, meaning those which the person had no possibility of preventing.³⁰

²⁹ Merely showing brain damage, eg, fronto-temporal dementia (FTD) – damage to the frontal lobes caused by trauma or disease – in a person does not lead inexorably to the conclusion that that person lost all inhibition, though that may have been an effect. Some people with FTD become disinhibited, but not all.

³⁰ We discuss this issue in Appx A.

- 4.36 This limb of the proposed new defence covers physical conditions where a person loses the ability to control their bodily actions whether because of a loss of consciousness, such as a person who suffers an epileptic seizure or who has a sleepwalking episode, or through a neurological deficit such as Huntington's disease. For example, a person who suffers from Tourette's Syndrome has no control over sudden movements of his head or "tics". In the pub, when sitting next to another man, his head jerks and makes contact with the other man's face, causing some injury. If prosecuted for assault, the person may plead that he was not criminally responsible by reason of recognised medical condition because he wholly lacked the ability to prevent that tic at that time.

The arguments for including in the defence an element reflecting the lack of capacity to control one's actions

- 4.37 If the basis of the new defence is that a person should not be held responsible for conduct which, due to a recognised medical condition, the person was unable to avoid performing, then it follows that a person should not be convicted of an offence where he or she could not control the physical action.³¹
- 4.38 This argument was recognised in the Irish case of *The People (Attorney General) v Hayes*³² where Justice Henchy stated:

The rules do not take into account the capacity of a man on the basis of his knowledge to act or to refrain from acting, and I believe it to be correct psychiatric science to accept that certain serious mental diseases, such as paranoia and schizophrenia, in certain cases enable a man to understand the morality or immorality of his act or the legality or illegality of it, or the nature and quality of it, but nevertheless prevent him from exercising a free volition as to whether he should or should not do that act.³³

- 4.39 An analogous argument has been considered by the courts in relation to the making of an Anti-Social Behaviour Order ("ASBO"). Though such an order is held to be civil in nature, if the subject of the order breaches it, then he or she will be subject to criminal proceedings. In *Cooke v DPP*³⁴ the appellant said that an ASBO should not have been made against him because he did not have the mental capacity to comply with it due to his personality disorder, post-traumatic stress disorder and possible Asperger's syndrome. The High Court held that an ASBO should not be made if the defendant is truly incapable of complying with it;

³¹ See paras A.74 and following in Appx A.

³² (30 Nov 1967) (unreported). Approved in *Doyle v Wicklow County Council* [1973] IESC 1, [1974] IR 55.

³³ Note that this development may have been driven by the absence of any diminished responsibility defence in Ireland. For more on Ireland, see Appx C to the Supplementary Material, para C.40. An alternative interpretation could be that some conditions prevent a person forming a judgment in a rational manner.

³⁴ [2008] EWHC 2703 (Admin), [2008] Mental Health Law Reports 348.

it would be a wrong exercise of the court's discretion to make one in those circumstances.³⁵

- 4.40 The argument in favour of including such a "capacity to control" limb in a mental disorder defence is not a recent invention:

No doubt, however, there are cases in which madness interferes with the power of self-control, and so leaves the sufferer at the mercy of any temptation to which he may be exposed; and if this can be shown to be the case, I think the sufferer ought to be excused.³⁶

- 4.41 Sir James Fitzjames Stephen went on:

I should be sorry to countenance the notion that the mere fact that an insane impulse is not resisted is to be taken as proof that it is irresistible. In fact such impulses are continually felt and resisted, and I do not think they ought to be any greater excuse for crime than the existence of other motives, *so long as the power of control or choice ... remains*.³⁷

Views of other bodies and jurisdictions

- 4.42 The Atkin Committee thought irresistible impulse should be added to the M'Naghten Rules: "it should be recognised that a person charged criminally with an offence is irresponsible for his act when the act is committed under an impulse which the prisoner was by mental disease in substance deprived of any power to resist".³⁸

³⁵ [2008] EWHC 2703 (Admin) at [12]. In the particular case it was said that "by reason of his impulsiveness, said by [the psychiatric nurse] to be a feature of his borderline personality disorder, he did not have the capacity to comply with the terms of such an order" but it had been found as a fact by the magistrates that it was not inevitable that the defendant would breach it. The High Court drew on the approach of Lady Butler-Sloss in *Wookey v Wookey Re S (a minor)* [1991] Fam 121.

³⁶ J F Stephen, *A History of the Criminal Law of England* (1883) vol II, p 170.

³⁷ J F Stephen, *A History of the Criminal Law of England* (1883) vol II, p 172 (emphasis added) cited by J Horder, *Excusing Crime* (2004) p 155. It is possible to argue that irresistible impulse was in fact part of the law of England and Wales in the nineteenth century. See Oxford's case (1840) 9 C & P 525; 173 ER 941, 950 where the Lord Chief Justice, Lord Denman, said "A person may commit a criminal act and not be responsible. If some controlling disease was in truth the acting power within him which he could not resist, then he will not be responsible". See also *Fryer* (1915) 24 Cox's Criminal Cases 403, 405 in which Mr Justice Bray said, "I am going to direct you in the way indicated by a very learned Judge [Mr Justice Stephen] and follow his direction that, if it is shown that he [the prisoner] is in such a state of mental disease or natural mental infirmity as to deprive him of the capacity to control his actions, I think you ought to find him what the law calls him – insane ...".

³⁸ The Atkin report, p 21. See paras D.3 to D.5 in Appx D to the Supplementary Material. This view led to the Criminal Responsibility (Trials) Bill 1924 which proposed to set out the M'Naghten Rules in statutory form and to add to them, "that the accused is entitled to a verdict of not guilty on the ground that he was insane if, at the time the act was done or omission made which caused the death, he was suffering from such a state of mental disease as therefrom to be wholly incapable of resisting the impulse to do the act or to make the omission". The proponents of the Bill thought that the jury could be relied upon not to deliver a special verdict in cases where it was undeserved. The Bill failed. (1924) 57 *Hansard* (HL) 443 to 476.

- 4.43 The Royal Commission on Capital Punishment regarded the shortcoming of the M’Naghten Rules to be the failure to cover cases “where a person knows what he is doing and that it is unlawful, but, as a result of insanity does not regard it as morally wrong or falls so far short of understanding or appreciating how wrong it is that he ought to be regarded as irresponsible”.³⁹ But they considered the rewording of the M’Naghten formula to be impracticable and favoured the addition of an extra limb in order to cover the instances where the accused “could not help doing it”.⁴⁰
- 4.44 The Butler Committee did not include any element to cover such instances, and nor did the draft Criminal Code. The Scottish Law Commission consulted on the issue, but decided against including such an element.⁴¹
- 4.45 Some other jurisdictions do include this element in mental disorder defences. For example, it is a defence in Ireland if at the time of the alleged offence the defendant was suffering from mental disorder such that he or she was unable to refrain from doing the act.⁴² Under the American Law Institute Model Penal Code, a person “is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law”. Another example may be found in the Criminal Code of Western Australia, where the defence of insanity may succeed if the accused can show that at the time of the offence he or she was in such a state of mental impairment as to be deprived of the capacity to understand what he or she was doing, the capacity to know that what he or she is doing was wrong, or the capacity to control his or her actions.⁴³
- 4.46 The inability to control one’s actions does play a part in the partial defence of diminished responsibility in English law. Section 2 of the Homicide Act 1957⁴⁴ now reads:

(1) A person (“D”) who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—

(a) arose from a recognised medical condition,

³⁹ Report of the Royal Commission on Capital Punishment (1953) Cmd 8932, para 310. See para D.9 in Appx D to the Supplementary Material.

⁴⁰ Report of the Royal Commission on Capital Punishment (1953) Cmd 8932, para 311.

⁴¹ See para D.70 in Appx D to the Supplementary Material.

⁴² Criminal Law (Insanity) Act 2006, s 5(1). See para C.40 in Appx C to the Supplementary Material.

⁴³ In Western Australia, the insanity defence is governed by ss 26 and 27 of the Criminal Code Act Compilation Act 1913 (WA). The Law Reform Commission of Western Australia reviewed the defence of insanity in 1991 and recommended the retention of the element of the defence relating to the lack of ability to control one’s actions. See also the laws of the Australian Capital Territory, of South Australia, the Northern Territory, Queensland and Tasmania outlined in Appx C to the Supplementary Material.

⁴⁴ As amended by the Coroners and Justice Act 2009, s 52. In the context of the defence of diminished responsibility as originally enacted in the 1957 Act, the courts accepted that the accused’s ability to control his or her physical acts was an integral part of the defence: see *Byrne* [1960] 2 QB 396, 403.

(b) substantially⁴⁵ impaired D's ability to do one or more of the things mentioned in subsection (1A), and

(c) provides an explanation for D's acts and omissions in doing or being a party to the killing.

(1A) Those things are—

(a) to understand the nature of D's conduct;

(b) to form a rational judgment;

(c) to exercise self-control.

(1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.

4.47 As can be seen, the ability to exercise self-control is one of the abilities at the heart of the defence. We understand that some judges may think that "loss of self-control" in this context is too vague. We take the point that what is in view here is what the accused did rather than, say, what the accused felt, and so the relevant lack of capacity is the capacity to control one's physical acts in relation to what he or she is alleged to have done. Whether the accused could have chosen differently is not the focus.

Arguments against an element reflecting an inability to control one's physical acts

4.48 There are theoretical arguments against exempting a person from criminal liability on the grounds that he or she lacked the capacity to control his or her physical actions.⁴⁶ One argument is that cases of lack of ability to control oneself are better explained as loss of capacity to act rationally⁴⁷ – but that is not the case for all instances of loss of self-control. For example, in the case of the compulsive hoarder, who acquires and keeps items to the point where it interferes with his or her ability to live the life he or she would choose, there may be no consciously-held irrational belief. The compulsive hoarder may well recognise that he or she does not "need" all the things that fill up the floors in his or her home – but that recognition will not in itself release him or her from the hoarding.

4.49 Another argument is that the idea of lack of capacity to control oneself amounts merely to saying that the agent acted on the strongest motivation or desire. It is not, however, always the case that a person acts in response to his or her strongest desire, unless the strongest desire is defined in a circular way as the one which constitutes the motivation for the action. McAuley gives a persuasive example of the person who compulsively washes her hands, not because it is

⁴⁵ "Substantially impaired" imposes an identical test to that which was applied under the previous version of the Homicide Act 1957, s 2. It has been held that the impairment must be "more than minimal": *Brown* [2011] EWCA Crim 2796, [2012] 2 Cr App R (S) 27.

⁴⁶ See paras A.74 and following in Appx A.

⁴⁷ See *HM Advocate v Kidd* 1960 SLT 86, and the summary by G Maher, "The New Mental Disorder Defences: Some Comments" [2013] *Scots Law Times* 1

what she most wishes to do, but even though she does not wish to do it.⁴⁸ (We do not think it is an answer to his example to say that she must “really” want to wash her hands.)

4.50 We now turn to the practical objections. The principal argument against extending the defence to those who, due to a recognised medical condition, claim they could not have acted otherwise, is the risk of undeserved special verdicts. As Bonnie has written: “the risks of fabrication and ‘moral mistakes’ in administering the defense are greatest when the experts and the jury are asked to speculate whether the defendant had the capacity to ‘control’ himself or whether he could have ‘resisted’ the criminal impulse”.⁴⁹

4.51 There is also the difficulty of acquiring expert evidence on the issue of control. It has been said to be impossible to measure the inability of a person to control him or herself on a past occasion: “it is simply not possible to determine scientifically the difference between an impulse which has not been resisted and an impulse which could not be resisted, either in a person who is clinically sane or a person who has a psychiatric illness”.⁵⁰ Kadish makes a similar point:

A jury can judge whether a person was physically compelled by another or physiologically compelled by a reflex. But (putting drug addiction to one side for the moment) how can a jury distinguish between a psychic compulsion and a strong desire that the person lacks the character to resist? Indeed, how is the psychiatrist to know? Using Greek nouns to describe repetitive stealing or fire setting is hardly an explanation.⁵¹

Mackay, on the other hand, has argued that such assertions are perhaps too negative.⁵²

4.52 The difficulties in extrapolating backwards from interviews with the accused after the event, to find out what he or she was thinking and feeling at the time of the event, may be particularly acute when it comes to establishing what degree of self-control the person had at the time.

⁴⁸ McAuley p 50. He describes such cases as ones “where a person’s beliefs and desires all support one course of action and yet the person persistently does another”. Another example would be the person who compulsively and repeatedly harms him or herself.

⁴⁹ R Bonnie, “The Moral Basis of the Insanity Defense” (1983) 69(2) *American Bar Association Journal* 194,196. See also G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 659. The Butler Committee commented that a difficulty with a test which is put in terms of ability to conform to the law is that “in such cases it is usually fair to say that the only evidence of incapacity to conform with the law was the act itself”: the Butler report, para 18.16.

⁵⁰ Peter Shea, “M’Naghten Revisited – Back to the Future?” (2000) 12(3) *Current Issues in Criminal Justice* 347, 357. Many others have made the same point. The Royal Commission on Capital Punishment thought, on the other hand, that it is possible to tell the difference: Royal Commission on Capital Punishment report, para 313. See para D.9 in Appx D to the Supplementary Material.

⁵¹ S H Kadish, “Excusing Crime” (1987) 75(1) *California Law Review* 257, 283.

⁵² Mackay (1995) p 116.

Conclusion

4.53 **Conclusion 5: Some recognised medical conditions are capable of depriving a person of control of his or her bodily actions. They produce, in that sense, involuntary actions. We accept that as a matter of practice, it can be difficult, particularly in the case of mental disorders, to discern when a person has genuinely lost the power to control his or her physical acts (such as may be the case for a person with a sleep disorder). We nevertheless think that in some cases it is possible for a medical condition to deprive a person of the power to control his or her actions, and that it is right in principle for the law to allow a defence in such cases.**

4.54 We do not think there would be a large number of people who would be able to rely on this “capacity to control” limb, partly because the defence requires a total loss of capacity to control oneself, and partly because there would have to be expert evidence of the underlying recognised medical condition, and partly because the condition would have to be a qualifying condition. We have confidence in the ability of judges, magistrates and juries to see the dangers, and we are encouraged by the fact that other jurisdictions include this element in a defence of mental disorder.

“RECOGNISED MEDICAL CONDITION”

4.55 The second question is what kind of condition should trigger the defence. The condition must be one which *could* cause the individual accused the lack of capacity which he or she claims in the particular case. Evidence of a recognised medical condition which could not have caused the lack of capacity would quite simply be irrelevant.

4.56 A significant feature of the proposed new defence is that it does not distinguish between physical and mental conditions provided they are recognised medical ones.⁵³

4.57 One benefit is that, since the defence is available for people with diverse types of condition, some of which carry stigma and some of which do not, then it might go some way to removing the stigma associated with the present “insanity” defence, and with mental illness in general. The defence will be capable of applying to physical, psychological or psychiatric conditions.⁵⁴ Well-known disorders, such as epilepsy, Alzheimer’s disease, schizophrenia, bipolar disorder, clinical depression, would no doubt be accepted by the courts as “recognised medical conditions”.

4.58 A further advantage of basing the defence on “recognised medical conditions” is that the law would be better equipped to remain in step with developments in

⁵³ We discuss in ch 2 why we think it is beneficial not to limit the defence to mental conditions.

⁵⁴ Some concern was expressed in Parliamentary debate about reform of the defence of diminished responsibility that “medical” excluded psychological conditions, but that concern seems to have been allayed: the amended defence now depends on a “recognised medical condition”.

medical understanding.⁵⁵ This is an important advantage: one of the main criticisms of the current law is that it has not kept pace with developments in psychiatric understanding.

What is not covered

- 4.59 Lack of capacity which is caused by something other than a recognised medical condition does not fall within the proposed new defence. For example, lack of capacity due to a reflex action such as swerving by a driver when a wasp flies into the car⁵⁶ or a stone smashes through the windscreen. The accused in such a case might plead automatism and be acquitted outright.⁵⁷
- 4.60 “Abnormal” physical and mental states which do not amount to a recognised medical condition would not fall within the defence. For example, an event which results in post-traumatic stress disorder would fall within the defence, but reactions to shock or bereavement which are not so severe as to trigger a medical condition would not.⁵⁸
- 4.61 In this respect the criminal defence would echo the criminal law in relation to offences against the person,⁵⁹ and the civil law which, on the issue of what kind of harm may give rise to a claim in tort for damages, distinguishes between recognisable psychiatric illness and the “ordinary emotions” of anxiety, fear, grief or shock:

Bereavement and grief are a part of the common condition of mankind which we will all endure at some time in our lives. It can be an appalling experience but it is different in kind from psychiatric illness and the law has never recognised this as a head of damage.⁶⁰

⁵⁵ For calls for the law to recognise new neurological syndromes which may underlie offending behaviour see O Lewis and S Carpenter, “Episodic Dyscontrol and the English Criminal Law” (1999) 1 *Journal of Mental Health Law* 13 cited by J Peay, “Mentally Disordered Offenders, Mental Health, and Crime” 496, 502 in M Maguire, R Morgan and R Reiner (eds), *The Oxford Handbook of Criminology* (4th ed 2007).

⁵⁶ Where it causes an automatic reaction. Compare *Moses* [2004] EWCA Crim 2506, where automatism was not pleaded and there was judicial comment that the driver ought to have stopped the vehicle to deal with the wasp.

⁵⁷ On which, see ch 5 below.

⁵⁸ We are taking the same line here as in our report on the partial defence of diminished responsibility. See paras 5.72 to 5.75 of *Partial Defences to Murder* (2004) Law Com No 290.

⁵⁹ For the purposes of proving “bodily harm” as a component of an offence against the person, “bodily harm” may include psychiatric injury: *Chan-Fook* (1994) 99 Cr App R 147, 152. See also *Ireland* [1998] AC 147 and *Dhaliwal* [2006] EWCA Crim 1139, [2006] 2 Cr App R 24.

⁶⁰ *Frost v Chief Constable of South Yorkshire* [1999] 2 AC 455, 465, by Lord Griffiths. In our report on liability in tort for psychiatric illness we considered whether it would be sensible to provide a statutory definition of what is a “recognisable psychiatric illness” but concluded it would not. See paras 5.2 to 5.3 of *Liability for Psychiatric Illness* (1998) Law Com No 249.

- 4.62 Similarly, an extreme mental or physical state would not necessarily qualify for this new defence: there would have to be a diagnosis of a recognised medical condition. This would mean that, for example, an incident of rage could not by itself be sufficient evidence of an exculpatory mental disorder.⁶¹

A question for the court

- 4.63 It is important to note that whether a condition is a “recognised medical condition” will be a legal concept to be determined by the judiciary. Whether the medical condition in question is a “recognised medical condition” which qualifies for the purposes of the defence involves the judge deciding whether it was a relevant condition, in other words, that there is evidence from which a jury could conclude that it caused the lack of capacity as alleged. If this initial condition is not satisfied, then there will be no legal basis on which the defence could go before the jury (or, in the magistrates’ court, on which the magistrates could consider the defence).
- 4.64 It is advantageous in individual cases to have a preliminary issue of this nature settled, on appeal if necessary,⁶² before the trial continues. It is also advantageous, when looked at on a broader basis, to have the notion of “recognised medical condition” considered by a higher court for the sake of consistency across courts.
- 4.65 In our view, restricting the issue of whether a condition is a recognised one as a matter for the court to decide has many advantages. It will save time and money by reducing trial length, avoid the jury being distracted by spurious claims, and ensure consistency of interpretation of the concept of medical condition. It will also prevent perverse jury verdicts (such as rejection of the defence simply because the jury is not persuaded that an unfamiliar medical condition exists).
- 4.66 There will be two aspects to the courts’ judgment: whether the condition is one accepted by the relevant profession, and whether it is one which qualifies for the purposes of a legal defence. We now discuss these two aspects.

“Recognised” professionally

- 4.67 The medical condition must be one that is *recognised* by professionals in the relevant field. This limitation would avoid idiosyncratic notions of what constitutes a medical condition; it would go some way to deterring spurious defences; and it would define an issue on which expert evidence could be admitted, in terms which the courts and medical experts can apply. Evidence that a condition is accepted by the relevant profession could be that it appears in an accepted classificatory system, such as the World Health Organisation’s International

⁶¹ See *Gemmill* [2004] VSCA 72 at [31], cited by A Carroll and A Forrester, “Depressive Rage and Criminal Responsibility” (2005) 12 *Psychiatry, Psychology and Law* 36, 39.

⁶² The prosecution may appeal against an unfavourable ruling, in some circumstances, under s 58 of the Criminal Justice Act 2003. A ruling following an appeal under s 58 can be determinative on a point of law, and therefore save argument and increase consistency in the lower courts.

Classification of Diseases (ICD-10) or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-1V).⁶³

- 4.68 The fact that a condition is listed in one of the accepted classificatory manuals does not mean that it will invariably constitute a recognised medical condition for the purposes of the new defence.⁶⁴ Equally, in some very rare cases, a condition which is not listed in either of these reference texts might be accepted by the courts as a "recognised medical condition" if there is adequate evidence of its general acceptance by professionals, such as evidence of peer review. This point was made in debate in relation to the use of the phrase in the reformed diminished responsibility defence:

There is also scope for conditions that are not included in such a list to be deemed recognised medical conditions for the purposes of the test, which addresses one of the concerns alluded to by the honourable Gentleman. Flexibility is important, as it caters for emerging conditions that, while they have not been recognised and put on the classificatory lists, are part way through being recognised and medical people out there are expert at dealing with them. The defence could therefore call a recognised specialist who has had their work peer-reviewed, although it *has not quite got on the list*.⁶⁵

DIFFICULTIES OF DIAGNOSIS

- 4.69 We acknowledge that it may be difficult in some cases to determine whether a person was suffering from a recognised medical condition, perhaps particularly in the case of mood disorders:

Affective illnesses [in other words, emotional disorders] pose particular challenges with respect to placing appropriate boundaries around the insanity defence. As compared to the cardinal symptoms of schizophrenia, such as delusions, hallucinations and formal thought disorder, which are generally considered to be categorically distinct from "normality", the symptoms of mood disorders are dimensional in nature and on a continuum with normal experience.

⁶³ The ICD is the international standard diagnostic classification for all general diseases and health-related conditions. Version 10, including the categories relating to mental health and mental illness, is in the process of being revised. The DSM-IV was the fourth edition of the manual which covers all mental health disorders for children and adults. Included in the manual are clinical syndromes (such as depression, schizophrenia), developmental and personality disorders, and physical disorders which play a part in the clinical syndromes and disorders. This has recently been updated to DSM-5, but this fifth edition was not accessible at the time of writing.

⁶⁴ As Hughes LJ said in *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576 at [40], "The presence of a 'recognised medical condition' is a necessary, but not always a sufficient, condition to raise the issue of diminished responsibility".

⁶⁵ Maria Eagle, Parliamentary Under-Secretary of State for Justice, Committee Debate on the Coroners and Justice Bill, *Session 2008-2009*, 3 Mar 2009, col 413. <http://www.publications.parliament.uk/pa/cm200809/cmpublic/coroners/090303/am/90303s02.htm> (last visited 10 Jan 2012) (emphasis added). See also the remarks of the Attorney General in debate *Hansard* (HL), 30 Jun 2009, vol 712, col 188 to 189. It has been pointed out to us by Nigel Eastman that it would be better if this read "has not yet got on the list": if work has been rejected in a peer-review process then it may not be of sufficient quality to count as a "recognised medical condition".

This is not to argue that, for example, depression can simply be equated with severe unhappiness: clearly depression in its severe forms is a distinct clinical entity. However, the precise point at which, for example, low self-esteem, misery or irritability become pathological is not clear-cut.⁶⁶

- 4.70 It seems to us that this difficulty is to some extent unavoidable. The requirement for expert evidence from two registered medical practitioners mitigates the difficulty.⁶⁷ Despite potential difficulties in some cases with some conditions, the advantage of the recognised medical condition criterion over the present law is obvious. It is a test based on modern medical understanding and not one languishing in the mid-19th century based on concepts such as “disease of the mind” and “insanity”.

APPLICATION TO CHILDREN

- 4.71 Some of those who contributed to the discussions facilitated by the Government on proposed reforms to diminished responsibility were concerned about the scope of “recognised medical condition” in relation to those under 18:

In discussions with stakeholders, it has emerged that a key concern is ensuring that the term “recognised medical condition” captures the conditions which, though not confined to under 18s, may be particularly prevalent among defendants in this age group; learning disability and autistic spectrum disorders have been cited as examples.⁶⁸

- 4.72 The issue is likely to be particularly relevant to young people with learning disabilities, partly because they are over-represented in the population of convicted offenders, and partly because mental illness tends not to be diagnosed before late adolescence.⁶⁹ The Government stated that:

⁶⁶ A Carroll and A Forrester, “Depressive Rage and Criminal Responsibility” [2005] 12 *Psychiatry, Psychology and Law* 36, 38.

⁶⁷ See paras 7.36 to 7.53 below.

⁶⁸ MoJ, *Impact Assessment on the Coroners and Justice Bill: Homicide Clauses* (Jan 2009) p 18.

⁶⁹ HMG, *Healthy Children, Safer Communities* (Dec 2009) p 25. Royal College of Psychiatrists, *Child Defendants*, Occasional Paper OP56 (Mar 2006) p 51: “The majority of child defendants are unlikely to show signs of serious mental illness such as schizophrenia; rather, they are likely to present with a severe, childhood-onset conduct disorder with a wide range of additional contextual psychosocial problems, which should be assessed in a methodical and forensically oriented manner”. See also Toulson LJ, “Can the Courts Provide a More Holistic Response to Developmentally Immature Young Defendants Without Compromising Justice?” Presentation (Apr 2009) p 6.

We recognise that there is debate around the appropriate terminology for such conditions and that not everyone is comfortable with them being labelled as “medical conditions”. We understand this but they are included in the relevant classificatory systems⁷⁰ and it is our view that, for these purposes, the term adequately covers them.⁷¹

- 4.73 At the workshops and in further conversations held by the Government with some key health professionals, there was a clear view that the diagnosis of recognised medical conditions would be possible in children with learning difficulties and autistic spectrum disorders, and that the use of this test was adequate to accommodate them.⁷²

DIFFICULTIES WITH EXPERTS USING DSM-IV AND ICD-10 AND THEIR SUCCESSORS

- 4.74 Whether a condition is a recognised medical condition is to be a question of law for the judge to determine. Expert evidence will be necessary, though not conclusive. The kind of expert evidence will depend on the kind of recognised medical condition which is in issue. We anticipate that in many cases experts may be helped by reliance on DSM-IV or its successor and ICD-10⁷³ in formulating their opinion on whether the accused suffered from a recognised medical condition. However, we acknowledge that these manuals are not immune from criticism. Reliable diagnosis in psychiatry is inevitably problematic.⁷⁴ There are differences in both syndrome and criterion levels between DSM and ICD and these differences can have a significant impact on diagnostic agreement.⁷⁵ Due to the fact that different diagnoses share many of the same criteria, it has been said that DSM lacks reliability because diagnosis lies partly in the perception of the practitioner.⁷⁶

⁷⁰ Reference to the ICD-10 and the DSM-IV (footnote in original).

⁷¹ MoJ, *Impact Assessment on the Coroners and Justice Bill: Homicide Clauses* (Jan 2009) p 18.

⁷² MoJ, *Impact Assessment on the Coroners and Justice Bill: Homicide Clauses* (Jan 2009) p 18.

⁷³ DSM-IV and ICD-10 are international manuals of classification of disorders. See n 63 above.

⁷⁴ “Attaining reliability in psychiatric diagnosis has been a struggle ...” K Soothill, P Rogers and M Dolan, *Handbook of Forensic Mental Health* (2008) p 231.

⁷⁵ A DSM-ICD Harmonisation Coordinating Group has been established to achieve, as far as possible, uniformity and harmonisation. International Advisory Group for the Revision of ICD–10 Mental and Behavioural Disorders, *Summary Report of the 3rd Meeting of the International Advisory Group for the Revision of ICD–10 Mental and Behavioural Disorders* (2008) available at http://www.who.int/mental_health/evidence/icd_summary_report_march_2008.pdf (last visited 12 Jan 2012).

⁷⁶ N McLaren, *Humanizing Madness* (2007) p 88.

- 4.75 Other criticisms are that the classification systems are not culturally sensitive and they underestimate cultural and social variables,⁷⁷ and that the DSM and ICD systems are limited by “inadequate biological understanding of the origin of common mental health problems and its difficulty [in] incorporating the patient’s experience of their difficulties”.⁷⁸
- 4.76 There is a risk that, as the manuals are revised, they will include conditions which do not have general public acceptance.⁷⁹
- 4.77 We note these criticisms of the standard reference manuals, but do not think they undermine the case for having “recognised medical condition” as one essential condition for the defence we propose, because the significance of the condition is the impact it has on the relevant capacities. The key is whether the accused could avoid doing what he or she is alleged to have done; the medical condition is only the explanation for the lack of capacity. In other words, it does not matter what the recognised medical condition is (so long as it is a condition which qualifies for the purposes of the defence)⁸⁰ if the result is that he or she retained the capacity to avoid committing the crime in question. In that event, the defence will fail.
- 4.78 Whether a particular condition is a “recognised medical condition”, and whether the accused suffered from it at the material time is not the end of the story: the condition must be a *qualifying* condition, and it must have given rise to the total lack of a relevant capacity.

“Recognised medical condition” as a legal concept

- 4.79 As stated above, the concept of “recognised medical condition” is a legal one, and a question of law for the court. As a matter of policy, there needs to be some limit on the kind of condition which can trigger a lack of capacity defence; not all medical conditions will qualify as “recognised medical conditions”.⁸¹ The reason is, as Lord Justice Hughes has recently stated, that ICD-10 and DSM-IV are diagnostic and statistical tools, and “there will inevitably be considerations of legal policy which are irrelevant to the business of medical description, classification, and statistical analysis”.⁸² He continued:

⁷⁷ T A Widiger and L M Sankis, “Adult Psychopathology: Issues and Controversies” (2000) 51 *Annual Review of Psychology* 377. See also A Bartlett and G McGauley (eds) *Forensic Mental Health* (2009) pp 14 to 15.

⁷⁸ A Bartlett and G McGauley (eds), *Forensic Mental Health* (2009) p 17.

⁷⁹ Prior to the publication of DSM-5, there were suggestions that the new versions of DSM-IV and ICD-10 would include predispositions to kinds of conditions. The British Psychological Society expressed concern about the inclusion of a range of “highly contentious disorders”: <http://www.bps.org.uk/news/bps-concerns-about-overmedicalisation> (last visited 12 Jan 2012) and about the diagnostic basis of DSM-5: <http://www.bps.org.uk/news/debate-over-basis-psychiatric-diagnosis> (last visited 17 June 2013).

⁸⁰ On which, see paras 4.79 and following below.

⁸¹ Similarly under the current law, whether a person has a “disease of the mind” in the M’Naghten sense is a question of law not medicine, as Lord Justice Hughes has recently affirmed: C [2013] EWCA Crim 223 at [17].

⁸² *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576 at [30].

ICD-10 includes, for example, “unhappiness” (R45.2), “irritability and anger” (R45.4), “suspiciousness and marked evasiveness” (R46.5), “pyromania” (F63.1), “paedophilia” (F65.4), “sado-masochism” (F65.5) and “kleptomania” (F63.2). DSM-IV includes similar conditions and also [conditions] such as “exhibitionism” (569) “sexual sadism” (573) and “intermittent explosive disorder” (663/667). The last of these is defined as “discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property, where the degree of aggression is grossly out of proportion to any precipitating psychosocial stressors”. Not all of these are treated by the classification systems as mental disorders, but all are, doubtless, “recognised medical conditions” in the sense that they are perfectly sensibly included in guides for description of patients by doctors. It follows that a great many conditions thus included for medical purposes raise important additional legal questions when one is seeking to invoke them in a forensic context. “Intermittent explosive disorder”, for example, may well be a medically useful description of something which underlies the vast majority of violent offending, but any suggestion that it could give rise to a defence, whether because it amounted to an impairment of mental functioning or otherwise, would, to say the least, demand extremely careful attention. In other words, the medical classification begs the question whether the condition is simply a description of (often criminal) behaviour, or is capable of forming a defence to an allegation of such.⁸³

“RECOGNISED MEDICAL CONDITION” IN THE DEFENCE OF DIMINISHED RESPONSIBILITY

- 4.80 This phrase appears in the recently reformed partial defence of diminished responsibility. It is a phrase that the Law Commission recommended to replace the unsatisfactory terms of the old diminished responsibility defence in the Homicide Act 1957.⁸⁴ The Government accepted our recommendation to base the definition of diminished responsibility on the concept of a “recognised medical condition”. Section 2 of the Homicide Act 1957 was therefore amended and it now sets out the diminished responsibility defence in those new terms.⁸⁵

⁸³ *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576 at [31].

⁸⁴ Law Com 304.

⁸⁵ Academic comment on the reformed defence was mixed. See, eg, R D Mackay, “The Coroners and Justice Act 2009 – Partial Defences to Murder (2) The New Diminished Responsibility Plea” [2010] 4 *Criminal Law Review* 290, and L Claydon, “Law, Neuroscience and Criminal Culpability” 141, 168 in M Freeman (ed) *Law and Neuroscience, Current Legal Issues* (2010). With regards to the “recognised medical condition” element, commentators have noted that whilst this initially appears to broaden the application of the defence in line with medical opinion, overall the defence is narrower and more stringent. See, eg, *Simester and Sullivan’s Criminal Law* p 720.

- 4.81 Of course, there are crucial differences between the proposed new defence and that of diminished responsibility. The new defence will be available for all crimes, not just murder, and the new defence will require a total loss of a relevant capacity, rather than a substantial impairment as with diminished responsibility. Nevertheless, the fact that Government and Parliament so recently endorsed the element of “recognised medical condition” as part of that test supports our decision to adopt it here at the heart of the insanity defence.
- 4.82 When reform of the partial defence of diminished responsibility was under discussion the Attorney General said that “The concept of ‘recognised medical condition’ represents in our view a much more helpful, up-to-date formulation than the current law and it has found widespread support”.⁸⁶ One of those supporters was Liberty, who “broadly support[ed]” tying the defence to a “recognised medical condition” because it thought that this would provide for “greater medical certainty”.⁸⁷
- 4.83 It seems to us highly desirable that the interpretation of “recognised medical condition” should be the same in the diminished responsibility defence as in the proposed new defence.⁸⁸ The interpretation will be a question of law in both defences.⁸⁹
- 4.84 Two conditions which it seems ought not to qualify as recognised medical conditions for either defence are acute intoxication and antisocial personality disorder. The Court of Appeal has held that “voluntary acute intoxication is not capable of founding diminished responsibility”.⁹⁰ We anticipate that the courts might construe the concept of recognised medical condition to exclude antisocial personality disorder for the defence of diminished responsibility. However, we cannot be confident that they will do so and certainly not that they will do so

⁸⁶ Baroness Scotland of Asthal, *Hansard* (HL), 30 Jun 2009, vol 712, col 189. The Ministry of Justice said in its consultation paper on the reforms we recommended that the concept of “recognised medical condition” was helpful “to accommodate future developments in diagnostic practice and encourage defences to be grounded in a valid medical diagnosis linked to the accepted classificatory systems which together encompass the recognised physical, psychiatric and psychological conditions”: MoJ, *Murder, Manslaughter and Infanticide: Proposals for Reform of the Law*, Consultation Paper 19/08 (July 2008) para 49. Many respondents to the Ministry of Justice’s consultation paper supported use of the concept, but there were concerns expressed. The Government “remain[ed] convinced” that the concept of recognised medical condition was the concept best suited to bringing the law up to date: MoJ, *Murder Manslaughter and Infanticide: Proposals for Reform of the Law, Summary of Responses and Government Position* (Jan 2009) pp 20 to 22.

⁸⁷ Liberty’s Second Reading Briefing on the Coroners and Justice Bill in the House of Commons (Jan 2009) para 32. See also J Miles, “The Coroners and Justice Act 2009: a ‘Dog’s Breakfast’ of Homicide Reform” [2009] 10 *Archbold News* 6. On the courts’ nervousness about psychiatric conditions which are not “recognised”, see A Buchanan and G Virgo, “Duress and Mental Abnormality” [1999] *Criminal Law Review* 517, 518.

⁸⁸ It would be possible, in order to bring about this uniformity, to make an amendment to s 2 of the Homicide Act 1957.

⁸⁹ R Fortson argues that it is a question of law “whether a condition is medically recognised for the purposes of revised s 2 Homicide Act 1957”, and this argument is borne out by the Court of Appeal’s approach in *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576. See R Fortson, “The Modern Partial Defence of Diminished Responsibility” 29 in A Reed and M Bohlander (eds) *Loss of Control and Diminished Responsibility* (2011).

⁹⁰ *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576.

imminently. Because we believe that both these conditions ought to be excluded from the new defence, we make that explicit in our proposals.

- 4.85 We could achieve this by making clear that the definition of recognised medical condition excludes these conditions. That would create a problem to the extent that the term “recognised medical condition” would bear a different meaning from when it is used in the diminished responsibility defence (at least unless and until the courts construe the term recognised medical condition in the Homicide Act 1957 to exclude antisocial personality disorder as described). To avoid that confusion, we have excluded the conditions by adding a further element to the new defence: that the recognised medical condition must be one that is a “qualifying condition”.
- 4.86 We explain in more detail why we think that these conditions ought always to be excluded from the scope of the new defence.

ACUTE INTOXICATION

- 4.87 At present, the accused may plead insanity if his or her intoxication results in a condition amounting to a “disease of the mind”, such as alcohol dependency syndrome, affecting his or her ability to reason at the time the actus reus of the offence was committed.⁹¹ This is the case even if the insanity is only temporary, and despite the fact that it was caused voluntarily.⁹² As Mr Justice Stephen explained in *Davis*,⁹³ “drunkenness is one thing and the diseases to which drunkenness leads are different things”. Accordingly, the accused need not have been intoxicated at the time of the offence in order to rely on the defence of insanity, since it is based on the disease of the mind and not the intoxication itself.
- 4.88 Under our proposal if the accused was suffering from a recognised medical condition, such as alcohol dependency syndrome, which is distinct from drunkenness, then it might be a qualifying condition.⁹⁴ In this respect our proposals would not produce a different outcome from the current law.⁹⁵ The new defence would be available notwithstanding that the condition usually stems from

⁹¹ See *DPP v Beard* [1920] AC 479, 500 to 501; *A-G for Northern Ireland v Gallagher* [1963] AC 349, 375 and 381; and *Kingston* [1995] 2 AC 355, 369. The point was recently re-emphasised by Hughes LJ in *C* [2013] EWCA Crim 223 at [17].

⁹² *Davis* (1881) 14 Cox’s Criminal Cases 563; approved by Lord Birkenhead LC in *Beard* [1920] AC 479.

⁹³ (1881) 14 Cox’s Criminal Cases 563, 564.

⁹⁴ Alcoholism is listed as a medical condition in the DSM-IV and ICD-10.

⁹⁵ And diminished responsibility: it was acknowledged by the Court of Appeal as within the ambit of diminished responsibility under s 2 of the Homicide Act 1957 prior to its recent reform: *Dietschmann* [2001] EWCA Crim 2052, [2002] Criminal Law Review 132 (the CA decision was reversed by the House of Lords on a different point: [2003] UKHL 10, [2003] 1 AC 1209); *Wood* [2008] EWCA Crim 1305, [2009] 1 WLR 496.

voluntary intoxication and despite the fact that the accused may have been intoxicated at the time of the offence.⁹⁶

4.89 However, we do make a significant proposal for change in relation to another aspect of intoxication. Under the present law, if a person is so drunk as to be suffering from “acute intoxication” and this affects his or her mental functioning or ability to reason, then this will be a disease of the mind and may found a plea of insanity, even though the effects are purely transitory.

4.90 “Acute intoxication” is recognised in the ICD-10⁹⁷ as a medical condition and is defined as:

A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen.

4.91 Although it is recognised as a medical condition, “acute intoxication” means “intoxication of clinical significance” which is transitory rather than prolonged or repeated. It is not a distinct condition *caused* by intoxication, like alcoholism or alcohol poisoning, but merely refers to particularly serious cases of intoxication itself; in other words, being very drunk. Since the symptoms of the condition are exactly the same as those of simply being intoxicated, we do not see why the courts should not apply the well-developed prior fault rules governing self-induced intoxication.

4.92 The indications from case law and judicial comment are that, in the context of a new “recognised medical condition” lack of capacity defence, the courts would endorse this approach.⁹⁸ In a recent judgment the Court of Appeal has emphasised the policy reasons behind the distinction between voluntary intoxication and insanity,⁹⁹ and judicial interpretation of “recognised medical condition” in the diminished responsibility defence has made it clear that acute intoxication is outside the scope of that defence. We provisionally propose that

⁹⁶ In the case of the addict, the approach in the case law has been that the prior fault on the accused’s part – the voluntary consumption – is too remote. The courts have tended towards the view that at least some of the drinking done by a person with alcohol dependence syndrome may be “a direct result of his illness or disease” and therefore involuntary. *Wood* [2008] EWCA Crim 1305, [2009] 1 WLR 496 at [41]. More recently the Court of Appeal has further recognised that it is unrealistic to try to separate such drinking into “voluntary” and “involuntary” instances, since “at some levels of severity what may appear to be ‘voluntary’ drinking may be inseparable from the defendant’s underlying syndrome”. *Stewart* [2009] EWCA Crim 593, [2009] 1 WLR 2507 at [28].

⁹⁷ See n 12 above.

⁹⁸ See p 21 of the Minty lecture given by Stanley Burnton LJ, “Doctors, Patients and the Human Rights Act” (Oct 2011) and the comments of Hughes LJ on the general approach of the English criminal law to voluntary drunkenness in *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576. We note also the approach of the Canadian Supreme Court in the recent case of *Bouchard-Lebrun* [2011] SCC 58. See para C.95 in Appx C in the Supplementary Material to the Scoping Paper.

⁹⁹ C [2013] EWCA Crim 223 at [17].

acute intoxication should not, of itself, constitute a qualifying recognised medical condition.

ANTISOCIAL PERSONALITY DISORDER

- 4.93 A personality disorder is a recognised medical condition,¹⁰⁰ but, again, on policy grounds, we think that antisocial personality disorder should not be a condition which qualifies as a “recognised medical condition” for the purposes of the defence.

WHAT ARE PERSONALITY DISORDERS?

- 4.94 “Personality disorder” is an umbrella term to describe a number of mental disorders illnesses characterised by enduring symptoms that play a central role in most, if not all, aspects of the individual’s life. They have been described as:

a combination of identifiable personality and behavioural traits which are maladaptive personally or/and socially.¹⁰¹

long-standing, maladaptive patterns of experience and conduct that compromise the functioning of a person across time, relationships and environments.¹⁰²

Specific personality disorders ... mixed and other personality disorders ... and enduring personality changes ... are deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems of social performance.¹⁰³

¹⁰⁰ See the glossary.

¹⁰¹ N Eastman and J Peay, “Sentencing Psychopaths: Is the ‘Hospital and Limitation Direction’ an Ill-considered Hybrid?” [1998] *Criminal Law Review* 93, 103.

¹⁰² R Kinscherff, “Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act” (2010) 38(4) *Journal of Law, Medicine and Ethics* 745, 746.

¹⁰³ ICD-10, Chapter V.

Personality Disorders are mental illnesses¹⁰⁴ that share several unique qualities. They contain symptoms that are enduring and play a major role in most, if not all, aspects of the person's life. While many disorders vacillate in terms of symptom presence and intensity, personality disorders typically remain relatively constant.¹⁰⁵

- 4.95 These kinds of disorders are distinguished in DSM-IV and ICD-10 by their relative stability and persistence as compared with other disorders.¹⁰⁶
- 4.96 Within these broad definitions are particular kinds of personality disorder which are often called "antisocial" personality disorders.¹⁰⁷ The same disorder may have a different label under a different system or within the same classification across time. For example, "psychopathic",¹⁰⁸ "dissocial" (ICD-10) or "anti-social" (DSM-IV) may be different labels for the same kind of disorders.¹⁰⁹ The Scottish Law Commission summed up this kind of personality disorder as follows:

In most general terms the condition is associated with forms of anti-social (including criminal) behaviour by a person who cannot apply, or is indifferent about applying, normal moral standards and feelings to his actions.¹¹⁰

¹⁰⁴ Whether personality disorders should be regarded as mental illnesses is not clear-cut, but this point is not significant for our purposes because our proposed defence does not rely on the concepts of mental illness or mental disorder. The DSM-IV section on personality disorders describes them as "mental illnesses that share several unique qualities", but see R E Kendell, "The Distinction between Personality Disorder and Mental Illness" (2002) 180 *British Journal of Psychiatry* 110 (footnote added).

¹⁰⁵ DSM-IV <http://allpsych.com/disorders/personality/index.html> (last visited 12 Jan 2011).

¹⁰⁶ R Kinscherff, "Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act" (2010) 38(4) *Journal of Law, Medicine and Ethics* 745, 746.

¹⁰⁷ The Centre for Mental Health states that there are "broadly", ten kinds of disorder. DSM-IV recognises these: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, and "not otherwise specified". ICD-10 lists the following specific personality disorders: paranoid, schizoid, dissocial, emotionally unstable, histrionic, anankastic, anxious, dependent, other specific personality disorders and unspecified personality disorder. Other kinds of personality disorder (such as habit and impulse disorders) are classified separately within the overall group of personality disorders.

¹⁰⁸ "Psychopathic personality disorder" does not appear in the DSM-IV.

¹⁰⁹ Some argue that psychopathy and antisocial personality disorder are distinct, the former being an affective disorder, whereas ASPD is "largely behavioral": T Nadelhoffer and W Sinnott-Armstrong, "Is Psychopathy a Mental Disease?" 231 in N A Vincent (ed) *Neuroscience and Legal Responsibility* (2013).

¹¹⁰ Scot Law Com 195, para 2.57.

4.97 The Centre for Mental Health gives this description:

Antisocial personality disorder (ASPD)

This is the personality disorder most usually associated with the classic “psychopathic personality”. People with this condition tend to have very little concern for the gravity of what they do, or the impact it has on other people (empathy) and emotionally they may seem “scripted”; as though they are repeating another person’s descriptions of feelings. They may be dependent upon substances or sexually promiscuous. They are often violent and have poor control of their emotions – snapping at the slightest provocation. People with ASPD can be impulsive and reckless and frequently end up in contact with the police and the prison service.¹¹¹

VIEWS OF OTHER REFORM BODIES AND JURISDICTIONS

4.98 In its recent report the Scottish Law Commission thought psychopathic personality disorder should not, by itself, count as a disorder which could be a defence. The Commission noted that a person with this kind of disorder would probably not be able to rely on a mental disorder defence because it could not be said that he or she could not appreciate the nature of his or her conduct. The Scottish Law Commission thought that:

Psychopathy does not have the effect that the person’s reasons for acting as he did are in any way “abnormal” or “crazy” or “disordered”. Rather, psychopathic personality disorder has the effect that because of the psychological makeup of the accused he has difficulties, not shared by the ordinary person, in complying with the requirements of the law. But such difficulties do not remove the person in question completely from responsibility for his actions. He appreciates what he is doing¹¹²

4.99 To put beyond doubt that this kind of disorder should not fall within the mental disorder defence the Scottish Commission thought it should be explicitly excluded from the scope of the defence. The resulting legislation provides specifically that:

A person does not lack criminal responsibility for [conduct constituting an offence] if the mental disorder in question consists only of a personality disorder which is characterised solely or principally by abnormally aggressive or seriously irresponsible conduct.¹¹³

¹¹¹ Centre for Mental Health, *Personality Disorder* (2009) http://www.centreformentalhealth.org.uk/pdfs/personality_disorder_briefing.pdf (last visited 17 Jan 2012).

¹¹² Scot Law Com 195, para 2.60.

¹¹³ Criminal Procedure (Scotland) Act 1995, s 51A.

- 4.100 Several other jurisdictions also exclude this kind of personality disorder from the scope of their “insanity” defences.¹¹⁴ The American Law Institute Model Penal Code expressly excludes “an abnormality manifested only by repeated criminal or otherwise antisocial conduct”,¹¹⁵ and several US states have followed this approach.¹¹⁶
- 4.101 Canada does not have such a blanket exclusion, but the courts have suggested that in practice a psychopath would not be entitled to the defence since he or she would not have lost the ability to decide rationally whether an act is right or wrong. The Supreme Court of Canada has held that “such a person is capable of knowing that his or her acts are wrong in the eyes of society and, despite such knowledge, chooses to commit them”.¹¹⁷

DISCUSSION

- 4.102 It has been argued that there should be no automatic bar to reliance on an insanity defence for a person with a personality disorder. Kinscherff puts this argument on two footings: that there is no scientific basis for such an absolute rule, and that it is jurisprudentially unwise.
- 4.103 The first difficulty he describes is that personality disorders cannot be reliably distinguished from other disorders. The categorisation of symptoms into particular diagnoses reflects cultural perceptions, and sometimes individual perceptions:

Diagnoses do not exist in some sort of Platonic perfect essence awaiting discovery by human beings, but are a kind of pragmatic shorthand for clinical hypothesizing, communication and selection of intervention.¹¹⁸

- 4.104 This must be right. As we have noted above, although the classifications of DSM-IV and ICD-10 have been accepted worldwide, they need not be accepted uncritically.

¹¹⁴ The Australian Model Criminal Code expressly includes “severe personality disorder” in the definition of mental impairment and the criminal codes of the Commonwealth and the Australian Capital Territory have adopted this approach. The Northern Territory, South Australian and Western Australian codes (which have, in all other respects, implemented the model provision) do not include this reference to personality disorder, but nor do they expressly exclude it. The report of the Western Australian Law Reform Commission says that the case law in that state and elsewhere suggests that personality disorder is not legally considered to be a mental illness, but explicitly advocates leaving the matter open so that future developments in psychiatry can be easily incorporated into the law.

¹¹⁵ Section 4.01.

¹¹⁶ See also California and Oregon which explicitly exclude from the insanity defence those suffering only from personality disorder: Cal Penal Code (2005) §25.5 and Oregon Rev Statute (2005) §161.295(2). It has been noted that even if the statute does not have such an exclusion, “a person will not ordinarily be regarded (in judicial practice) as having a mental disease based solely on diagnosis of personality disorder. The same can be said of persons who are characterized as ‘psychopaths’”: R Kinscherff, “Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act” (2010) 38(4) *Journal of Law, Medicine and Ethics* 745, 746.

¹¹⁷ *Oommen* [1994] 2 SCR 507.

¹¹⁸ R Kinscherff, “Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act” (2010) 38(4) *Journal of Law, Medicine and Ethics* 745, 747.

4.105 This criticism is not merely a matter of theory. Kinscherff writes that “convergent research in neurocognitive sciences and behavioral genetics has increasingly rendered meaningless any distinction between those mental disorders with a ‘biological’ basis and those that are ‘merely’ a ‘psychological’ disorder”. We acknowledge the validity of this point: that a denial of a defence in law may be unjust if it is based on a view of the human condition which is shown by subsequent scientific developments to be invalid.

4.106 The second difficulty is that the incapacities represented by a diagnosis of personality disorder may be the kinds of incapacity which would justify an insanity defence (or a defence of recognised medical condition). If there is a blanket exclusion on all personality disorders the accused may unfairly be excluded from the defence. We agree that loss of capacity is key, and that what is important “is the legally relevant functional impact of the impairment, not its diagnostic origin”.¹¹⁹ Kinscherff gives the following example to make his point:

Whether John Hinckley was motivated to attempt to assassinate Ronald Regan due to delusions arising from “schizophrenia” or delusions arising from a “delusional disorder, erotomantic type”, the real issue was whether the delusions were sufficiently impairing of his capacities along the “cognitive” or “volitional” prongs of the legal test for insanity in effect at his trial.¹²⁰

4.107 We accept both the above arguments, but take the provisional view that there comes a point at which they lose all force. That point is where the evidence of the recognised medical condition (of a personality disorder) is no more than evidence of what would ordinarily be regarded as serious criminal behaviour. We would therefore say that there is a particular kind of personality disorder which should not qualify as a recognised medical condition which might provide the foundation for the defence.

4.108 We believe that there are two reasons why it would be neither appropriate nor workable to express the non-qualifying kind of personality disorder in terms of a current label or category. First, there is disagreement within the psychiatric profession whether personality disorders should be classified on a categorical or a dimensional basis.¹²¹ Secondly, whatever name is adopted for the types of disorder we have in mind, the name itself does not delineate the aspects of a person which make it fair to hold him or her criminally responsible. To put it another way, if we say that at the time of the alleged offence the accused had a borderline personality disorder, that does not provide a specific enough basis for identifying what it is about the accused’s mental state that should or should not exculpate him. If, however, we say that the accused’s condition was

¹¹⁹ R Kinscherff, “Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act” (2010) 38(4) *Journal of Law, Medicine and Ethics* 745, 750.

¹²⁰ R Kinscherff, “Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act” (2010) 38(4) *Journal of Law, Medicine and Ethics* 745, 753.

¹²¹ See R E Kendell, “Author’s Reply” (2002) 181 *British Journal of Psychiatry* 77. See also J Peay: “Arriving at an empirical view of law and personality disorder is fraught: personality disorder has no agreed definition. Moreover, those definitions that exist are based on shifting sands, and sands that are likely to shift again with the revisions to be embodied in DSM-V”: “Personality Disorder and the Law: Some Awkward Questions” (2011) 18(3) *Philosophy, Psychiatry and Psychology* 231, 241.

manifested¹²² only by abnormally aggressive or seriously irresponsible behaviour then we can see that there is no reason to exculpate the accused, unless it can be shown that there was some “other” underlying condition.

- 4.109 A person who claims to have acted out of a depressive burst of rage, but can only point to the incident of rage as evidence of the depression,¹²³ should not be allowed to rely on that behaviour itself to justify non-responsibility. The position should be the same, in our view, for a person whose behaviour would ordinarily be viewed as criminal and who cannot identify any other recognised medical condition as giving rise to the criminal behaviour.
- 4.110 This approach will allow the law to deal rationally with defendants who have a diagnosed personality disorder alongside another recognised medical condition.¹²⁴ In such circumstances the judge will permit the defence to be considered by the jury on the grounds of the other recognised medical condition, and it may be right for the defendant to be held “not criminally responsible”, but that will not be because of the quasi-criminal personality. As with other situations which a jury may face, the determination as to which was the predominant cause of the lack of criminal capacity may be difficult, but we think that is nevertheless the right question for the jury to consider.
- 4.111 In our proposed defence, whether an accused person has a “recognised medical condition” is a matter of legal interpretation by the court. This is, as we have been at pains to emphasise, only one of a number of issues to be addressed. The accused also bears an evidential burden as to his or her total lack of capacity in specified ways. So, for example, a person who claims that her ability to control her physical actions in relation to the charge alleged was *reduced* because of the mental illness and personality disorder from which she suffered at the time of the alleged offence will not succeed in the proposed defence: the loss of capacity to control herself must have been total. Similarly, a person with a personality disorder is not necessarily incapable of forming a judgment rationally.¹²⁵
- 4.112 We have discussed above two kinds of medical condition which we think should not qualify for the purpose of a criminal defence of non-responsibility. It may be that the common law will evolve to make it clear that “recognised medical condition” in diminished responsibility does not include both those conditions, but we would want to put the matter beyond doubt in our proposed new defence.

¹²² We use “manifested” rather than “characterised” because we do not intend this kind of non-qualifying condition to be limited to those conditions which are diagnosed by reference to corresponding criteria. We are grateful to Dr Adrian Grounds for this point.

¹²³ See A Carroll and A Forrester, “Depressive Rage and Criminal Responsibility” (2005) 12(1) *Psychiatry, Psychology and Law* 36.

¹²⁴ There is a high rate of co-occurrence of personality disorder and mental illness, with or without addiction: Centre for Mental Health, *Personality Disorder* (2009) http://www.centreformentalhealth.org.uk/pdfs/personality_disorder_briefing.pdf (last visited 4 July 2011).

¹²⁵ The empirical research carried out by Mackay (see Part 3 in the Supplementary Material to the Scoping Paper) suggests that personality disorders as a sole diagnosis do not qualify for the insanity defence under the M’Naghten Rules. In his view this is because such a disorder on its own will not result in the required cognitive impairment.

- 4.113 We have also considered whether our proposals should cater for other conditions which ought not to be “recognised medical conditions” for the purposes of a criminal defence. One possibility is to state that the defence depends on the accused having had a qualifying recognised medical condition, and to leave the interpretation to the courts. We think that approach would not make the law as clear as it should be, and probably lead to inconsistent decisions across different courts.
- 4.114 Another possibility is for there to be an exhaustive list of conditions which qualify. We think this would not be workable: the list would be extremely long and might well leave out conditions which ought to qualify.
- 4.115 A third possibility is for some conditions to be specifically stated to be non-qualifying conditions, and to provide a power to the Secretary of State to add to that list. This would provide some certainty but the question of whether a condition is a qualifying condition should remain a question of law to be determined by the court, and it seems to us that the courts will need some guidance to deal with cases concerning a condition which is not in the list.
- 4.116 We therefore provisionally conclude that the best approach is for some conditions to be specifically stated to be non-qualifying conditions, and for the court to decide, with the guidance of the Court of Appeal, whether any condition which is not in the list is nevertheless not a qualifying condition.

The role of expert witnesses in the determination of whether a condition is a recognised medical condition

- 4.117 Initially the expert evidence would go to the questions:
- whether the condition is a medical condition recognised by the relevant profession; and
 - whether the condition the accused is said to have could cause a lack of capacity as is claimed in the particular case.
- 4.118 If the recognised medical condition is, in the court’s view, a qualifying condition,¹²⁶ and the court considers that it could have caused the lack of capacity, then expert evidence would be needed on the following issues:
- whether the accused did in fact have that condition at the time of the alleged offence; and
 - whether the accused did in fact lack the relevant capacity in relation to what he or she is alleged to have done.
- 4.119 This brings us to the relationship between the expert evidence and the verdict. It is obvious that a verdict contains a judgment which is not a physical fact about a person: “Discovering and identifying a state of responsibility is not like discovering and identifying a brain tumour. Rather, it is a moral judgment about a

¹²⁶ See paras 4.55 and following above.

person's motives and behaviour".¹²⁷ The question whether a person is criminally responsible is, in our view, a moral one rather than a scientific one, because it is about the relationship of the individual to the state, about public condemnation, and the attribution of blame.

- 4.120 This issue is relevant for the formulation of a lack-of-capacity defence because it bears on the question whether the verdict is ultimately an expert judgment or a judgment of the jury or magistrates. If the test is cast in medical terms, then it is more likely that the expert opinions will be determinative.¹²⁸ But if, on the other hand, the verdict is primarily a judgment by a jury or magistrates as to whether he or she should bear criminal responsibility, then it should be informed by expert opinion, but not determined by it.
- 4.121 This is an issue which has been touched on by previous reforming bodies. The Royal Commission on Capital Punishment thought that the question of responsibility is not a medical one but largely an ethical question which the jury is best placed to answer,¹²⁹ as did the Butler Committee.¹³⁰
- 4.122 We conclude that the ultimate question – whether a person is not responsible due to his or her lack of capacity – is one for the tribunal of fact, namely the jury or magistrates.

THE NEW DEFENCE

- 4.123 To recap, the defence which we propose is to be available in respect of any kind of offence, irrespective of whether mens rea is required for the offence.
- 4.124 The defence is subject to the principle of prior fault which exists in the current law, which means that it will not be available to any person who has culpably caused his or her total loss of capacity. Where such an individual is charged with a specific intent offence,¹³¹ to be consistent with the rules on intoxication he ought to be acquitted. Where in those circumstances he is charged with a basic intent offence he should be convicted.¹³²

¹²⁷ See E P Trager, "The Insanity Defence Revisited" (1998) 4(1) *Medico-Legal Journal of Ireland* 15, 18. See also Bonnie: "at bottom, the debate about the insanity defense and the idea of criminal responsibility raises fundamentally moral questions, not scientific ones": R Bonnie, "The Moral Basis of the Insanity Defense" (1983) 69(2) *American Bar Association Journal* 194, 195 and G Williams: "responsibility (in the absence of further definition) is not a scientific or objective fact". G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 640.

¹²⁸ Or, as Mackay has put it, there is a danger that a medically-based test "will take the real decision-making out of the hands of the jury": Mackay (1995) p 140. Claydon has made this criticism of the reformed partial defence of diminished responsibility: "Law, Neuroscience and Criminal Culpability" 141, 168 in M Freeman (ed) *Law and Neuroscience, Current Legal Issues 2010* (2011).

¹²⁹ Royal Commission on Capital Punishment report, paras 327 and 283.

¹³⁰ The Butler report, para 18.17.

¹³¹ Specific intent offences are those for which the predominant mens rea is one of knowledge, intention or dishonesty,

¹³² The relationship with the rules on intoxication is discussed in ch 6.

- 4.125 The defence must be constructed so as not to prevent an outright acquittal of a defendant who, though lacking capacity at the time of the offence, would have been acquitted even if he or she had not had any medical condition. For example, if the prosecution has to prove, as part of its case, that D was the perpetrator but cannot do so because for example D has an alibi, then D should be simply acquitted.
- 4.126 The defence consists of a total lack of one or more of the relevant capacities arising from a qualifying recognised medical condition at the time of the alleged offence.
- 4.127 The relevant capacities are the capacity:
- rationally to form a judgment about the relevant conduct or circumstances;
 - to understand the wrongfulness of what he or she is charged with having done; or
 - to control his or her physical acts in relation to the relevant conduct or circumstances.
- 4.128 Whether the medical condition in question qualifies as a “recognised medical condition” is to be a question of law. In most cases, its status will not be in dispute. The court may therefore hold that a medical condition, such as acute intoxication or a personality disorder which is manifested solely or principally by abnormally aggressive or seriously irresponsible conduct, is not a qualifying condition for the purposes of the defence.
- 4.129 The defence is to be available in the magistrates’ courts as well as in the Crown Court.¹³³
- 4.130 The defence, if successful, will lead to a special verdict of “not criminally responsible by reason of recognised medical condition”. The verdict will be a matter for the tribunal of fact, whether jury or magistrates. (Whether a verdict has to be returned by the tribunal of fact where both prosecution and defence are agreed it is the only suitable verdict is an issue we discuss at paragraphs 7.54 to 7.86 below.)

Who may raise the issue

- 4.131 The accused, self-evidently, may raise the issue. In cases where the accused does not plead the defence then evidence as to his or her medical condition may be irrelevant.
- 4.132 Because the “recognised medical condition” is personal to the accused, the potential criminal liability of other people engaged in the criminal enterprise should be unaffected. There is no reason for any other person, whether an accessory or inchoate offender, to be excused or exempted on the strength of it. There is, therefore, no reason for a co-accused to be able to raise the defence on behalf of the defendant.

¹³³ We discuss this issue fully in ch 7 below.

- 4.133 The prosecution may not seek to prove the defence, other than in three exceptional cases. First, if the charge is murder and the defendant pleads not guilty by reason of diminished responsibility, then the prosecution may adduce or elicit evidence that the special verdict should be returned.¹³⁴ Secondly, if the accused pleads a defence of automatism, then the prosecution may adduce or elicit evidence that the special verdict may be returned. Thirdly, where the accused denies mens rea and the prosecution has evidence that the basis for the lack of mens rea is a qualifying recognised medical condition, then the prosecution may adduce evidence of that condition.
- 4.134 An accused who pleads not guilty on the basis, say, of lack of mens rea, due to a medical condition, would have to decide whether the basis of his or her defence was the medical condition or not. If not, then the case would proceed in the normal way, with the result that if it was not proved that the accused had the requisite mens rea, then he or she would be acquitted,¹³⁵ but if the accused pleaded the recognised medical condition defence, and in the course of the case sufficient evidence was adduced to support the new defence, then it may be left to the tribunal of fact.

The burden of proof

- 4.135 We discuss whether the burden of proving the recognised medical condition defence should lie on the prosecution (as we propose here) or on the defence in chapter 8 below. We conclude that there should be an elevated evidential burden on the defendant, and that, once that evidential burden is satisfied, it shall be for the prosecution to disprove it, applying the normal criminal standard.

Satisfying the evidential burden

- 4.136 The current law states that to support a defence of insanity there must be oral or written evidence from two or more registered medical practitioners, at least one of whom must be approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder.¹³⁶
- 4.137 In chapter 7 below we consider whether there should still be a requirement for two expert reports, and conclude that there should. Here, we consider whether one of those experts would always need to be a psychiatrist. This issue relates only to evidence leading to verdict and not to disposals.
- 4.138 The new defence extends to recognised medical conditions which may be diagnosed by qualified people such as psychologists who do not hold medical qualifications. We propose, therefore, that while retaining the requirement that oral or written evidence from two or more experts must be given, we will remove (i) the specification that they must both be registered medical practitioners, and (ii) the specification that at least one of them must be approved as having special experience in the diagnosis or treatment of mental disorder. For example, a person's lack of capacity might be due to learning difficulties, and in that instance

¹³⁴ As happens now in relation to the special verdict of not guilty by reason of insanity: Criminal Procedure (Insanity) Act 1964, s 6.

¹³⁵ For the situation where the accused lacks mens rea due to voluntary intoxication, see ch 6, especially para 6.66.

¹³⁶ Section 6(1) of the 1991 Act.

the expert evidence might appropriately be given by a psychologist rather than a doctor or a psychiatrist.¹³⁷

- 4.139 Where, however, the relevant expert is a psychiatrist, he or she should continue to be one who is “approved”. The provision which allows for official approval acts as a guarantee of the standard of expertise. This requirement would continue to apply in respect of evidence given as to the suitability of a hospital order, and so the same standard of expertise should be required in relation to the defence.¹³⁸

Connections with other defences

- 4.140 A person charged with murder who sought to rely on the lack of capacity to control limb of the defence might also plead the partial defence of loss of control.¹³⁹ There is a superficial similarity between the two defences, but they are quite distinct. In the partial defence there is no link to a medical condition of any kind and no need for expert evidence; there is no requirement to show loss of capacity for self-control, simply that the accused did lose self-control.

- 4.141 A person charged with murder might plead the partial defence of diminished responsibility as an alternative to the defence of recognised medical condition. There is more congruence between this partial defence and the defence we propose. Both require proof of a recognised medical condition and its impact on specified abilities. The difference in the degree of impairment of the specified abilities (what we call the relevant capacities) is highly significant, and the partial defence is, of course, only available in relation to charges of murder and reduces the offence to one of manslaughter. In addition, we make clear that some recognised medical conditions will not qualify. The burden of proving the partial defence falls on the accused, whereas, if the recognised medical condition defence was in issue, it would be for the prosecution to disprove it. Careful directions to the jury would be needed.

Consequences for other alleged perpetrators

- 4.142 It may be that the conviction of a person, D, is contingent on proof of the commission of an offence by a person (E) who has pleaded the defence of recognised medical condition. In that event, D’s liability should not be affected by a special verdict being returned in relation to E. This is the position under the current law with regard to the insanity defence,¹⁴⁰ so we are not proposing any change in substance here.
- 4.143 For example, if D is charged with handling stolen goods, then the prosecution will have to prove that the goods in question had been stolen. If E is prosecuted for the theft of those goods but is found not criminally responsible by reason of

¹³⁷ See Appx F to Law Com 304.

¹³⁸ We are grateful to Dr Adrian Grounds for this point.

¹³⁹ Coroners and Justice Act 2009, s 54.

¹⁴⁰ And also with regard to the partial defence of diminished responsibility: Homicide Act 1957, s 2(4).

recognised medical condition for the theft, it should nevertheless be possible for D to be convicted of handling stolen goods without proof of theft by E.¹⁴¹

Disposals following the special verdict

- 4.144 Following the special verdict, we propose that the Crown Court may make a hospital order, with or without a restriction order, a supervision order or an absolute discharge.

Hospital orders

- 4.145 It is obvious that a hospital order is only an appropriate disposal for a person who satisfies the conditions for such an order. At present those conditions are that the court is satisfied on the written or oral evidence of two registered medical practitioners, one of whom is “approved” under the 1983 Act as having special experience in the diagnosis or treatment of mental disorder, that the offender is suffering from a mental disorder which is of a nature or degree which makes it appropriate for him or her to be detained in hospital; and appropriate medical treatment is available.¹⁴² The court must also be of the opinion that, “having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of a [hospital] order”.¹⁴³
- 4.146 Detention in a psychiatric hospital for treatment for a mental disorder is clearly inappropriate where the lack of capacity does not arise from a mental disorder for which appropriate treatment is available.¹⁴⁴ Moreover, detention in such circumstances would risk breaching article 5(1)(e) of the ECHR.¹⁴⁵ There has to be a close correspondence between the expert medical evidence and the criteria for detention. It seems to us that a hospital order which was made in respect of a person who did not have such a condition would be unlawful.
- 4.147 We do not propose any change to the statutory specification for expert evidence in relation to disposal. Thus evidence will continue to be required from at least two registered medical practitioners, at least one of whom is approved under the 1983 Act, so that a hospital order may not be made unless the court has received

¹⁴¹ We would be following recent statutory precedent: the statutory amendments introducing a new partial defence of loss of control provide that just because one accused succeeds in the partial defence “does not affect the question whether the killing amounted to murder in the case of any other party to it”: Coroners and Justice Act 2009, s 54(8).

¹⁴² Section 37(2)(a)(i) of the 1983 Act.

¹⁴³ Section 37(2)(b) of the 1983 Act.

¹⁴⁴ The fact that a condition is untreatable does not prevent detention under the 1983 Act as it used to. The Mental Health Act 2007 amended the treatability test, so a dangerous mentally disordered patient may be detained if “appropriate medical treatment” is available. Formerly, the condition was that medical treatment was “likely to alleviate or prevent a deterioration of [the patient’s] condition”.

¹⁴⁵ See paras 5.36 to 5.41 in Part 5 of the Supplementary Material to the Scoping Paper.

expert psychiatric evidence stating that the accused has a mental disorder which warrants compulsory detention in a hospital.¹⁴⁶

- 4.148 Simester, Spencer, Sullivan and Virgo suggest, in their discussion of compliance with article 5(1)(e) of the ECHR, that “in criminal law contexts, findings of insanity which are compatible with objective medical expertise would be greatly facilitated if courts would use, as a benchmark, those mental conditions which permit compulsory civil commitment”.¹⁴⁷ We accept that using concepts which are common to civil and criminal powers of detention should help avoid detention of a person in contravention of article 5(1)(e). We are not proposing any finding of insanity or mental disorder as part of the new verdict. The disposal of a hospital order is tied, in section 5 of the 1964 Act, to the 1983 Act and specifically to section 37 of the 1983 Act. Together they provide sufficient protection against detention in breach of article 5 for a person who is found “not criminally responsible by reason of recognised medical condition”.¹⁴⁸

Supervision order

- 4.149 If supervision by a court-appointed officer was thought necessary in relation to a defendant found not criminally responsible by reason of a recognised medical condition, then the court could make a supervision order, with a requirement to attend for specified treatment if appropriate. This is exactly the kind of purpose for which the supervision orders currently available were introduced. The Attorney General said, when they were being discussed in Parliament:

The new supervision order seeks to provide a disposal to deal with those cases in which the defendant is not mentally disordered – he might be unfit to plead or not guilty by reason of insanity because of some physical disorder such as diabetes or epilepsy – but it is still thought that some intervention is required. ...

... the supervision order is available to provide a structure for whatever treatment is appropriate to address the risk of further harm.¹⁴⁹

- 4.150 Our proposals would enable the court to make use of such orders without having to label people inappropriately as “insane”. For example, if a person is prone to sleepwalking, and is found to have committed a sexual assault while sleepwalking, a simple acquittal with no power to require the accused to take any action to prevent any future assaults would be unsatisfactory. A supervision order with a treatment requirement could oblige the accused to submit to a medical assessment so it can be established whether any risk of repetition is more than negligible and whether any treatment would be effective. There would be no

¹⁴⁶ We acknowledge that it may be argued that the relevant expert might not have to be a psychiatrist, but whether this is so will depend on the context in which a hospital order is being sought, and we do not think it is appropriate within this project to change the provisions governing disposal by hospital order following a special verdict.

¹⁴⁷ *Simester and Sullivan’s Criminal Law* p 712.

¹⁴⁸ See para 5.41 of the Supplementary Material to the Scoping Paper.

¹⁴⁹ Baroness Scotland of Asthal *Hansard* (HL), 11 Mar 2004, vol 658, col 1419.

criminal penalty because there is no criminal culpability, but steps could be taken to protect the public from future harm.

- 4.151 It might be that the power of the courts to make supervision orders following a special verdict could usefully be extended to allow such orders to last more than two years. This is an aspect of supervision orders we would like to consider in the context of our work on unfitness to plead.

Absolute discharge

- 4.152 It may be that the trial judge considers there is no treatment or action that is required, and as the foundation of the verdict is one of non-culpability, no punitive disposal could be appropriate. In such circumstances the court should be able to discharge the defendant absolutely.

Disposals for children and young people

- 4.153 Youth Rehabilitation Orders (“YROs”), may be made in relation to a child or young person who has been convicted of an offence.¹⁵⁰ These are in essence a kind of supervision order, and therefore provide a good model for an appropriate disposal following the special verdict. Some of the requirements that can be attached to YROs are punitive in nature, and this makes the YRO as it currently stands unsuitable as a disposal for someone who was not criminally responsible.¹⁵¹ We consider, however, that a new form of Rehabilitation Order to which non-punitive requirements can be attached would be a potentially appropriate disposal following a special verdict of “not criminally responsible by reason of recognised medical condition” on a child or young person. The kinds of requirements which could be attached to such an order would be those such as a mental health treatment requirement, or a medical requirement.

Sanctions in the event of breach

- 4.154 Under the current law, if a person who has received a supervision order following a special verdict breaches the terms of that order, there is no sanction available. On the one hand, this seems unsatisfactory: it should be possible for an order of the court to be enforced, as in, for example, contempt proceedings.¹⁵² On the other hand, it is questionable whether a person should receive a criminal sanction for breaching a non-penal order made in circumstances where the individual was found not to be responsible for his or her actions.¹⁵³

¹⁵⁰ Criminal Justice and Immigration Act 2008, s 1.

¹⁵¹ There are sixteen requirements that may be attached, some of which are clearly penal, such as a curfew requirement, and some of which are clearly aimed at treatment such as an intoxicating substance treatment requirement.

¹⁵² One respondent to the Scoping Paper commented that “supervision orders are not really understood in practice and are of little benefit in treating a mentally disordered offender, as compared to a hospital order (which might lead to a community treatment order)”. A community treatment order offers the possibility of detaining the individual in hospital compulsorily.

¹⁵³ A similar point can be made in relation to anti-social behaviour orders (“ASBOs”) made under s 1 of the Crime and Disorder Act 1998: criminal sanctions can be imposed in respect of a failure to desist from certain forms of behaviour which in and of themselves are not criminal.

- 4.155 A supervision order may include a requirement to undergo medical treatment.¹⁵⁴ Any proposal to introduce sanctions in the case of breach therefore raises important questions about the legitimacy of coercing a person (by the threat of criminal sanction) into complying with medical treatment. Article 25(2) of the United Nations Convention on the Rights of Persons with Disabilities requires that health care be provided to persons with disabilities “on the basis of free and informed consent”. Consent is unlikely to be free and informed where a person feels they have no choice – because of the threat of sanction – but to acquiesce to the treatment required.¹⁵⁵
- 4.156 Other types of orders which require medical treatment, and to which sanctions for breach may attach, include safeguards for the protection of autonomy. For instance, a mental health treatment requirement given as part of a community order can only be imposed where an offender has expressed a willingness to comply with such a requirement in the first place.¹⁵⁶ When making such a community order, the court is also under a duty to ensure that, so far as practicable, any requirement imposed avoids conflict with an offender’s religious beliefs and any interference with the times that an offender may normally work or attend an educational establishment.¹⁵⁷ The 1964 Act does not include any such safeguards.
- 4.157 Given the concerns about threats to autonomy and the legitimacy of imposing criminal sanctions for breach of a non-penal order, we think that further consideration of the likely effectiveness of sanctions in this context is required. The rate of breach for other types of orders to which criminal sanctions attach is relatively high.¹⁵⁸ Research into orders which provide for non-criminal sanctions in the event of breach (such as readmission to hospital for failing to comply with the requirements of a community treatment order)¹⁵⁹ similarly fails to show that

¹⁵⁴ 1964 Act, Sch 1A, para 4(1).

¹⁵⁵ The definition of consent in para 23.31 of the Code of Practice to the MHA 1983 states that “consent is the voluntary and continuing permission of a patient to be given a particular treatment ... Permission given under any unfair or undue pressure is not consent”. This of course raises the question of whether the threat of criminal sanction amounts to “unfair or undue pressure”.

¹⁵⁶ Criminal Justice Act 2003, s 207(3)(c).

¹⁵⁷ Criminal Justice Act 2003, s 217(1).

¹⁵⁸ 57.3% (12,408) of ASBOs issued between 1 June 2000 and 31 Dec 2011 were breached at least once. 52.7% of individuals who breached their ASBOs were given an immediate custodial sentence and a further 24.6% were given a community sentence. See Ministry of Justice. “Statistical Notice: Anti-Social Behaviour Order (ASBO) Statistics England and Wales 2011” (18 Oct 2012), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116702/asbo11snr.pdf (last visited 1 May 2013). There were 27,535 terminations of community orders in the period of Oct to Dec 2012 (as an indication of the proportion of orders which were terminated, there were 78,054 community orders on 30 Sept 2012). Of the 27,353 orders terminated early, 14% were terminated for failure to comply with requirements and 11% for conviction of an offence. See MoJ, Offender Management Statistics Quarterly, Probation Tables, Tables 4.7 and 4.11, available at <https://www.gov.uk/government/publications/offender-management-statistics-quarterly--2> (last visited 1 May 2013).

¹⁵⁹ Community treatment orders were introduced by s 32 of the MHA 2007 and are only available in respect of patients detained in hospital.

the threat of sanction increases compliance.¹⁶⁰ However, differences between these types of orders and supervision orders imposed under the 1964 Act makes it difficult to draw conclusions about the likely effectiveness of attaching sanctions to the latter type of order. We propose to return to this difficult issue in more detail, and in consultation with practitioners, in the context of our work on unfitness to plead (where the disposal regime is the same).

PROVISIONAL PROPOSALS

A new defence and special verdict

4.158 **Proposal 1: We provisionally propose that the common law rules on the defence of insanity be abolished.**

4.159 **Proposal 2: We provisionally propose the creation of a new statutory defence of not criminally responsible by reason of recognised medical condition.**

4.160 **Proposal 3: The party seeking to raise the new defence must adduce expert evidence that at the time of the alleged offence**

the defendant wholly lacked the capacity:

(i) rationally to form a judgment about the relevant conduct or circumstances;

(ii) to understand the wrongfulness of what he or she is charged with having done; or

(iii) to control his or her physical acts in relation to the relevant conduct or circumstances

as a result of a qualifying recognised medical condition.

4.161 **Proposal 4: We provisionally propose that certain conditions would not qualify. These include acute intoxication or any condition which is manifested solely or principally by abnormally aggressive or seriously irresponsible behaviour.**

4.162 **Proposal 5: We provisionally propose that if there is a dispute as to whether the medical condition which the accused claims to have had is a recognised medical condition and/or whether it is a qualifying condition, then this shall be a question of law and not one for the tribunal of fact.**

4.163 **Proposal 6: We provisionally propose that if sufficient evidence is adduced on which, in the opinion of the court, a properly directed jury could reasonably conclude that the defence might apply, the defence should be left to the tribunal of fact to consider. The prosecution then bears the burden of disproving the defence beyond reasonable doubt.**

¹⁶⁰ See T Burns and others, "Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial" (2013) 381 *The Lancet*.

4.164 **Proposal 7: The jury (or magistrates) shall return a special verdict of “not criminally responsible by reason of recognised medical condition” unless satisfied beyond reasonable doubt that the accused did not suffer a complete loss of capacity by reason of a qualifying recognised medical condition.**

4.165 **Proposal 8: We provisionally propose that the special verdict of “not criminally responsible” may only be returned where evidence on the accused’s medical condition has been received from two or more experts, one of whom is a registered medical practitioner.**

4.166 **Proposal 9: We provisionally propose that whether a person has been or is going to be held not criminally responsible by reason of recognised medical condition shall not affect the criminal liability of any other person.**

Disposal following the new special verdict

4.167 **Proposal 10: We provisionally propose that the following disposals should be available following a special verdict of “not criminally responsible by reason of recognised medical condition”: a hospital order (with or without a restriction), supervision order, or an absolute discharge.**

4.168 **Proposal 11: We provisionally propose that in respect of a defendant who is under 18, the court should also have the power to make a non-penal Youth Supervision Order following a special verdict of “not criminally responsible by reason of recognised medical condition”.**

TABLE COMPARING THE OUTCOMES OF CASES UNDER THE PRESENT LAW WITH OUTCOMES UNDER OUR PROPOSED DEFENCE

4.169 The following table illustrates how existing cases would be decided were they to be tried under the law contained in our proposals.¹⁶¹ (If a mental disorder defence¹⁶² were in place rather than a defence based on “recognised medical condition”, then the outcomes would differ significantly from those shown.)

¹⁶¹ The citations for the cases listed in the table are as follows: *Kemp* [1957] 1 QB 399; *Bratty* [1963] AC 386; *Sullivan* [1984] AC 156; *Quick* [1973] QB 910; *T* [1990] *Criminal Law Review* 256; *Charlson* [1955] 1 WLR 317; *Watmore v Jenkins* [1962] 2 QB 572; *Lipman* [1970] 1 QB 152; *Bailey* [1983] 1 WLR 760; *Broome v Perkins* [1987] 85 Cr App R 321; *Hennessy* [1989] 1 WLR 287; *Burgess* [1991] 2 QB 92; *A-G’s Reference (No 2 of 1992)* [1994] QB 91; *DPP v Harper* [1997] 1 WLR 1406; *Roach* [2001] EWCA Crim 2698; *C* [2007] EWCA Crim 1862; *Kay v Butterworth* (1945) 61 TLR 452.

¹⁶² On which, see para 3.29 above.

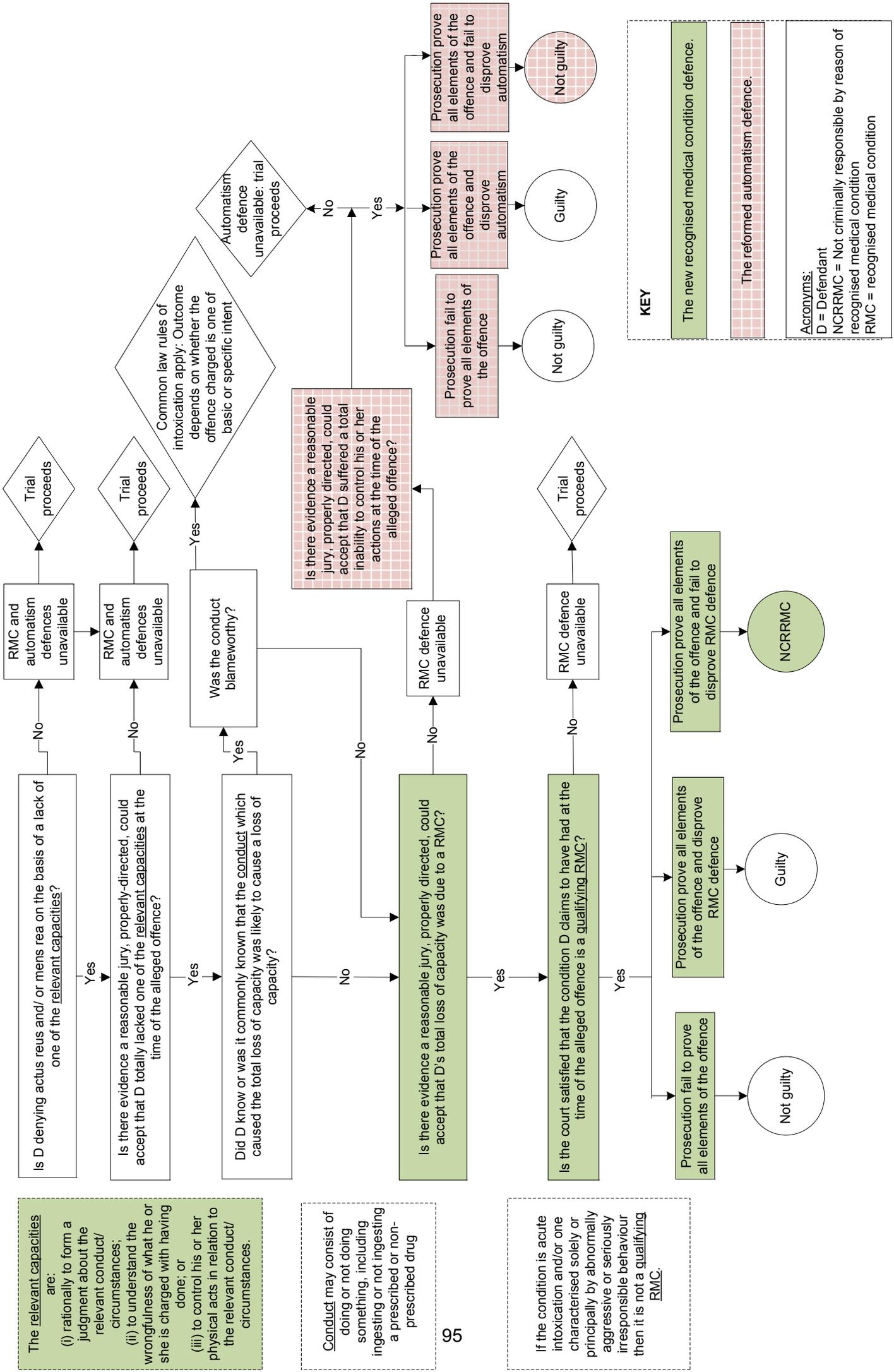
Name of case	Where facts are described	Nature of disorder	Current law	New defence
<i>Kemp</i>	2.25	Arteriosclerosis	Only permitted to plead insanity	RMC
<i>Bratty</i>	2.31	Epilepsy	Only permitted to plead insanity, convicted as plea rejected	RMC
<i>Sullivan</i>	2.30	Epilepsy	Only permitted to plead insanity	RMC
<i>Quick</i>	10.70	Hypoglycaemia	Insanity and automatism should have been left to the jury	RMC
<i>T</i>	9.48(2)	Post-traumatic stress disorder	Automatism plea succeeded	RMC
<i>Charlson</i>	2.67	Brain tumour	Automatism plea succeeded [but should have been insanity under the current law]	RMC
<i>Watmore v Jenkins</i>	n/a	Hypoglycaemia	Automatism plea failed as incomplete loss of control	RMC would also fail if loss of capacity was not total
<i>Lipman</i>	n/a	Self-induced intoxication	Convicted of manslaughter, self-induced intoxication no defence to the charge	Would continue to be dealt with under intoxication rules, so same verdict
<i>Bailey</i>	2.76	Hypoglycaemia	Automatism plea failed, convicted	RMC likely to fail if based on the same medical evidence
<i>Broome v Perkins</i>	9.24	Hypoglycaemia	Automatism plea failed as incomplete loss of control	RMC but would fail if loss of capacity was not total
<i>Hennessy</i>	2.70	Hyperglycaemia	Only permitted to plead insanity	RMC

<i>Burgess</i>	2.34	Sleepwalking	Only permitted to plead insanity	RMC
<i>A-G's Reference (No 2 of 1992)</i>	9.23	Driving without awareness	Automatism plea failed as incomplete loss of control, convicted	Unlikely to be a RMC
<i>Harper</i>	9.8	Manic-depressive psychosis	Insanity plea failed because no mens rea required for the offence (driving with excess alcohol)	RMC available even for strict liability offences
<i>Roach</i>	2.80	Anti-social personality disorder	Insanity and automatism should have been left to the jury	Not a qualifying RMC
<i>C</i>	9.23	Hypoglycaemia	Automatism	RMC
<i>Swarm of bees (example given in Kay v Butterworth)</i>	2.62	n/a	Automatism	Automatism

FLOWCHART

- 4.170 The next page shows the steps a court would take where a defendant enters either a not guilty plea or a plea of not criminally responsible by reason of recognised medical condition.

D enters a plea of Not Guilty or Not Criminally Responsible



The relevant capacities are:

- (i) rationally to form a judgment about the relevant conduct/ circumstances;
- (ii) to understand the wrongfulness of what he or she is charged with having done; or
- (iii) to control his or her physical acts in relation to the relevant conduct/ circumstances.

Conduct may consist of doing or not doing something, including ingesting or not ingesting a prescribed or non-prescribed drug

If the condition is acute intoxication and/or one characterised solely or principally by abnormally aggressive or seriously irresponsible behaviour then it is not a qualifying RMC.

CHAPTER 5

A REFORMED DEFENCE OF AUTOMATISM

- 5.1 In chapter 4 we described the new defence that we provisionally propose should be available to those who suffer from a qualifying recognised medical condition and who, at the time of the offence, completely lack a relevant capacity as a result of that condition. In this chapter we focus on our proposed statutory automatism defence which complements the recognised medical condition defence. The reformed automatism defence would apply in a considerably narrower range of circumstances than at present. It would be available only where the accused suffered a total loss of capacity to control his or her actions which was not caused by a recognised medical condition. The prior fault principles – in other words, the common law under which the defence is not available if the accused has culpably caused the loss of capacity – would continue to apply.

THE PRESENT LAW

Definition and scope of defence

- 5.2 It is difficult to identify a consistent definition of automatism from the case law. In short, it is a defence that arises when the accused's conduct lacks the basic requirement of being voluntary.¹ Viscount Kilmuir LC in *Bratty* suggested that automatism is a term connoting the state of a person who, though capable of action, is not "conscious of what he is doing ... it means unconscious voluntary action".² We suggest that the correct definition of the defence is focused not on whether the accused was conscious or unconscious,³ but on whether he or she was conscious of what he or she was doing, in other words, whether he or she was acting with or without control at the time of the alleged offence.⁴ We agree with Simester, Spencer, Sullivan and Virgo who suggest that:

What counts is the inability *deliberatively* to control one's conduct – that one's movements are not responsive to a capacity to reason and deliberate about one's conduct. Obviously, where the defendant is altogether unconscious her reasoning capacities will be inactive. But a defendant need *not* be unconscious before these capacities may be suppressed or inoperative.⁵

¹ Involuntary is not to be equated with irrational or disinhibited: *C* [2013] EWCA Crim 223 at [22] and [46].

² *Bratty v A-G for Northern Ireland* [1963] AC 386, 401.

³ As the Court of Appeal held in *C* [2013] EWCA Crim 223 at [23]: "automatism does not require that".

⁴ See also the comment of Bastarache J of the Canadian Supreme Court in *Stone* [1999] 2 SCR 290 at [156] that the term "unconscious" is in fact inaccurate in this context: "Indeed, the expert evidence in the present case reveals that medically speaking, 'unconscious' means 'flat on the floor', that is, in a comatose-type state. I therefore prefer to define automatism as a state of impaired consciousness, rather than unconsciousness, in which an individual, though capable of action, has no voluntary control over that action".

⁵ *Simester and Sullivan's Criminal Law* pp 112 to 113 (emphasis in original).

- 5.3 A succinct definition was given in a recent case where it was alleged that the accused had caused grievous bodily harm with intent. It was said that a defence of automatism is:

A complete loss of voluntary control that is not caused by what the person could reasonably foresee and is not self-induced incapacity or one that is a result of a disease of the mind.⁶

- 5.4 It is abundantly clear that the defence is not satisfied by proof only that the defendant cannot remember the incident alleged to constitute a crime, although in many cases of automatism the defendant will suffer amnesia after the episode depriving him or her of control.⁷

- 5.5 There is some dispute about whether a plea of automatism is a denial of mens rea or actus reus. Some jurisdictions treat automatism as a denial of mens rea. In Scotland, for example, the defence is regarded as one “concerned not with what the accused did but with whether his or her conscious mind was in control of the actions”⁸ and is therefore seen as going to the mental element of the offence. In *Ross v HM Advocate* Lord Justice-General Hope said that:

In principle it would seem that in all cases where a person lacks the evil intention which is essential to guilt of a crime he must be acquitted. Hume on *Crimes* (3rd edn), i, 21 describes *dole* or *mens rea* as “that corrupt and evil intention which is essential (so the light of nature teaches, and so all authorities have said) to the guilt of any crime”. So if a person cannot form any intention at all because, for example, he is asleep or unconscious at the time, it would seem impossible to hold that he had *mens rea* and was guilty in the criminal sense of anything he did when he was in that state.⁹

- 5.6 There is some uncertainty in New Zealand as to whether the defence of automatism is a denial of the actus reus or mens rea.¹⁰

⁶ Andrew Smith J in *Smallshire* [2008] EWCA Crim 3217 at [8].

⁷ See H Kalant, “Intoxicated Automatism: Legal vs Scientific Evidence” (1996) 23 *Contemporary Drug Problems* 631, 634. See also *Bratty* [1963] AC 386, 409; *Watmore v Jenkins* [1962] 2 QB 572, 579; *Hartridge* (1966) 57 DLR (2d) 332; and *Isitt* [1978] RTR 211, 67 Cr App Rep 44.

⁸ J M Ross, “A Long Motor Run on a Dark Night: Reconstructing *HM Advocate v Ritchie*” [2010] *Edinburgh Law Review* 193, 194. For critical comment, see: P Ferguson, “The Limits of the Automatism Defence” (1991) 36 *Journal of the Law Society of Scotland* 446; compare: I MacDougall, “Automatism – Negation of Mens Rea” (1992) 37 *Journal of the Law Society of Scotland* 57; P Ferguson, “A Rejoinder” (1992) 37 *Journal of the Law Society of Scotland* 58.

⁹ 1991 JC 210, 213.

¹⁰ See eg *Burr* [1969] NZLR 736, 743, by North P; *Cottle* [1958] NZLR 999; *Bannin* [1991] 2 NZLR 237, 243; and contrast with *Kilbride v Lake* [1962] NZLR 590, 593. For a discussion of influential Canadian law see: H Phoenix, “Automatism: A Fading Defence” (2010) 56 *Criminal Law Quarterly* 328, 329 and W Holland, “Automatism and Criminal Responsibility” (1982-83) 25 *Criminal Law Quarterly* 95.

- 5.7 There is no unanimity on the definition amongst the academic community. Some eminent academics have suggested that it was an “unnecessary refinement”¹¹ to regard the plea as something more than a denial of mens rea. Some suggest that it is a requirement of actus reus. Others take different views. Robinson,¹² for example, argues that, although the requirement that an act be voluntary in order to attract criminal liability is often treated as an aspect of actus reus, it is in fact an entirely separate doctrine, referred to as the “voluntariness requirement”. In England and Wales, there is now little academic support for treating automatism as a denial of mens rea, and most academic authors prefer to view it as a denial of actus reus: an act done without voluntary control is not an act at all for the purposes of the criminal law.¹³
- 5.8 We believe that the correct classification of the defence is as a denial of actus reus. That classification is important in reflecting the true basis of the defence as a denial of voluntary “action”, and it is significant in practical terms because it means that the plea is available for individuals charged with offences of strict liability or negligence.¹⁴
- 5.9 What underlies the defence is a denial of responsibility, as Hart explained:
- What is missing in these cases appears to most people as a vital link between mind and body; and both the ordinary man and the ordinary lawyer might well insist on this by saying that in these cases there is not “really” a human action at all and certainly nothing for which anyone should be made criminally responsible however strict legal responsibility might be.¹⁵
- 5.10 It should be emphasised that the definition of the offence remains one of law not of medicine or of psychiatry (although it is most unlikely that automatism would be left to the jury without some expert evidence). As Mackay explains:

¹¹ G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 663. See also J W C Turner, *Russell on Crime* (12th ed 1964) pp 37 to 39.

¹² P H Robinson, “Should the Criminal Law Abandon the Actus Reus-Mens Rea Distinction?” 187, 196 to 197 in S Shute, J Gardner and J Horder (eds), *Action and Value in Criminal Law* (1993).

¹³ R A Duff, *Intention, Agency and Criminal Liability* (1990) p 117; W Wilson, *Central Issues in Criminal Theory* (2002) p 115; McAuley p 84; *Principles of Criminal Law* p 87; and A Norrie, *Crime, Reason and History* (2nd ed 2001) p 160 where the judgment of Dickson J in the Canadian case of *Perka* (1984) 2 SCR 232 is quoted in support of this view. See also W Wilson, *Criminal Law* (2011 4th ed) p 71 where the criticisms of this approach are noted. Mackay states that in the United States the difficulties surrounding the distinction between sane and insane automatism have been largely avoided by treating automatism as a denial of actus reus rather than a separate defence: Mackay (1995) p 65.

¹⁴ See the comments of Lord Denning in *Bratty* [1963] AC 386 at p 409; Lord Kilmuir at p 407; Lord Morris at p 415. See also Lord Edmund Davies in *DPP v Majewski* [1977] AC 491. The point was made clearly in the arguments of the Attorney General in *A-G’s Reference (No 4 of 2000)* [2001] EWCA Crim 780.

¹⁵ H L A Hart, “Acts of Will and Responsibility” in *Punishment and Responsibility* (1968) p 107.

Although neuroscience may help to explain some of the mechanics of voluntary action, this in itself will do little to assist us in our quest for a satisfactory legal analysis of automatism.¹⁶

Categories of automatism

- 5.11 We identify four categories in which the cause of the automatism would result in distinct legal outcomes if the plea was successful. In summary these are:
- 5.12 (1) Automatism arising from a “disease of the mind” (eg epilepsy). If successful, this results in a special verdict irrespective of the charge.¹⁷
- 5.13 (2) Automatism arising from an internal malfunctioning of the body which did not constitute a disease of the mind. This should give rise to a defence of sane, not insane, automatism. An example might be where an accused, who is driving, experiences a sudden cramp in his leg, causing him to press on the accelerator and crash the car. There is no external factor which triggers the symptom – it has a purely internal cause – yet there has been no impairment of the accused’s mental functioning and the effect is purely physical. There is therefore no disease of the mind in the sense adopted in *Sullivan*¹⁸ which could found a defence of insane automatism. This results in a complete acquittal unless the defendant was at fault in inducing or failing to avoid the loss of control.
- 5.14 Such a case has never, to our knowledge, been directly considered by the courts. We take the view that if one were to arise, it would be treated as sane automatism. This is supported by a non-binding comment about self-induced automatism in *Quick*, where Lord Justice Lawton says:

A self-induced incapacity will not excuse ... nor will one which could reasonably have been foreseen as a result of either doing something, or omitting to do something, as, for example, taking alcohol against medical advice after taking certain prescribed drugs, or failing to have regular meals while taking insulin.¹⁹

- 5.15 We recognise that this departs from the orthodox understanding of the internal/external distinction, but we think that this must be the present state of the law. This is because the defendant in the cramp example above cannot be categorised either as having a disease of the mind (so that he could be included within the insane automatism category), nor as being incapacitated due to any external cause. He must, therefore, fall into the sane automatism category, but with an internal cause.
- 5.16 (3) Automatism arising from the accused ingesting or taking substances (for example, the accused who, having taken insulin, suffers a hypoglycaemic episode). This results in a complete acquittal unless the accused was at fault in inducing or failing to avoid the loss of control. If the accused was at fault, either

¹⁶ Mackay (1995) p 27.

¹⁷ See eg *Sullivan* [1984] AC 156; contrast *Cottle* [1958] NZLR 999. If the plea is one of insane automatism, then there must also be a “disease of the mind” and a total loss of voluntary control. We are grateful to Professor Ronnie Mackay for this point.

¹⁸ [1984] AC 156.

¹⁹ *Quick* [1973] QB 910, 922.

because he foresaw the likelihood of a loss of control and unreasonably failed to avert it or because he took a drug commonly known to create loss of control, he or she will be liable for any offences of basic intent charged.²⁰ A recent example of this is the case of *C*²¹ in which it was said that for the automatism defence to succeed, the accused, who claimed a hypoglycaemic attack, would have to show an evidential basis for a conclusion that he was “totally unable to control the car due to an unforeseen hypoglycaemic attack” and “that he could not reasonably have avoided the attack, by advance testing, and that there were no advance warnings during the course of his drive”.

- 5.17 (4) Automatism arising from some external physical factor other than the accused taking substances (for example, the accused has been stung by a wasp while driving, or struck by a stone thrown up from the road surface causing a reflex action).²² A person suffering a blow to the head causing concussion is another example.²³ If successful, this leads to a not guilty verdict for any offence charged.

The courts’ general approach to sane automatism

- 5.18 The courts’ approach to defining the defence of sane automatism, its relationship to insanity and the application of the defence in practice have been influenced by a deeply-held scepticism.²⁴ The courts are aware that sane automatism is relatively easy to plead and can result in a complete acquittal to any charge, no matter how serious. We do not know how many defendants plead not guilty each year on the basis of sane automatism, nor how many of those pleas succeed.²⁵ As throughout this area of law, the courts struggle to strike the correct balance between the need for public protection and fairness to the individual who lacked voluntary control over his or her actions.
- 5.19 The courts have, in consequence, drawn the scope of the sane automatism defence narrowly by adopting an expansive approach to the mutually exclusive category of insane automatism.²⁶ Under the present law, if the defendant claims that his or her loss of control was due to a condition which constitutes an

²⁰ Basic intent offences are all those for which the predominant mens rea is not intention, knowledge or dishonesty (this includes offences of recklessness, belief, negligence and strict liability). Although the plea commonly arises in relation to road traffic offences there are examples of it arising more widely, including, in the civil context, in a case of viewing pornography in a hypoglycaemic state: *City of Edinburgh Council v Dickson* [2009] UKEAT (Scot) 2 Dec 2009.

²¹ [2007] EWCA Crim 1862 at [16].

²² See Pearson J in *Hill v Baxter* [1958] 1 QB 277, 286; *Kay v Butterworth* (1945) 61 TLR 452, per Humphreys J. These examples are frequently used in the academic literature. See eg H L A Hart, *Punishment and Responsibility* (1968) p 96.

²³ See Viscount Kilmuir LC in *Bratty* [1963] AC 386 at p 403; Lord Diplock in *Sullivan* [1984] AC 156, 172; *Budd* [1962] *Criminal Law Review* 49; *Revelle v R* (1981) 2 CR (3d) 161, 166; *Minor* (1955) 15 WWR 433, Sask CA; *Donald* (2000) WL 571272 (defence failed); and *Henry* 2012 Ontario Court of Justice 767 (defence failed).

²⁴ See H Phoenix, “Automatism: A Fading Defence” (2010) 56 *Criminal Law Quarterly* 328, 332.

²⁵ Those who responded to the Scoping Paper said that automatism is very rarely pleaded. One reason for the lack of data may be that if a plea of automatism is successful, it results in an acquittal and will be recorded as an acquittal, but the reason for the acquittal will not be recorded.

²⁶ See Viscount Kilmuir LC in *Bratty* [1963] AC 386, 403 to 404.

“internal” malfunctioning of the body amounting to “a disease of the mind”, as very widely construed, that constitutes a plea of “insane automatism” within the M’Naghten Rules. Whether it does so is a question of law not of medicine or psychiatry.²⁷ If the alleged condition is a disease of the mind, the onus is on the defendant to prove, on the balance of probabilities, that he or she was suffering from that condition and that it caused the insane automatism, and that the other elements of the insanity plea are met. If successful the plea will result in a verdict of not guilty by reason of insanity.

- 5.20 In contrast, if the alleged condition is a result of an external factor operating on the accused’s mind or body it constitutes a plea of sane automatism. In the rare cases in which that plea is advanced, the defendant has to adduce evidence of the defence and it is for the prosecution to disprove the defence so the jury are sure that it did not apply. If the prosecution fails to do so, and the defendant was not at fault in inducing the state, the defence succeeds and results in a complete acquittal for any offence charged.
- 5.21 The distinction between external and internal causes of automatism has been subjected to cogent and sustained criticism, and we identify particular difficulties which it causes at paragraphs 5.39 and following below.

Loss of control

- 5.22 The courts’ scepticism has also led to a controversially strict approach to the elements of the sane automatism defence, in particular to the degree of control that must be lost for a successful plea of sane automatism, and the duration of the loss of control.
- 5.23 In all recent cases the Court of Appeal has held that the defence is only available if there is a total loss of control. As Lord Justice Hughes stated in *C*:

The essence of it is that the movements or actions of the defendant at the material time were wholly involuntary. The better expression is complete destruction of voluntary control.²⁸

And as Lord Taylor remarked in a road traffic case, “Impaired, reduced or partial control is not enough.”²⁹

- 5.24 This narrow interpretation has been consistently adopted when the plea is raised in prosecutions for road traffic offences.³⁰ In *Broome v Perkins*,³¹ for example, the defendant was suffering from a hypoglycaemic state and was thus clearly not fully conscious, but was found guilty of driving without due care and attention because now and again he exercised apparently conscious control over the car

²⁷ For analysis of the philosophical and psychiatric background to this area of law see Mackay (1995) ch 1.

²⁸ *C* [2013] EWCA Crim 223 at [22], citing *Watmore v Jenkins* [1962] 2 QB 572 and *A-G’s Reference (No 2 of 1992)* [1994] QB 91, [1994] Criminal Law Review 692 (Heavy Goods Vehicle driver “driving without awareness”).

²⁹ *A-G’s Reference (No 2 of 1992)* [1994] QB 91, [1994] Criminal Law Review 692.

³⁰ *Watmore v Jenkins* [1962] 2 QB 572, 586 and 587. It is also implicit in Lord Denning’s approach in *Bratty* [1963] AC 386, 390.

³¹ (1987) 85 Cr App R 321.

(such as swerving away from other vehicles). Thus it could not be said that there was a “complete destruction of voluntary control”, despite the fact that the defendant’s consciousness was obviously very seriously impaired.

- 5.25 The requirement of a total loss of control in sane automatism has not been universally accepted by the courts or commentators and it was not clear that it applied in relation to all charges. Some academic commentators writing before *C*³² suggested that the requirement of a total loss of control is restricted to the road traffic context and that if the plea is raised in relation to other offences it is sufficient that the accused had or may have had an impaired consciousness.³³
- 5.26 Some cases certainly support that broader interpretation. In *Charlson*,³⁴ for example, the defendant hit his 10-year-old son over the head and then threw him out of the window. He was permitted to raise the defence of automatism, and was ultimately found not guilty of causing grievous bodily harm, on the grounds that he may have been suffering from a brain tumour which could cause sudden violent outbursts which he could not control. His sudden impulsive attack was caused by a cerebral tumour. He could, however, recall hitting his son and therefore could not be said to have suffered from a “complete destruction of voluntary control”, but a plea of automatism was held to be available to him.³⁵ *Quick*,³⁶ in which the accused committed an assault in the course of a hypoglycaemic episode, is similarly a case where it could be said that the accused was able to rely on the defence of automatism even though he had not lost consciousness nor, it is argued, complete control of his actions.
- 5.27 Earlier academic writing also supports the broader view. For example, Williams commented 30 years ago that:

The great weight of authority shows that a person whose consciousness is badly impaired can have the defence of automatism even though he is still able to co-ordinate his movements as in driving a car.³⁷

Russell on Crime suggested an equally generous approach.³⁸

- 5.28 The cases suggesting that something less than a total loss of control is sufficient are, however, few in number and have subsequently been expressly

³² C [2013] EWCA Crim 223.

³³ Simester, Spencer, Sullivan and Virgo prefer this broader approach to the defence: see *Simester and Sullivan’s Criminal Law* p 112. Note that in the offence of dangerous driving (and causing death by dangerous driving) the offence is constructed in such a way that it is sufficient if the defendant has an awareness of lapsing into a dangerous state. Awareness of one’s own circumstances is akin to awareness of the dangerous state of the vehicle and sufficient to establish liability.

³⁴ [1955] 1 WLR 317, [1955] 1 All ER 859.

³⁵ But note that case is now regarded as wrong in light of the decision in *Kemp* [1957] 1 QB 399 and *Bratty* [1963] AC 386.

³⁶ [1973] QB 910.

³⁷ G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 663.

disapproved. *Charlson* was disapproved by the House of Lords in *Bratty*, where Lord Denning said that:

In Charlson's case, Mr Justice Barry seems to have assumed that other diseases such as epilepsy or cerebral tumour are not diseases of the mind, even when they are such as to manifest themselves in violence. I do not agree with this. It seems to me that any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind. At any rate it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal.³⁹

- 5.29 Despite these earlier cases, we suggest that the overwhelming weight of the recent authority supports the narrower view, especially in light of *C*⁴⁰ in which the Court of Appeal considered the defence of automatism in a context which did not involve driving offences.
- 5.30 One problem with this narrow approach remains, which is that the level of loss of control for sane automatism is quite different from that for insanity. This is a consequence of the different kind of capacity that is at issue. For insanity, the relevant loss of capacity must be either that the defendant did not know the nature and quality of his or her act, or that if he or she did, he or she did not know that it was wrong. Clearly, there will be cases in which a defendant continues to exercise some degree of control over his or her movements while lacking these capacities. He or she will nevertheless be entitled to rely on a defence of insanity. With that same lack of capacity he or she would not be entitled to rely on a plea of sane automatism.⁴¹ The courts would no doubt justify that distinction on the basis of the different verdicts that result.
- 5.31 As to whether the narrower approach is one that is applicable in all cases, and not just those dealing with road traffic offences, there seems little doubt that policy lies behind the courts' adoption of the strict approach in cases involving control of a vehicle. This policy is explicit in cases such as *Moses v Winder*⁴² where a defence of automatism was held not to be available in part because the defendant, whether or not he was in an automatic state at the time of the accident, should not have been driving since he knew he was susceptible to diabetic coma and that he was about to have an attack. Lord Justice Roskill said that "to allow a defence of automatism to succeed in a case of this kind would add greatly to the dangers to the lives and limbs of those on the roads".⁴³ This

³⁸ Turner describes the defence as applying not just to a person who is unaware that he (or she) was making the movements constituting the alleged crime: J W C Turner, *Russell on Crime* (12th ed 1964) p 37.

³⁹ *Bratty* [1963] AC 386, 412.

⁴⁰ *C* [2013] EWCA Crim 223.

⁴¹ A diabetic who had not taken insulin and slipped into a hyperglycaemic coma would be allowed to plead insanity despite retaining some control; a diabetic who took insulin and went into a hypoglycaemic state would not be able to plead sane automatism unless totally incapacitated.

⁴² [1981] RTR 37.

⁴³ [1981] RTR 37, 41.

leads some academics to suggest, as noted, that the strict test of total loss of control should be restricted to road traffic offences.⁴⁴

- 5.32 Adopting a broader test, requiring only partial loss of control in all cases other than road traffic offences might, we believe, create arbitrariness. Some road traffic offences require proof of mens rea, and some are of a serious nature carrying heavy maximum penalties. It would be difficult to justify a defence of automatism based on partial loss of control for mainstream offences that involve mens rea or carry grave sentences while requiring a stricter test requiring a total loss of control for road traffic offences with the same or similar mens rea requirements and/or maximum penalties.

Evidence required to support the defence

- 5.33 A further consequence of the courts' sceptical approach to sane automatism is apparent when considering the evidence needed to prove that defence. The courts have emphasised that it is essential that a proper foundation for the defence must be laid by introducing evidence from which it may reasonably be inferred that the defendant's conduct was involuntary.⁴⁵ Whether such a foundation has been laid is a question of law. As Lord Denning declared, the accused's own word that he suffered a "blackout" will rarely be sufficient, unless it is supported by medical evidence.⁴⁶
- 5.34 Not only will the defendant seeking to plead sane automatism have to provide some evidential foundation for the loss of control, but also, it seems, evidence of the fact that he or she was not culpable in bringing about the loss of control. As Lord Justice Moses noted recently in the case of a diabetic driver who had lapsed into a coma, the defendant would "have to provide an evidential basis for asserting that he could not reasonably have avoided the [hypoglycaemic] attack by advance testing."⁴⁷
- 5.35 Against that background we turn to consider the effect our proposals would have on the four categories of case in which automatism might arise under the present law.

(1) AUTOMATISM RESULTING FROM A DISEASE OF THE MIND

- 5.36 As noted, a plea of insane automatism within the M'Naghten Rules arises if the defendant claims that his or her loss of control was due to a condition that constitutes an "internal" malfunctioning of the defendant's body amounting to "a disease of the mind". Reported cases in which the courts have held the loss of control to be "insane automatism" arising from a "disease of the mind" include

⁴⁴ *Simester and Sullivan's Criminal Law* p 112.

⁴⁵ *Dervish* [1968] Criminal Law Review 37.

⁴⁶ In *Stripp* (1978) 69 Cr App Rep 318, it was held that the accused's evidence that he had a "blackout" was insufficient to raise the defence. See also *Cook v Atchinson* [1968] Criminal Law Review 266.

⁴⁷ C [2007] EWCA Crim 1862 at [35] and [38].

those suffering: psychomotor epilepsy;⁴⁸ defendants in hyperglycaemic states following a failure to take insulin for their diabetes;⁴⁹ sleepwalkers;⁵⁰ and those suffering from arteriosclerosis.⁵¹

- 5.37 This category of insane automatism arises irrespective of whether the loss of control is likely to recur.⁵² There is no requirement for the condition that causes the lack of control to be a permanent one.

Problems with this category of the present law

- 5.38 As we discussed in detail in paragraphs 4.30 and following of the Supplementary Material to the Scoping Paper, there are significant defects in the current law's definition of the defence of insane automatism. The principal problem is that the distinction between "sane automatism" and "insane automatism" does not make sense. It depends on a crude distinction based on whether the cause of the loss of control is due to a factor that is "external" or "internal" to the accused.

Arbitrary classifications

- 5.39 First, this distinction results in classifications and verdicts which are incoherent and arbitrary.

- (1) A, a diabetic who lapses into a hyperglycaemic coma having not taken insulin, is treated as pleading insane automatism and receives the special verdict irrespective of whether he has been at fault in failing to take the drug.
- (2) B, a diabetic who takes insulin but fails to eat and lapses into a hypoglycaemic coma⁵³ is treated as a sane automaton and can plead not guilty. The verdict in his case will depend on whether he has been at fault in inducing his loss of capacity and the nature of the offence charged.

- 5.40 The courts have sought to deny that this distinction is an arbitrary one by suggesting that there is a greater likelihood of recurrence in cases of insane

⁴⁸ *Bratty* [1963] AC 386; *Sullivan* [1984] AC 156. For detailed analysis of the condition and the plea of automatism see M Blackbeard, "Epilepsy and the Criminal Law" (1996) 9 *South African Law Journal* 191; G M Paul and K W Lange "Epilepsy and Criminal Law" (1992) 32 *Medicine, Science and the Law* 162.

⁴⁹ *Hennessy* (1989) 89 Cr App R 10; *Bingham* [1991] *Criminal Law Review* 433; compare *Bailey* [1983] 2 All ER 503; *Quick* [1973] QB 910.

⁵⁰ *Burgess* [1991] 2 All ER 769.

⁵¹ *Kemp* [1957] 1 QB 399.

⁵² Lord Denning sought to define the concept of insane automatism by reference to the likelihood of recurrence in *Bratty*. That view was not shared by any other member of the House. In some jurisdictions the likelihood of recurrence has been accepted as a legitimate factor in determining whether the automatism should be treated as insane or sane: *Falconer* (1990) 65 ALJR 20; *Woodbridge* [2010] NSWCCA 185.

⁵³ Such comas can arise for non-diabetics. See eg *Toner* (1991) 93 Cr App R 382 (fasting followed by high carbohydrate intake) and *Stellmacher* 1983 (2) SA 181 where D had been on a strict diet and had performed hard labour before drinking brandy. Contrast *Victor* 1943 TPD 77. Cited in M Blackbeard, "Epilepsy and Criminal Liability" (1996) 9 *South African Journal of Criminal Justice* 191, 191 to 210.

automatism arising as they do from diseases of the mind. As Mr Justice Devlin stated in *Hill v Baxter*:⁵⁴

For the purposes of the criminal law there are two categories of mental irresponsibility, one where the disorder is due to disease and the other where it is not. The distinction is not an arbitrary one. If disease is not the cause, if there is some temporary loss of consciousness arising accidentally, it is reasonable to hope that it will not be repeated and that it is safe to let an acquitted man go entirely free. But if disease is present the same thing may happen again, and therefore, since 1800, the law has provided that persons acquitted on this ground should be subject to restraint.

- 5.41 The validity of basing policy on the distinction between causes of automatic behaviour which are supposedly likely to recur and those which are supposedly isolated instances is questionable.⁵⁵ In the former situation, the courts have been concerned about the prospect of recurrence and have therefore resisted a conclusion which would lead to a complete acquittal and the prospect of further harm. In the latter situation judges have been less concerned about the chances of recurrence and have therefore been more likely to have accepted that the defendant truly was in a state of automatism.⁵⁶ However, it is not necessarily the case that internal causes are likely to recur and external causes are not.
- 5.42 We noted above that the policy objective behind the internal/external distinction is that of social protection, but the distinction is a highly imperfect tool for achieving this policy objective. Some defendants who are currently classed as insane pose little or no continuing danger to the public⁵⁷ while others who are acquitted on the basis of sane automatism may in fact be liable to react in the same way again.
- 5.43 Claims that insane automatons are more likely to lose control than sane automatons cannot, we suggest, be maintained when the concept of disease of the mind is so widely construed as to include conditions such as diabetes. Taking our earlier examples in paragraph 5.39, we suggest that there is no greater likelihood that A will repeat his behaviour than that B will do so.⁵⁸ There is no greater likelihood that A will be more dangerous in the course of the commission of his or her offence than B would be. Despite the similarities in these material respects, the outcomes in the two cases are starkly different.
- 5.44 This failure of the internal/external test to reflect accurately the policy concern of recurrence has led the courts in other common law jurisdictions to reject the internal/external distinction as an all-encompassing test. It was rejected by the

⁵⁴ [1958] 1 QB 277, 285.

⁵⁵ See eg *Bratty* [1963] AC 386, 412, by Lord Denning; *Sullivan* [1984] AC 156, 172, by Lord Diplock; *Hennessy* [1989] 1 WLR 287, 294, by Lord Lane CJ.

⁵⁶ The fact that there is little danger of recurrence, however, does not mean that a condition cannot be a disease of the mind: *Sullivan* [1984] AC 156, 172, by Lord Diplock; followed in *Burgess* [1991] 2 QB 92, 100.

⁵⁷ For example, in *Burgess* [1991] 2 QB 92, 101 the evidence was that there were no recorded cases of violence of this sort recurring.

⁵⁸ In *Harman* [2004] EWCA Crim 1527, the Court of Appeal heard evidence that occasional hypoglycaemia is almost inevitable for a long term insulin-dependent diabetic.

High Court of Australia in *Falconer*.⁵⁹ Doubt was also cast on the usefulness of the test in the Supreme Court of Canada in *Parks*⁶⁰ where the court held that it should not be mechanically applied. La Forest J downgraded the internal/external distinction from an all-encompassing test to an “analytical tool” to be considered alongside the continuing danger theory and any other relevant policy considerations. This approach was approved by the court in *Stone*⁶¹ and in *Bouchard-Lebrun*.⁶²

The mismatch between law and medicine

- 5.45 Second, the internal/external categorisation is not one that is recognised by the medical profession.⁶³ The test lacks any psychiatric or medical foundation. The legal meaning of “disease of the mind” and therefore of automatism and insane automatism remains constant, irrespective of developments in medical understanding or nomenclature.⁶⁴

Risk of mis-categorisation

- 5.46 Third, in practice, the internal/external distinction poses a grave risk of being applied in an overly simplistic fashion both by practitioners advising clients and by the courts. Cases in which the accused’s loss of control arises otherwise than from an external physical factor tend to be regarded as cases of insane automatism. This ignores the requirement that insanity as defined in the M’Naghten Rules turns on whether the accused had a “disease of the mind”. Although the concept of a “disease of the mind” is construed broadly, to mean a disease affecting “mental faculties of reason, memory and understanding”⁶⁵ it cannot, we suggest, be so wide as to encompass all internal malfunctioning of the body, as for example with an attack of cramp. The danger is that those cases in which the defendant is suffering from temporary loss of control owing to such an internal malfunctioning will be wrongly categorised as cases of insane automatism.

Incoherence in cases of non-physical external factors

- 5.47 Fourth, the crude internal/external distinction also fails to provide a coherent approach to cases where the loss of control is attributable to external factors that are non-physical in nature. The most obvious examples are those in which the defendant suffers a loss of control at the time of the offence because he or she acts in a dissociative state due to some emotional trauma.

⁵⁹ (1990) 65 ALJR 20.

⁶⁰ [1992] 2 SCR 871. Note, however, that *Burgess* [1991] 2 QB 92 was distinguished purely on the grounds that the expert evidence in that case was “completely different” and the court did not rule out sleepwalking being categorised as insanity in another case and on other evidence.

⁶¹ [1999] 2 SCR 290 at [68], by Binnie J (giving judgment for the minority) and at [206] by Bastarache J (for the majority). See the discussion in H Phoenix, “Automatism: A Fading Defence” (2010) 56 *Criminal Law Quarterly* 328, 329 and 349 to 354.

⁶² [2011] 3 SCR, 2011 SCC 58.

⁶³ See the Butler report, para 18.23.

⁶⁴ Lord Diplock in *Sullivan* [1984] AC 156.

⁶⁵ Lord Diplock in *Sullivan* [1984] AC 156, 172.

- (1) C, on hearing that a girl, V, he is attracted to does not share those feelings for him hits V on the head causing her grievous bodily harm. He claims to have been in a dissociative state at the time of doing so. The Canadian courts have held that this amounts to a plea of insane automatism⁶⁶ and it is anticipated that the English courts would reach the same conclusion. In *Rabey* it was held that the reaction of a normal person to external factors which were part of “the ordinary stresses and disappointments of life” could not give rise to a defence of sane automatism.
- (2) D attacked V and robbed him. She claims that at the time of the attack she was suffering post-traumatic stress disorder (“PTSD”) as she had been raped a short time before. The court in *T*⁶⁷ held that this is a case of sane automatism.
- 5.48 It is easy to distinguish between the cases involving C and D on the basis that D suffered physical violence to her person and that since that is an external physical factor, the internal/external distinction operates appropriately. However, that is regarded by many as unduly simplistic. The loss of control in each of these cases was as a result of an emotional trauma. It would be easy to conceive of circumstances in which D’s PTSD was caused by the impact of some non-physical event such as seeing her daughter being raped. When faced with such cases the courts would struggle to reach a just and coherent conclusion by applying the internal/external distinction.⁶⁸
- 5.49 Similarly, attempts to distinguish the cases of C and D on the basis of the severe nature of the incident causing the trauma creates difficulties. That factor would cut across the fundamental question whether the cause is an internal or an external one, exposing that distinction as redundant.⁶⁹ An emotional event as traumatising as rape “could have an appalling effect on any young woman, however well-balanced normally” and thus could be classified as an external factor giving rise to a defence of sane automatism. At the other end of the spectrum, the “possible disappointment or frustration caused by unrequited love [is] not to be equated with something such as concussion”⁷⁰ and thus a plea of automatism. Other emotional events would be categorised less easily.
- 5.50 An alternative approach, and one more consistent with the internal/external distinction, would be to focus on whether the person of reasonable fortitude could

⁶⁶ *Rabey* [1980] 2 SCR 513.

⁶⁷ [1990] *Criminal Law Review* 256. Although not featuring commonly in the law reports, there are concerns about the number of military personnel who suffer PTSD and who commit violent offences: see for a Canadian perspective B J Kormos, “The Post Traumatic Stress Defence in Canada: Reconnoitring the ‘Old Lie’” (2008) 54 *Criminal Law Quarterly* 189.

⁶⁸ See *Beaton* (12 Sept 1924) *Daily Telegraph* (unreported) (poisoning of children in extreme distress on bereavement of husband).

⁶⁹ Compare K Campbell, “Psychological Blow Automatism: A Narrow Defence” (1980-81) 23 *Criminal Law Quarterly* 342, 350.

⁷⁰ *Burgess* [1991] 2 All ER 769, 773, CA; *Hennessey* [1989] 2 All ER 9, 14.

have been expected to withstand the trauma.⁷¹ Thus, the defendant in *Rabey* was suffering from “an abnormal condition in his mind under the influence of which he acted unnaturally and violently to an imagined slight to which a normal person would not have reacted in the same manner”. This amounted to a disease of the mind, in the sense that it constituted a malfunctioning of the mind causing him to deviate from the level of sensitivity of a healthy mind and react in a way a normal person would not have done. The gravity of the shock is therefore a relevant factor in determining the defendant’s level of sensitivity which, if it reaches a certain level above that of the average person, is a disease of the mind.⁷²

5.51 This view is not without controversy. Although consistent with the traditional internal/external distinction, it illustrates the illogicality of that distinction. Thus, Mackay has argued that it is “extreme and illogical” to classify one accused who is susceptible to emotional shock as suffering from a disease of the mind but to classify as an automaton another accused who is not abnormally susceptible but who suffers the same reaction to the same or even greater shock.⁷³ By contrast, Justice Dickson in *Rabey*, dissenting, took the view that it is not acceptable that “whether an automatic state is an insane reaction or a sane reaction may depend upon the intensity of the shock”.⁷⁴

5.52 The difficulties posed by the internal/external test in dealing with cases of emotional trauma was influential in leading a majority of the Australian High Court to reject it as an all-encompassing test in *Falconer*.⁷⁵ Chief Justice Mason, Justice Brennan and Justice McHugh (in a joint judgment) held that:

There seems to be no reason in principle why psychological trauma which produces a transient non-recurrent malfunction of an otherwise healthy mind should be distinguished from a physical trauma which produced like effect.⁷⁶

5.53 A further problem with the internal/external distinction is that it creates difficulties in terms of directing the jury. If the defence being pleaded is one of sane automatism, the defendant must satisfy an evidential burden in raising the defence, but the burden lies on the prosecution to disprove it, to the criminal standard. If, however, the defendant raises the defence of insanity (including insane automatism), then the burden of proving that defence falls on the defendant, on the balance of probabilities.

⁷¹ In *Rabey*, Martin JA’s judgment seems to be understood by Dickson J (dissenting) to be a test based on whether the reasonable person would have reacted adversely to the stressful situation. An alternative view is that it is not to do with the gravity of the situation but whether the defendant has a particular vulnerability that could be regarded as a “disease of the mind”. Compare K Campbell, “Psychological Blow Automatism: A Narrow Defence” (1980-81) 23 *Criminal Law Quarterly* 342, 354.

⁷² The length of time elapsed between the event and the loss of control may be another.

⁷³ Mackay (1995) p 53.

⁷⁴ *Rabey* [1980] 2 SCR, 513, 516. It may, of course, be that the unusual susceptibility does amount to a mental disorder; and it does not seem extraordinary that the effect of a shock might depend on the intensity of the shock.

⁷⁵ (1990) 65 ALJR 20.

⁷⁶ (1990) 65 ALJR 20 at [25].

- 5.54 Finally, the internal/external distinction strains the concepts of “internal cause” and “disease of the mind”. For example, a plea that the offence was committed in the course of an episode of sleepwalking is now regarded by the courts as a plea of insane automatism.⁷⁷ Since sleep disorders are a particular source of confusion, we examine them more closely.

Sleepwalking

- 5.55 The courts’ approach to cases of crimes committed while sleepwalking has changed over time. In the nineteenth century case of *Tolson*⁷⁸ the court was clear that it produced a state of automatism, and the House of Lords took the same view in a non-binding part of the judgment in *Bratty*.⁷⁹ However in *Burgess*⁸⁰ the Court of Appeal held that the defence of sane automatism was not available to a defendant who claimed his action was unconscious and committed while asleep, and that he could only rely on insane automatism.
- 5.56 In *Burgess*,⁸¹ the court concluded that whilst sleep itself was a normal condition, sleepwalking, in particular violent sleepwalking, was not normal, and constituted a “disease of the mind” within the M’Naghten test. Expert evidence was admitted to the court suggesting that sleepwalking was treatable, that it could be regarded as a pathological condition and that there was a danger of recurrence. According to Lord Chief Justice Lane:

It seems to us that if there is a danger of recurrence that may be an added reason for categorising the condition as a disease of the mind.⁸²

- 5.57 There are signs, in very recent years, that in applying *Burgess*, the lower courts have taken a generous approach, treating sleepwalking as a plea of sane automatism. Recent examples include *Bilton*,⁸³ where the defendant, who had a history of sleepwalking, was acquitted of rape after the jury accepted his claim that he had been sleepwalking at the time. As Mackay and Mitchell point out, this case does not seem to have resulted from an episode of “confusional arousal

⁷⁷ For detailed discussion see Mackay (1995) pp 22 to 30 and Williams, writing in 1983, who regarded sleepwalking as a classic case of automatism: G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 663.

⁷⁸ [1889] QBD 168, 187.

⁷⁹ See *Bratty* [1936] AC 386 at 409, by Lord Denning and at 415, by Lord Morris of Borth-y-Gest.

⁸⁰ [1991] 2 QB 92.

⁸¹ *Burgess* [1991] 2 All ER 769, [1991] 2 QB 92.

⁸² *Burgess* [1991] 2 All ER 769, [1991] 2 QB 92, 99.

⁸³ *Bilton* (20 Dec 2005) *The Guardian* (unreported). See also *Lowe* (19 Mar 2005) *The Times* (unreported) and *Pooley* (12 Jan 2007) *The Daily Mail* (unreported) and R D Mackay and M Reuber, “Epilepsy and the Defence of Insanity: Time for Change?” [2007] *Criminal Law Review* 782, 791. In response to recent cases, the CPS issued guidance on sleepwalking, particularly within the context of rape and other sexual offences: *Defences – Sleepwalking as a Defence in Sexual Offences Cases*: http://www.cps.gov.uk/legal/d_to_g/defences_-_sleepwalking_as_a_defence_in_sexual_offence_cases/ (last visited 13 Jan 2012).

disorder⁸⁴ but rather appears to be a clear somnambulistic episode, traditionally within the ambit of *Burgess* and the insane automatism defence.⁸⁵

- 5.58 The strict approach in *Burgess* may also be contrasted with the Canadian case of *Parks*,⁸⁶ in which the Supreme Court treated sleepwalking as sane automatism. The court concluded that sleep was a normal condition and that the impairment of the defendant's faculties of reason, memory and understanding was caused by this normal condition, rather than by a "disease of the mind". In discussing the internal/external distinction, the court stated:

It is merely an analytical tool and is not universal. In particular, it is not helpful in assessing the nature of a somnambulistic condition. The distinction between internal and external causes is blurred during sleep.⁸⁷

- 5.59 The application of the internal/external distinction makes little medical sense in the context of sleep disorders. In particular if the evoked behaviour is complex, the confusional arousal (regarded by experts Ebrahim and Fenwick as triggered by an external factor) may trigger a sleepwalking episode.⁸⁸ As Mackay states:

Naturally, it is difficult to accept that sleepwalking does not have an internal cause. But does this mean that external factors have no role to play in the onset of such episodes?⁸⁹

- 5.60 There is even less clarity in the correct legal approach where internal and external factors co-exist, for instance, where an individual sleepwalks and suffers from alcohol-induced confusional arousal.⁹⁰ This confusion can be seen in the contrasting cases of *Lowe*⁹¹ and *Pooley*.⁹²

⁸⁴ A confusional arousal describes an episode in which a person arouses from sleep and remains in a confused state. Confusional arousals occur in both sleepwalkers and non-sleepwalkers. They occur in response to a sudden disturbance during the deep phase of sleep. The subject awakens into a confusional state, and this may result in an unprovoked violent episode. The confusional state may last for a few minutes before the subject returns to consciousness. See I Ebrahim and P Fenwick, "Sleep-related Automatism and the Law" (2008) 48(2) *Medicine, Science and the Law* 124.

⁸⁵ R D Mackay and B J Mitchell, "Sleepwalking, Automatism and Insanity" [2006] *Criminal Law Review* 901.

⁸⁶ *Parks* (1992) 2 SCR 871.

⁸⁷ *Parks* (1992) 2 SCR 871, La Forest, L'Heureux-Dubé and Gonthier JJ.

⁸⁸ I Ebrahim and P Fenwick, "Sleep-related Automatism and the Law" (2008) 48(2) *Medicine, Science and the Law* 124. The episodes of confusional arousal may be complex where the subject is a sleepwalker because the individual will arouse into a state similar to a non-sleepwalker but intermixed with sleepwalking behaviour; electroencephalography (the recording of the electrical activity of the brain) changes. In this way, the confusional arousal leads into a sleepwalking episode. Conditions implicated in sleep-related violence are described in I Ebrahim, "Medicolegal Evaluation of Sleep Related Automatism" 14 June 2013, Keele University.

⁸⁹ Mackay (1995) p 46.

⁹⁰ I Ebrahim and P Fenwick, "Sleep-related Automatism and the Law" (2008) 48(2) *Medicine, Science and the Law* 124.

⁹¹ *Lowe* (19 Mar 2005) *The Times* (unreported).

5.61 In *Lowe*, the defendant fatally attacked his aged father one night whilst voluntarily intoxicated. The defence argued that the attack occurred while sleepwalking or, alternatively, when he was in a confusional arousal state. The defendant's plea of insane automatism was accepted and he was hospitalised for eight months.⁹³

5.62 However, in *Pooley*,⁹⁴ the defendant was *acquitted* of rape after he successfully proved that he was suffering an episode of parasomnia, a sleep disorder which can include sleepwalking, despite his own voluntary intoxication. His Honour Judge Tyrer stated that:

Concurrent causes can allow for the defence of sane automatism to be left to the jury even if one of the concurrent causes is self-induced intoxication.⁹⁵

5.63 *Lowe* also raises questions about the function of expert medical evidence in automatism cases.⁹⁶ Medical experts in *Lowe* understandably were not able to confirm whether the attack was committed while sleepwalking or while in a confusional arousal state.

5.64 Finally, an important consideration is that the court has a disposal discretion including absolute discharge and supervision, but these powers depend on a finding of insanity; in cases where there is a successful defence of sane automatism, the only option available to the court is complete acquittal. As Wilson, Ebrahim, Fenwick and Marks state:

English law remains bereft of a satisfactory method of dealing with defendants who, although lacking fault, have a condition which poses a potential threat to the public.⁹⁷

⁹² *Pooley* (12 Jan 2007) *The Daily Mail* (unreported) and R D Mackay and M Reuber, "Epilepsy and the Defence of Insanity: Time for Change?" [2007] *Criminal Law Review* 782, 791.

⁹³ R D Mackay and B J Mitchell, "Sleepwalking, Automatism and Insanity" (2006) *Criminal Law Review* 901.

⁹⁴ *Pooley* (12 Jan 2007) *The Daily Mail* (unreported) and R D Mackay and M Reuber, "Epilepsy and the Defence of Insanity: Time for Change?" [2007] *Criminal Law Review* 782, 791.

⁹⁵ R D Mackay and M Reuber, "Epilepsy and the Defence of Insanity: Time for Change?" [2007] *Criminal Law Review* 782, 791. See also CPS guidance on self-induced intoxication: *Defences – Sleepwalking as a Defence in Sexual Offences Cases*. http://www.cps.gov.uk/legal/d_to_g/defences_-_sleepwalking_as_a_defence_in_sexual_offence_cases/ (last visited 13 Jan 2012).

⁹⁶ W Wilson, I Ebrahim, P Fenwick and R Marks, "Violence, Sleepwalking and the Criminal Law: Part 2: The Legal Aspects" (2005) *Criminal Law Review* 614.

⁹⁷ W Wilson, I Ebrahim, P Fenwick and R Marks, "Violence, Sleepwalking and the Criminal Law: Part 2: The Legal Aspects" (2005) *Criminal Law Review* 614, 622.

If, for example, an HGV driver crashes into another vehicle and there is expert evidence that it was a case of undiagnosed sleep apnoea,⁹⁸ he may be reluctant to plead insane automatism, but without the special verdict the court will not be able to direct medical treatment for the condition.

Our provisional proposal –

(a) Redefining the boundary between recognised medical condition and sane automatism

- 5.65 Both the proposed defences of recognised medical condition and of automatism depend on a lack of capacity. In cases of automatism, the essence of the defence is that the accused was not able to control his or her actions. One aspect of the defence of recognised medical condition is, similarly, the lack of capacity to control oneself. There is therefore a feature which they have in common. The significant difference is that for the defence of recognised medical condition, the accused's lack of capacity to control him or herself must arise from a qualifying recognised medical condition.
- 5.66 If the defence of insanity were reformed as we suggest in chapter 4, those defendants who suffer a total loss of control due to a recognised medical condition, including for example diabetes or epilepsy, would fall within the new recognised medical condition defence unless they were at fault in bringing about their loss of capacity. If they were at fault in bringing about their incapacity they would be dealt with under the rules governing prior fault, as described in chapter 6.
- 5.67 Some conditions which have been treated as falling within the defence of sane automatism under the current law will, if supported by a medical diagnosis, fall within the new recognised medical condition defence. For example, C who assaults V while suffering from PTSD would currently be able to plead sane automatism. He would be entitled to plead not guilty. Under our proposals his condition, which is likely to be accepted by the court as a recognised medical condition,⁹⁹ would mean that he would be able to plead the defence of recognised medical condition and might be subject to the special verdict.
- 5.68 This would also be the case where the trigger for the condition was an external cause. D, who robbed V while in a state of PTSD¹⁰⁰ having been raped, would at present be treated as a sane automaton and entitled to an acquittal. Under our proposals the plea would be one of recognised medical condition resulting in the special verdict. Although the condition is triggered by an external cause (the rape) the cause of the loss of control is the medical condition that resulted from

⁹⁸ Obstructive sleep apnoea is a medical condition that causes interrupted breathing during sleep. It can make the person very tired, and prone to fall asleep in the daytime. On sleep apnoea and drivers, see J Horne, "Sleepiness, Sleep Disorders and Driving" 14 June 2013, Keele University.

⁹⁹ It appears in ICD-10. Whether a condition is a recognised condition for the purposes of the proposed defence is, ultimately, a question for the court. See para 4.63 above.

¹⁰⁰ As in *T* [1990] *Criminal Law Review* 256; contrast *Narbrough* [2004] EWCA Crim 1012 in which the expert evidence of PTSD was rejected as it failed to refer to any research supporting the conclusion that PTSD can "so affect a person's normal mental process that he ... behaves as an automaton".

the rape. A verdict of not criminally responsible is an appropriate verdict to reflect that fact.

(b) Advantages of the proposal

- 5.69 By redefining the boundary between what is currently insane and sane automatism, and by abolishing the distinction based on internal or external causes, our proposals will have numerous advantages.
- 5.70 First, the incoherence of the internal and external distinction will disappear. The diabetic who, without fault, lapses into a coma will be treated in exactly the same way whether the coma is a result of the diabetes or the insulin, in other words whether it is hyperglycaemic or hypoglycaemic. In both cases the defendant would be entitled to rely on the new recognised medical condition defence and receive the special verdict.
- 5.71 Second, the overly-simplistic application of the internal/ external distinction will be avoided. The courts' decision to treat all internal causes of a loss of control as being "diseases of the mind" will be unnecessary. All cases in which the loss of control is caused by a qualifying recognised medical condition will be treated alike whether they are mental or physical illnesses.
- 5.72 As was noted in the commentary to the Draft Criminal Code:
- There is not so far as we can see, a satisfactory basis for distinguishing between (say) a brain tumour or cerebral arteriosclerosis on the one hand and diabetes or epilepsy on the other. If any of these conditions causes a state of automatism in which the sufferer commits what would otherwise be an offence of violence, his acquittal should be [on the basis of the special verdict].¹⁰¹
- 5.73 Third, the new defence of recognised medical condition will be more in line with medical and psychiatric thinking and there will no longer be the conflict between medical understanding and legal classifications of insane and sane automatism.
- 5.74 Fourth, the new defence of recognised medical condition will accommodate those cases in which extreme trauma causes a total loss of capacity – whether the trauma is caused by a physical or emotional blow. The rape victim who commits crime while in a state of PTSD and the individual who attacks his victim while in a dissociative state will both be eligible to rely on the new defence provided the conditions they suffer are ones that are proved, to the judge's satisfaction, to be qualifying recognised medical conditions and subject to the other criteria in the defence.
- 5.75 Fifth, the courts will avoid having to strain legal concepts to deal with hard cases where external factors have triggered internal vulnerabilities.¹⁰² The question will not be how extreme the event was, or how grave the shock of the trauma, or whether it was physical or emotional. The question will be simply whether the

¹⁰¹ Law Com 177, para 11.28.

¹⁰² See paras 9.51 to 9.53 above.

accused had a recognised medical condition – such as PTSD – and suffered a total loss of a relevant capacity.

- 5.76 This approach allows for greater public protection than does the current law. Under the current law, as we have described, a person who is acquitted on the grounds of automatism may have caused harm and the situation might be one which would recur, as with a diabetic failing to eat after taking insulin. The court has no powers to take steps for the protection of the public if a person is acquitted, but if, say, the diabetic in the example at paragraphs 5.39(2) above, or the person suffering from PTSD in the example at paragraph 5.47(2) above, receives the new special verdict, then the court would be able to direct that he or she should receive medical treatment, and in that way a recurrence would be made less likely.

(2) AUTOMATISM CAUSED BY AN INTERNAL FACTOR OTHER THAN A DISEASE OF THE MIND

- 5.77 The definition of disease of the mind is, as noted at paragraph 5.36 above, very broad. Despite this breadth, in some rare cases the malfunctioning of the accused's body may be caused by some internal factor that the law would not, we suggest, regard as a "disease of the mind".

- 5.78 In *Kemp*¹⁰³ Mr Justice Devlin stated that "there is ... no general medical opinion upon what category of diseases are properly to be called 'diseases of the mind.'" This cleared the way for the courts to adopt their own definition of that concept.

- 5.79 Lord Diplock in *Sullivan* declared:

I agree with what was said by Devlin J in *Kemp* ... that "mind" in the McNaghten Rules is used in the ordinary sense of the mental faculties of reason, memory and understanding. If the effect of a disease is to impair these faculties so severely as to have either of the consequences referred to in the latter part of the rules, it matters not whether the aetiology, of the impairment is organic, or functional or whether the impairment itself is permanent, or is transient and intermittent, provided that it subsisted at the time of the commission of the act.¹⁰⁴

- 5.80 Even on this broad definition, it is arguable that there are some internal malfunctionings of the body that would not be regarded as diseases of the mind because they would not impair the faculties of "reason, memory and understanding". Consider the following possibilities.

E, an athlete, completes a training session then drives home and suffers an unexpected and uncontrollable spasm of cramp in her leg, resulting in a loss of control of the vehicle.

¹⁰³ Criticism of *Kemp* has been sustained from JWC Turner, *Kenny's Outlines of the Criminal Law* (19th ed 1966) pp 87 to 89 to M Jefferson, *Criminal Law* (9th ed 2009) p 358.

¹⁰⁴ [1984] AC 156, 172.

F, a pregnant woman, has a spasm as she suffers an unexpected contraction causing her to suffer a loss of control. She was driving at the time she lost control. She caused a collision resulting in damage.¹⁰⁵

5.81 We suggest that under the present law, these cases ought not to be seen as constituting insane automatism. Although the lack of capacity in each of these examples is one arising from an internal malfunctioning of the individual's body, we believe that the courts could avoid labelling these as insane. These cases are distinguishable from other cases of physical malfunctionings that are treated as insanity – including for example diabetes, or a stroke – where although the illness would not ordinarily be regarded as a disease of the mind, it would qualify as such in law because it would affect the “faculties of reason, memory and understanding”.

5.82 In our view, this category of cases, namely those in which the defendant's loss of voluntary control is due to an internal factor which does *not* amount to a disease of the mind, should give rise to a defence of sane, not insane, automatism. We recognise that this suggestion of a category of internal non-insane automatism is not a universally held view. Eminent academics have treated the definition of disease of the mind as synonymous with any internal malfunctioning. For example, Sir John Smith stated:

Any “internal factor”, mental or physical, is, in law, a disease of the mind. So automatism caused by a cerebral tumour or arteriosclerosis, epilepsy or diabetes arises from a disease of the mind. These are all “internal” to the accused.¹⁰⁶

Problems of the present law

5.83 The most obvious difficulty presented by the present law is that we cannot state with any certainty whether such a category exists. We have found no reported cases of such internal sane conditions. That may be explicable for a number of reasons – they are not prosecuted, they lead to acquittals, they are not appealed etc.

5.84 If the category is not one that is recognised by law, this provides a further illustration of the nonsensical nature of the internal/external distinction. The insane automatism categorisation would be over-inclusive. The insanity plea would be demonstrated to have a further degree of incoherence if it were held to apply to cases which did not involve diseases of the mind.

5.85 Assuming that the category does exist as a matter of law, the fact that there is no judicial recognition of the category highlights the lack of understanding of this area of law. It might also highlight the lack of understanding of the profession who have avoided challenging the over-simplified categorisation based on internal/external factors.

¹⁰⁵ To be effective, the accused's denial would have to be a denial of the actus reus.

¹⁰⁶ J C Smith, *Smith and Hogan, Criminal Law* (10th ed 2001) p 39.

Our proposals

- 5.86 Under our proposals, the individuals in these cases at paragraphs 5.39(2) and 5.47(2) above would not be relying on the defence of automatism. They could all be regarded as suffering from a recognised medical condition. Whether they were entitled to rely on the recognised medical condition defence would depend on whether they were at fault in inducing their total loss of control. If the accused's loss of capacity to control his or her actions is due to something the accused culpably did or failed to do, then the prior fault rules will apply. We explain this more fully in chapter 6 below. In the present context, that will have an impact on the examples above as follows.

If E was aware that after training she always needed to warm down and stretch fully to avoid severe cramp, but on this occasion she chose, unreasonably, to drive despite that risk, she should not be entitled to rely on the recognised medical condition defence.

If F, knowing she was already suffering labour contractions decided, unreasonably, to drive herself to the maternity unit, and in the course of the journey suffered a severe contraction causing her to lose control and crash, she should not be entitled to rely on the recognised medical condition defence.

Advantages of our proposals for cases in this category

- 5.87 Our proposal would have the obvious advantage of making the law clear.
- 5.88 It would also ensure consistency by treating all recognised medical conditions that cause loss of capacity alike. This has important implications for promoting positive public attitudes to mental illness. Mental and physical conditions will be treated in the same way by the criminal courts where the sufferer of the condition claims to have lacked criminal capacity because of it. This is explored more fully in chapter 2 above.

(3) AUTOMATISM CAUSED BY AN EXTERNAL FACTOR INVOLVING CONSUMPTION OF SUBSTANCES

- 5.89 We examine in detail in chapter 6 the relationship between intoxication and automatism. We believe we are right to have regard to the close relationship between those excuses in our consideration of insanity and automatism generally. As Mackay has observed:

Problems stem from the fact that intoxication is regarded as a plea which is separate and distinct from automatism when this is plainly not so.¹⁰⁷

Present law

- 5.90 A state of automatism can arise out of intoxication by drugs commonly known to create loss of capacity (alcohol, LSD etc) and also from prescribed medicines and other drugs whether taken in accordance with a prescription or otherwise.

¹⁰⁷ R D Mackay, "Intoxication as a Factor in Automatism" [1982] *Criminal Law Review* 146, 152. See also the discussion in C [2013] EWCA Crim 223.

- (1) G drinks a litre of vodka and flails around kicking his legs out causing injury to V when he has become so drunk that he cannot control his limbs.
- (2) H is administered anaesthetic by a dentist and kicks out and strikes the dentist V when unconscious in the chair.
- (3) J takes a prescribed medicine but one that has not been prescribed for him. He suffers an adverse reaction and loses control of his limbs, kicking V in the process.

5.91 In each of these cases the defendant has become an automaton within the definition explained above. Although normally thought of as cases of intoxication, each is really a case of automatism. "Automatism arising out of a state of intoxication can and should be treated in the same way as any other condition which results in automatism".¹⁰⁸

5.92 That is not to say that all intoxicated defendants are to be treated as automatons. Some intoxicated defendants will lack mens rea but will not be automatons because they retain voluntary control over their actions.

5.93 If the state of automatism through intoxication is one that is self-induced, then the rules on prior fault apply as described in chapter 6. As we note above:

A self-induced incapacity will not usually excuse nor will one which could have been reasonably foreseen as a result of either doing, or omitting to do something, as for example, taking alcohol against medical advice after using certain prescribed drugs, or failing to have regular meals whilst taking insulin.¹⁰⁹

5.94 However, self-induced incapacity can excuse crimes of specific intent.

5.95 In relation to crimes of basic intent, following *Bailey*¹¹⁰ the defendant may be able to rely on self-induced incapacity providing he or she was not reckless in becoming intoxicated. A self-induced incapacity caused by taking dangerous drugs or drinking alcohol will not excuse as the defendant will be deemed to be reckless.¹¹¹ This is because the effects of these substances are well known, it is common knowledge that they may cause unpredictable or aggressive behaviour and therefore a person who persists in this conduct will be taken to have been aware of the risks. In all other cases of self-induced incapacity the defendant will be entitled to an acquittal, providing he or she has not been reckless.

5.96 As we explain in chapter 6, there are four possible interpretations as to what standard of recklessness is required. We think the following one is to be preferred: the defendant will not be able to rely on his or her self-induced loss of

¹⁰⁸ R D Mackay, "Intoxication as a Factor in Automatism" [1982] *Criminal Law Review* 146.

¹⁰⁹ *Quick* [1973] QB 910, 922.

¹¹⁰ [1983] 1 WLR 760.

¹¹¹ However, a D who is charged with a crime of basic intent and has suffered a self-induced loss of capacity caused by dangerous drugs or alcohol will still be entitled to an acquittal where he or she would have been unaware of the risk even if sober: *Richardson and Irwin* [1999] 1 Cr App R 392.

capacity to excuse a crime of basic intent if, at the time of becoming intoxicated, the defendant was aware of the risk that he or she may lose capacity or control.

- 5.97 This reflects the principle that where the defendant foresaw that his or her actions would result in a loss of control, the defendant will be prevented from relying on that loss of control as a defence.
- 5.98 Under the present law, in the following cases there would be no defence of automatism to crimes of basic intent:
- (1) K drinks a litre of vodka and flails around kicking his legs out causing injury to V when he has become so drunk that he cannot control his limbs. He will be able to rely on the defence of automatism if the crime charged is one of specific intent. He will be liable for any basic intent crime charged.
 - (2) L, who knows he reacts adversely to anaesthetic fails to warn the dentist that he can become violent. H is administered anaesthetic by a dentist and kicks out and strikes the dentist V when unconscious in the chair.
 - (3) M takes a prescribed medicine but one that has not been prescribed for him. He suffers an adverse reaction and loses control of his limbs, kicking V in the process.

Problems with the present law

- 5.99 First, there may be some uncertainty as to whether the prior fault rules apply to all failures to avoid as well as to action inducing the state of loss of voluntary control. The only case law is that involving diabetes. In *C* the court stated:

R v Quick [1973] QB 910 explains the defence of automatism in the context of a hypoglycaemic attack, not whilst driving, but during the course of treatment of a patient at a mental hospital. That case is essentially concerned with whether or not the automatism was due to a disease of the mind. But importantly, it provides support for the principle which is of crucial importance in the instant case. An incapacity due to a hypoglycaemic attack which might reasonably have been foreseen, as a result of doing or omitting something will not be an excuse. As Lawton LJ, said (at page 920):

“[Automatism] must be caused by some factor which he could not reasonably foresee and not by a self-induced incapacity.”¹¹²

- 5.100 As the court held in *C*, the first question is whether there is evidence to support the defence of automatism; the next question is about whether the loss of capacity could reasonably have been avoided:

¹¹² *C* [2007] EWCA Crim 1862 at [16].

If there was evidence, as we think there was, that the defendant was driving as an automaton immediately before the collision, and lost total control due to a hypoglycaemic attack, the next and consequential issue was whether that attack could reasonably have been avoided (see Lawton LJ in *Quick*).¹¹³

Both questions will need to be addressed in order for criminal liability to be clear. This approach has recently been confirmed by the Court of Appeal.¹¹⁴

- 5.101 Second, the ascription of criminal responsibility can depend, in cases where automatism is pleaded, not just on the application of the law on automatism, but also on the distinction between basic and specific intent offences and on the distinction between voluntary and involuntary intoxication, as developed in the case law. The picture is complicated, although this is perhaps unavoidable.

Our provisional proposals

- 5.102 Under our proposals, where the accused's loss of capacity to control his or her actions is due to something the accused culpably did or failed to do, then the new defence of automatism should not be available to him or her. His or her liability will turn on the principles of prior fault. We explain this more fully in chapter 6 below. In this respect we are not proposing any change to the law.

Advantage of our provisional proposals

- 5.103 Our proposals, although not making any substantive change to the law on prior fault, would have the advantage of clarifying the application of the rules, particularly in cases of a failure by the accused to avoid a loss of capacity by his omission.

(4) AUTOMATISM CAUSED BY AN EXTERNAL FACTOR NOT INVOLVING CONSUMPTION OF SUBSTANCES

- 5.104 These cases are very rare. Examples might include:

- (1) N who is driving along when a stone chip flies through his open window hitting him on the side of the head, causing him momentarily to lose control.
- (2) P who is driving along when a swarm of bees enters the car causing her to swerve.
- (3) Q, a crane operator who is stung by a wasp and in a reflex reaction releases the cable, dropping his container load onto a workmate.

Problems

- 5.105 There are few reported cases and it is therefore difficult to assess the extent to which the defence operates effectively in practice.

¹¹³ C [2007] EWCA Crim 1862 at [31].

¹¹⁴ C [2013] EWCA Crim 223 at [19]. Rarely, a hypoglycaemic episode can occur without warning: V Marks, "Hypoglycaemia and Automatism" 14 June 2013, Keele University.

Our provisional proposal

5.106 The defence of automatism would lead to a simple acquittal in cases of automatic conduct caused by something other than a recognised medical condition.¹¹⁵

- (1) R is at the archery stand on a corporate “away day”. She has never performed any archery before, is not intoxicated and is trying to follow the archery instructor’s advice. Some other activity at the away day involves a race, and a starting pistol is fired. R is startled and as a reflex action releases the bow and swings her body, with the result that the arrow hits someone else. Such a case would no doubt be dealt with by way of an absolute discharge if R was convicted of an offence, but if the action which would otherwise have been a criminal offence was a reflex action then some might argue that a simple acquittal would be more appropriate.
- (2) S is hypnotised at a public show, which he has voluntarily attended, during which he is instructed to help himself to items from a stand. Unknown to him, he is still hypnotised when he leaves the show because the hypnotist has failed to bring him out of the trance. On his way home he takes items from a stand, which ought to be paid for, but does not pay. He lacks criminal responsibility for the theft in the same way as when directly under the influence of the hypnotist at the show.¹¹⁶

The provisional proposal would not mean a different outcome for the driver who was hit on the head by a stone, (as in N in paragraph 5.104). N would be acquitted, as under the present law. If, instead, a blow to the head led to concussion, that could amount to a recognised medical condition.

5.107 If the accused’s loss of capacity to control his or her actions is due to something the accused culpably did or failed to do, then the defence of automatism should not be available to him or her. For example, if the accused is handling materials which she knows are dangerous and can cause temporary blindness, then if she handles them so carelessly that she is unable to see and causes damage while in such a state, the defence of automatism might well not be available to her. We explain this more fully in chapter 4 below. In this respect we are not proposing any change to the law.

THE REFORMED AUTOMATISM DEFENCE

General features

5.108 As with the defence of recognised medical condition, the reformed automatism defence would be available in respect of all offences. No distinction would be drawn between charges of basic and specific intent.

¹¹⁵ Clearly someone whose recognised medical condition caused reflex actions – eg St Vitus’ dance – would be pleading the defence of not criminally responsible by reason of recognised medical condition and not the new defence of automatism. Similarly, where a sting causes an allergic reaction, the defendant will be relying on the recognised medical condition defence.

¹¹⁶ See C Finkelstein, “Involuntary Crimes, Voluntarily Committed” 142, 153 and following in S Shute and A Simester (eds), *Criminal Law Theory: Doctrines of the General Part* (2002).

- 5.109 The reformed automatism defence would not lead to a special verdict. If successful, this defence would result in a simple acquittal.
- 5.110 It would not be available where the loss of capacity was due to a recognised medical condition. In practice, therefore, the defence of automatism is likely to be applicable in relation to automatic reflex reactions, or to transient states or circumstances; if a person's condition persists and worsens it might then qualify as a recognised medical condition.

No prior fault

- 5.111 If the accused's loss of capacity to control his or her actions is due to something he or she culpably did or failed to do (as provided for by the common law), then the defence of automatism should not be available to him or her. In this respect we are not proposing any change to the law.

Denial of actus reus or of mens rea?

- 5.112 As we have seen above, commentators do not agree as to whether the defence of automatism is a denial of the actus reus or of the mens rea, and at least one commentator would see it as a denial that there has been any voluntary act. Our proposed defence allows that there is an act but provides that D is not guilty if that act occurs in particular circumstances.

Total loss of control or loss of effective control?

- 5.113 As we discuss above, the essence of the defence of automatism lies in a lack of capacity to control one's actions (or inactions). The loss of ability to control the body may be accompanied by loss of consciousness, but that is not an essential feature. The next question is what degree of lack of control should be required for a defence of automatism.
- 5.114 We note in Appendix A that there is potential for confusion about the precise meaning of "voluntary" and "involuntary",¹¹⁷ so we do not propose to put the defence in terms of loss of voluntary control. (In the draft Criminal Code we thought the word "involuntary" was best avoided, because of "the variable use to which it tends to be put".)¹¹⁸
- 5.115 As noted, the case law on the current defence of (sane) automatism requires there to be a "total destruction of voluntary control" on the part of the accused, even if only for a short time, in order for a plea of automatism to succeed.¹¹⁹ The draft Code referred instead to a person being deprived of "effective control".¹²⁰ It did so because the authors believed that a person in the position of the defendant

¹¹⁷ The term "voluntary" is open to misunderstanding. It might be used to describe conduct which is accompanied by a particular attitude, desire, intention or simple awareness, but whether conduct is "voluntary" in that sense will not always tell us whether it is conduct for which the agent is to be held responsible. "Voluntary" may not be the opposite of "involuntary" when it is used to mean "willed". Behaviour may be unthinking or automatic in the sense of habitual, without being involuntary in the sense that a sneeze is involuntary.

¹¹⁸ Law Com 177, para 11.1.

¹¹⁹ *A-G's Reference (No 2 of 1992)* [1994] QB 91. See para 5.3 above.

¹²⁰ See cl 33(1)(a) of the draft Criminal Code.

in *Broome v Perkins* should not be convicted.¹²¹ In *Broome v Perkins*¹²² the accused had suffered an episode of hypoglycaemia and had driven five or six miles in that state, driving erratically and causing a collision. The Divisional Court held that the defence of automatism was not open to him because on the evidence he must have had control for at least some of the journey. Under our proposals someone in this position would rely on the defence of not criminally responsible by reason of recognised medical condition.

- 5.116 Was the draft Criminal Code right to shift the requirement from total loss of control to loss of effective control? Ashworth has written that in this respect the draft Code “rightly recognizes that total absence of control should not be required, but it therefore leaves us with a test dependent on a judgment of degree and value (‘effective’), and does so without identifying the relevance of the defendant’s capacity rather than awareness and ‘choice’”.¹²³ We noted above that the cases seemed to set a higher standard where the offence was a driving offence, and that this might be for reasons of policy, namely, the need to avoid the risk of dangerous drivers being acquitted. That risk was mitigated by requiring the driver to show total loss of control. If, however, the requirement were only for loss of the capacity for effective control, then it would be a more flexible standard for the courts to define, one which could accommodate a greater variety of situations. We suspect the courts would interpret the notion of loss of effective control as amounting to something close to total loss of control in driving cases, but the more flexible standard would not require them to do so in every case.
- 5.117 There is, however, a risk that a defence in terms where the accused says he or she was deprived of “effective control” will lead to litigation about what amounts to “effective control”. That will have significant implications in cost and delay at trial.

Conclusion

- 5.118 Our provisional conclusion is that the defence of automatism should require the accused to have a total loss of capacity to control his or her physical actions. We are not limiting the new defence to cases of unconsciousness.

Relationship to the recognised medical condition defence

- 5.119 The two defences are to be mutually exclusive. That is, if a person’s loss of capacity is due to a recognised medical condition, then the defence of automatism is not to be available.
- 5.120 In some cases, neither defence will be available even though the accused has a condition which is a recognised medical condition. This will arise where the condition in question is not a qualifying “recognised medical condition”.¹²⁴ The automatism defence would not be available if the loss of capacity was the result

¹²¹ Law Com 177, para 11.4.

¹²² *Broome v Perkins* (1987) 85 Cr App R 321.

¹²³ *Principles of Criminal Law* p 94. Compare Law Com No 177, paras 11.3 to 11.4, with the discussion of the case of *T* by J Horder, “Pleading Involuntary Lack of Capacity” (1993) 52 *Cambridge Law Journal* 298, 312 to 315 (footnote in the original).

¹²⁴ See paras 4.55 and following above for discussion of what constitutes a qualifying recognised medical condition.

of recognised medical condition, but the recognised medical condition defence will not be available if the condition is not a *qualifying* medical condition. So, for example, a person with antisocial personality disorder who committed an assault when he lost his temper and who says that this is because of the personality disorder will not be able to rely either on the automatism defence or on the recognised medical condition defence because the personality disorder is not a qualifying medical condition. He or she will stand to be convicted or acquitted subject to the other evidence in the case and any other available defences.

Burden of proof

- 5.121 Under the current law, where a person pleads not guilty and claims to have acted in a state of automatism, the burden of proof lies on the prosecution to disprove that defence. We are not proposing any change to the law in that respect.

Actions or conduct?

- 5.122 Although we have written above about a person's loss of capacity to control his or her actions, in very exceptional circumstances it could be that a defendant failed to act when he or she should have acted. We therefore refer, in our provisional proposal, to the capacity to control conduct, which encompasses action and inaction.

PROVISIONALLY PROPOSED DEFENCE OF AUTOMATISM

- 5.123 **Proposal 12: We provisionally propose that the common law rules on the defence of automatism be abolished.**
- 5.124 **Proposal 13: We provisionally propose that where the magistrates or jury find that the accused raises evidence that at the time of the alleged offence he or she wholly lacked the capacity to control his or her conduct, and the loss of capacity was not the result of a recognised medical condition (whether qualifying or non-qualifying), he or she shall be acquitted unless the prosecution disprove this plea to the criminal standard.**

CHAPTER 6

THE RELATIONSHIP TO THE LAW ON PRIOR FAULT AND INTOXICATION

- 6.1 In this chapter we discuss the relationship between our proposed new defences and the principle of prior fault – that a person may not rely on an excuse where he or she has culpably brought about the excusing condition. It is a well established principle of criminal law that a defendant cannot rely on excuses arising from his own prior fault. This is readily seen in the law’s response to voluntary intoxication.¹ We discuss the common law rules which cater for a variety of situations. We demonstrate that our proposals will fit well with the existing principles of prior fault and with the intoxication rules as they appear in the current law, but explain that there is one adjustment which is necessary in order to avoid creating anomalies. In the course of the discussion we also consider how the courts would deal with cases of concurrent and successive causes of loss of capacity.
- 6.2 For the sake of clarification, we emphasise from the outset that under our proposals, where an accused relies on his or her voluntary intoxication as an excuse for his or her conduct, the common law rules will continue to apply. Voluntary intoxication is not a defence.² The one aspect of the common law which we would seek to change is the case where the accused relies on involuntary intoxication which led to a total loss of one of the relevant capacities, and the underlying cause of the loss of capacity is a recognised medical condition. In that event, we would disapply the intoxication rules. The consequence of this proposed change is that whereas that accused would presently be acquitted, he or she would under our proposals be found not criminally responsible by reason of a recognised medical condition, and would be subject to the disposal powers discussed above in chapter 4.

PRINCIPLES OF PRIOR FAULT AND CULPABILITY

Theoretical justifications

- 6.3 The fundamental question underlying the reforms in this paper, as we have already said, is when it is unfair to hold someone criminally responsible for what they have done. The answer is that a person who is incapable of conforming his or her behaviour to the criminal law should be exempted from criminal responsibility. The problem is that this simple statement does not go far enough; it would, for example, put someone whose mental faculties are impaired by voluntary drunkenness in the same category as one whose mental faculties are damaged by disease. Most people would find this unacceptable because, where a defendant commits a crime having voluntarily drunk him or herself into an

¹ And duress: see *Hasan* [2005] UKHL 22 at [38], [2005] 2 AC 467 in which it was held that “If a person voluntarily becomes or remains associated with others engaged in criminal activity in a situation where he knows or ought reasonably to know that he may be the subject of compulsion by them or their associates, he cannot rely on the defence of duress to excuse any act which he is thereafter compelled to do by them”.

² A common law principle recently restated in *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576 and *Asmelash* [2013] EWCA Crim 157.

incapacitated state, there is a degree of prior fault on the defendant's part for which he or she should be held responsible. Thus a defendant should only be entitled to rely on a defence based upon a lack of capacity if he or she had not been culpable in bringing about that lack of capacity.

6.4 The law recognises that where an intoxicated accused engages in criminal conduct and there is a degree of fault in the accused's decision to become so intoxicated, that fault, albeit arising well before the criminal conduct, is sufficient to provide the necessary blameworthiness to convict the defendant.³ This is so even though at the time of the criminal conduct the accused does not have the prescribed fault element for the offence because he or she is too intoxicated to form it. Thus, even if due to voluntary intoxication the defendant did not have mens rea for the offence charged he or she will not be convicted of a specific intent offence,⁴ but may be convicted of a basic intent offence.⁵

6.5 The present law recognises a principle that where the defendant voluntarily induces a loss of capacity by ingesting substances commonly known, or known to the accused, to be likely to cause that effect, he or she can be found guilty of most crimes even though at the time of the offence he or she lacked the relevant mens rea or was acting as an automaton. Three core elements of this principle need to be examined in more detail:

(i) for which crimes will it be possible to convict the defendant on the basis of prior fault;

(ii) what level of fault must the defendant have in relation to his or her loss of capacity; and

(iii) how much capacity must be lost for the principle to apply?

(i) For which crimes will it be possible to convict the defendant on the basis of his or her prior fault?

6.6 It seems clear that the defendant's prior fault in inducing the loss of capacity is sufficient to justify his or her conviction for all offences of basic intent, though not offences of specific intent.⁶

6.7 We are not proposing any change to the law in this respect.

³ *Principles of Criminal Law* p 81; *Simester and Sullivan's Criminal Law* p 119. Ashworth writes, "The aim of the doctrine of prior fault is to prevent D taking advantage of a condition if it arose through D's own fault": *Principles of Criminal Law* p 93.

⁴ *DPP v Majewski* [1977] AC 443.

⁵ We define specific intent offences as those for which the predominant mens rea is one of knowledge, intention or dishonesty, and basic intent offences as all those for which the predominant mens rea is not intention, knowledge or dishonesty (this includes offences of recklessness, belief, negligence and strict liability).

⁶ In our report on intoxication and criminal liability we said that the distinction between offences of basic intent and offences of specific intent is ambiguous, misleading and confusing and should be abandoned. It is beyond the scope of this project to pursue that approach. See *Intoxication and Criminal Liability* (2009) Law Com No 314, para 1.28.

(ii) Level of fault in losing capacity

- 6.8 For crimes of basic intent, a self-induced incapacity will not usually excuse. This is equally true whether that incapacity results from doing or omitting to do something, as for example, taking alcohol against medical advice after using certain prescribed drugs, or failing to have regular meals whilst taking insulin.

CASES INVOLVING DANGEROUS DRUGS OR ALCOHOL

- 6.9 Where a defendant's self-induced incapacity is caused by alcohol or dangerous drugs, the law regards that as a sufficient prior fault⁷ to found liability for basic intent offences. This is so even if the accused was unaware of the specific effects of that voluntary intoxication or of the incapacitating qualities of the particular drug.⁸
- 6.10 This distinction, between substances which are commonly known to cause aggression or unpredictability and those which are not, has been criticised as having no clear legal basis. Norrie, for example, has written:

The prospect emerges of an unstable distinction being drawn between different classes of drugs ... the line is being drawn not according to fault, but according to a straight-forward policy judgment that some kinds of drug-taking will not be tolerated while others will.⁹

- 6.11 In our view, however, such a policy-based distinction is justified. A person who takes drugs, especially prohibited ones, which are widely known to be likely to make a person unpredictable or aggressive (or drugs which the defendant knows are likely to have this effect on him or her), is more culpable in losing capacity than one who takes drugs which do not usually have such effects. In the former case it will be very unlikely that the defendant acted reasonably, while in the latter case it may be possible to show that the defendant's conduct was reasonable in the circumstances or that the defendant was unaware of the likely effects.

LOSS OF CAPACITY BY NON-DANGEROUS DRUGS OR OTHER CONDUCT

- 6.12 There are at least four possible interpretations as to what standard of prior fault is required in this context. They are:
- (1) At the time of becoming intoxicated the defendant ought to have been aware of the risk of subsequently losing control.

⁷ However, a defendant charged with a crime of basic intent who suffered a self-induced loss of capacity caused by dangerous drugs or alcohol may be acquitted where he or she would not have foreseen the risk if sober: *Richardson and Irwin* [1999] 1 Cr App R 392. This follows the specific rule in relation to Public Order Act offences, see s 6(5) of the Public Order Act 1986 where it states, "For the purposes of this section a person whose awareness is impaired by intoxication shall be taken to be aware of that which he would be aware if not intoxicated, unless he shows either that his intoxication was not self-induced or that it was caused solely by the taking or administration of a substance in the course of medical treatment". If, however, awareness is not relevant (as in offences of negligence or strict liability), then self-induced intoxication affecting awareness makes no difference.

⁸ *Allen* [1988] Criminal Law Review 698. In *Allen*, A claimed that the wine he had consumed was stronger than he had thought, but this did not allow him to escape responsibility.

⁹ A Norrie, *Crime, Reason and History* (2nd ed 2001) p 118.

- (2) At the time of becoming intoxicated the defendant was aware of a risk of committing the actus reus of the offence with which he or she is subsequently charged.
 - (3) At the time of becoming intoxicated the defendant was aware of the risk of losing the capacity to form the mens rea of the offence with which he or she is charged.
 - (4) At the time of becoming intoxicated the defendant was aware of the risk that he or she may lose capacity or control.
- 6.13 The first of these interpretations adopts an objective test. There is some support in policy terms for such a strict approach. This would be the same approach as is adopted for those cases where the cause of the loss of capacity is a dangerous drug. Arguably the same approach should apply to all instances of self-induced incapacity, regardless of whether the cause of the loss of capacity is ingesting dangerous drugs, non-dangerous drugs or some other conduct. However, if this approach were to be applied in that way, it would produce unduly harsh results. For example, a person who was unaware of the risks of becoming incapacitated by taking an over the counter medicine would be liable for any basic intent offence committed while in an incapacitated state. It seems unduly harsh to suggest that his or her “fault” in taking the drug was a fair substitute for the fault that would be required as the mens rea for the offence charged (but which the defendant clearly lacked at the point of commission).
- 6.14 Further, although it has been suggested that there is some dispute in the cases over whether the prior fault is to be assessed subjectively or objectively,¹⁰ commentators agree that subjective recklessness is required.¹¹ This is supported by the decision in *Hardie*.¹² In that case, the defendant’s relationship with the woman with whom he was living had broken down and she had told him to leave. He became upset and took one tablet of valium, a sedative drug, belonging to the woman. Subsequently he had taken two more in front of her, and she had said, “Take as many as you like. They are old stock and will do you no harm”. He took a couple more.
- 6.15 It was undisputed that he later started a fire in the bedroom of the flat while the woman and her daughter were in the sitting room. There was also evidence that before, during and after the fire he showed signs of intoxication which might have been the result of having taken the valium. He was charged with offences of arson with intent to endanger life and (in the alternative) being reckless as to whether life was endangered.¹³ The defence was that, due to the consumption of

¹⁰ G R Douglas, “Automatism, Drunkenness and *Hardie*” (1988) 85 (42) *Law Society Gazette* 25.

¹¹ A Norrie, *Crime, Reason and History* (2nd ed 2001) p 117; W Wilson, *Criminal Law* (4th ed 2011) p 202. See also S Gough, “Intoxication and Criminal Liability: The Law Commission’s Proposed Reforms” [1996] 112 *Law Quarterly Review* 335, 338. As to the relationship between intoxication and the distinction between specific intent and basic intent offences, see Gough (above) and J Horder, “Sobering Up” [1995] 58 *Modern Law Review* 534, 536 and J Horder, “The Classification of Crimes and the Special Part of the Criminal Law” 20, 22 in R A Duff and S Green, *Defining Crimes* (2005).

¹² [1985] 1 WLR 64.

¹³ Contrary to the Criminal Damage Act 1971, s 1(2) and (3).

the valium, he had neither the mens rea of intention nor of recklessness. As regards proof of recklessness, the issue was whether “assuming that the effect of the valium was to deprive the appellant of any appreciation of what he was doing”, the case should properly be regarded as one of self-induced intoxication and thus no defence.¹⁴

6.16 Lord Justice Parker stated:

There was no evidence that it was known to the appellant or even generally known that the taking of valium in the quantity taken would be liable to render a person aggressive or incapable of appreciating risks to others or have other side effects such that its self-administration would itself have an element of recklessness. It is true that valium is a drug and it is true that it was taken deliberately and not taken on medical prescription, but the drug is, in our view, wholly different in kind from drugs which are liable to cause unpredictability or aggressiveness. ...

In the present case the jury should not, in our judgment, have been directed to disregard any incapacity which resulted or might have resulted from the taking of valium. They should have been directed that if they came to the conclusion that, as a result of the valium, the appellant was, at the time, unable to appreciate the risks to property and persons from his actions they should then consider whether the taking of the valium was itself reckless. We are unable to say what would have been the appropriate direction with regard to the elements of recklessness in this case for we have not seen all the relevant evidence, nor are we able to suggest a model direction, for circumstances will vary infinitely and model directions can sometimes lead to more rather than less confusion. It is sufficient to say that the direction that the effects of valium were necessarily irrelevant was wrong.¹⁵

6.17 The court was clearly applying a subjective test requiring the individual defendant to have appreciated the likely consequences of his conduct in taking the valium. This is a particularly strong authority because Hardie was charged with criminal damage, which at the time would be satisfied by proof of objective recklessness as mens rea.¹⁶ If Hardie had been sober it would have been sufficient that a reasonable person would have realised the risk of the damage etc. Nevertheless the court held that his prior fault in taking the drugs would only be sufficient to justify his conviction if he was subjectively aware of the risk.

¹⁴ *Hardie* [1985] 1 WLR 64, 68.

¹⁵ *Hardie* [1985] 1 WLR 64, 69 to 70.

¹⁶ The leading authority at the time was *Caldwell* [1982] AC 341 in which the House of Lords held that “reckless” was to be assessed objectively, meaning that it was not necessary for the prosecution to prove that the defendant personally perceived the risk in question; it was sufficient to show that the accused had not given any thought to it or had recognised that there was some risk but had nevertheless gone on to take it. The obviousness of the risk was to be assessed by how the situation would appear to the ordinary prudent person.

6.18 We therefore reject the objective interpretation of prior fault for non-dangerous drugs.

6.19 The second possible interpretation (see paragraph 6.12 above) applies a subjective test. This approach gains some support from the decision in *Bailey*.¹⁷ The defendant was charged with a specific intent offence, namely wounding with intent contrary to section 18 of the Offences Against the Person Act 1861 (“the OAPA”) and, in the alternative, with the basic intent offence of malicious wounding contrary to section 20 of the OAPA.¹⁸ The accused had quarrelled with another man and hit him with an iron bar. In his defence he denied that he had the requisite mens rea and claimed that he had been in a state of automatism caused by hypoglycaemia as a result of failing to eat after a dose of insulin. The trial judge had directed the jury that a defence of automatism was not available to the basic intent offence if the automatism was self-induced, and it was self-induced because the accused had failed to eat when he should have done.

6.20 The Court of Appeal noted the principle in *DPP v Majewski*¹⁹ that:

Automatism resulting from intoxication as a result of a voluntary ingestion of alcohol or dangerous drugs does not negative the mens rea necessary for crimes of basic intent, because the conduct of the accused is reckless and recklessness is enough to constitute the necessary mens rea in assault cases where no specific intent forms part of the charge.

6.21 The court went on to consider whether recklessness could be proved and stated:

In our judgment, self-induced automatism, other than that due to intoxication from alcohol or drugs, may provide a defence to crimes of basic intent. The question in each case will be whether the prosecution have proved the necessary element of recklessness. In cases of assault, if the accused knows that his actions or inaction are likely to make him aggressive, unpredictable or uncontrolled with the result that he may cause some injury to others and he persists in the action or takes no remedial action when he knows it is required, it will be open to the jury to find that he was reckless.²⁰

6.22 Thus it could be argued that recklessness in this context means that the accused must have foreseen the risk of unpredictable, aggressive or uncontrolled conduct that may cause him to commit the actus reus of the offence, in this case wounding or causing grievous bodily harm.

¹⁷ [1983] 1 WLR 760.

¹⁸ An offence contrary to s 18 of the OAPA is, in short, one of wounding with intent to do some grievous bodily harm or causing grievous bodily harm with intent to do some grievous bodily harm. Section 20 of the OAPA creates lesser offences of malicious wounding or maliciously inflicting grievous bodily harm. A person charged with a s 18 offence may be convicted of a s 20 offence because the more serious includes the less serious.

¹⁹ *DPP v Majewski* [1977] AC 443.

²⁰ *Bailey* [1983] 1 WLR 760, 765.

- 6.23 This would be a very narrow approach. In many cases it would be difficult to show that the defendant's prior fault was as specific as an appreciation that he might commit the actus reus of an offence which, by definition, he had no intention to commit.
- 6.24 The third interpretation (see paragraph 6.12 above) also involves a subjective test. On this interpretation, the defendant would be reckless where he or she foresaw the risk that taking the non-dangerous drug or failing to take medication etc may lead to an inability to form the mens rea of the offence, but continued to take the risk regardless.
- 6.25 Arguably, this approach is supported by the decision in *Hardie*, although not explicitly so. In *Hardie* the defendant was prevented from forming the mens rea of the offence with which he was charged due to the effects of valium:

There was no evidence that it was known to the appellant or even generally known that the taking of valium in the quantity taken would be liable to render a person aggressive or *incapable of appreciating risks* to others or have other side effects such that its self-administration would itself have an element of recklessness.²¹

- 6.26 There are difficulties with this approach. It would often be difficult in practice to establish what the defendant appreciated the effects of his or her conduct might be on his or her subsequent abilities to see risks.
- 6.27 The final interpretation (see paragraph 6.12 above) also adopts the widely supported view that recklessness is to be judged by a subjective standard. We consider that it is to be preferred as the most accurate expression of the current law. This interpretation requires that the defendant foresaw a risk of loss of capacity. This reflects the principle that where the defendant foresaw that his or her actions would result in a loss of capacity, the defendant will be prevented from relying on that loss of capacity as a defence.
- 6.28 It is our view that the decisions in the cases discussed above are all facets of this broader principle. Although the decisions in individual cases understandably deal with the specifics of the risk of the type of behaviour that relates to the crime in question, the underlying reasoning is that the defendant should not be able to rely on a loss of control if he or she had personally been aware of the risk of that loss of control occurring and had proceeded unreasonably to take that risk.

(iii) Degree of loss of capacity

- 6.29 The prior fault principles apply where the basic intent offence is charged and the defendant is claiming that at the time of the offence he lacked a relevant capacity. The extent of the loss of capacity depends on the plea that is being put forward. If the defendant is pleading that he or she lacked mens rea due to intoxication, then the question is whether the defendant had that mens rea for the offence – the question is not about whether the defendant had the ability to form the mens rea, but whether he or she actually possessed the relevant mens rea at the time of the

²¹ *Hardie* [1985] 1 WLR 64, 69 to 70 (emphasis added).

offence.²² If the defendant is pleading not guilty on the basis of automatism (whether under the current law or under our reformed defence) then the loss of capacity needs to be total.²³ Under our proposed new defence, if the defendant is pleading lack of criminal responsibility due to recognised medical condition, then the defendant must have suffered a total loss of one of the relevant capacities at the time of the alleged offence.

THE INTERACTION OF PRIOR FAULT (INCLUDING INTOXICATION) PRINCIPLES AND OUR PROVISIONALLY PROPOSED DEFENCES

- 6.30 All cases that are currently categorised as insanity would be likely to fall within the new defence of recognised medical condition. The new defence would also include cases of automatic conduct resulting from medical conditions (including some which would currently be sane automatism, such as Post-Traumatic Stress Disorder). The prior fault principle will apply to the new recognised medical condition defence and to the automatism defence (which will be much narrower than under the present law).
- 6.31 We think that the doctrine of prior fault should apply to both categories in order to ensure consistency across all situations in which the defendant was at fault in inducing his or her lack of capacity and relies on that lack of capacity to deny criminal responsibility. The same rules should apply where the defendant was at fault for ingesting a substance, for *failing* to ingest a substance, or for doing or failing to do anything else which caused the loss of capacity. In our view there is no logical distinction between, for example, a diabetic who culpably misuses his insulin knowing that this is likely to make him lose capacity, and one who culpably *fails* to take insulin knowing that this is likely to have the same effect.²⁴ A similar approach has been proposed by Mackay who suggests:

[Replacing] the term “voluntary intoxication” with a more general term such as “self-induced incapacity” or “voluntary incapacity”... whilst retaining the reference to drink or drugs, expanding the accepted definition of “voluntary intoxication” to include other forms of culpable incapacity where the defendant knowingly abstains from medical advice or otherwise knowingly allows himself to become incapacitated when such incapacity could have been avoided by him.²⁵

- 6.32 We therefore propose that the same rules should apply wherever the defendant was culpable in bringing about his or her incapacitated state, no matter how he or she brought it about. This is discussed further at paragraphs 6.75 and following below.

²² We discuss the situation where the defendant lacks a relevant capacity but nevertheless pleads lack of mens rea in circumstances where the defendant has an underlying medical condition at para 4.134 above. As regards a case where the defendant did not wholly lack a relevant capacity, see para 6.38 below.

²³ See paras 5.113 and following above.

²⁴ See paras 6.75 to 6.79 below.

²⁵ R D Mackay, “Intoxication as a Factor in Automatism” [1982] *Criminal Law Review* 146, 156.

- 6.33 In making proposals for reform of the insanity defence, we are keen to ensure that they do not conflict with the existing law in relation to other excuses based on lack of capacity, but we are also keen to ensure that the proposals do not perpetuate incoherence. We are reforming only the law relating to insanity and automatism. We are not therefore seeking to change any existing rules governing the availability of a plea of intoxication for those individuals who do *not* have a recognised medical condition and who become voluntarily or involuntarily intoxicated.
- 6.34 The factors affecting criminal liability under the present rules are:
- (a) whether the defendant was at fault in losing capacity,
 - (b) whether the crime charged is one of specific or basic intent,²⁶ and
 - (c) whether the defendant had a disease of the mind or internal malfunctioning.
- 6.35 In relation to (a), we are not proposing any change. In the case of a defendant whose prior fault lies in ingesting substances, the well established common law rules will apply. We believe that the present law also treats the defendant in the same way where his or her prior fault lies in culpably *failing* to do something to avoid a loss of capacity.
- 6.36 We are not proposing any change to any cases turning on factor (b). These are general rules governing intoxication. We cannot attempt to alter those rules within the present project.
- 6.37 In relation to (c), under our proposals as explained in this chapter, if the defendant has been culpable in bringing about his or her loss of capacity, we believe that the recognised medical condition verdict ought not to be available to him or her. An assessment of culpability would have to take account of the effects of a person's medical condition: in some circumstances the condition itself may cause the accused to take or fail to take medication which controls the condition. In that event, the accused would not be culpable.

Involuntary intoxication under our proposals

- 6.38 Where the defendant becomes involuntarily intoxicated, for example, by having a drink spiked by a third party, this is not in itself an excuse for any crimes he or she subsequently commits while in that state. If the defendant formed the mens rea required for the offence, it is irrelevant to the question of criminal liability that his or her inhibitions were lowered or that he or she would not have acted in that way if sober.²⁷ Our proposals will not affect this category of case. Even if the defendant had a recognised medical condition in such a case, he or she would not be suffering a total loss of capacity. The defendant would be liable for the offence charged.
- 6.39 If, on the other hand, the defendant was so involuntarily intoxicated that he or she did not form the necessary mens rea, or was an automaton, then there will be no

²⁶ See n 3 above for the definition of specific and basic intent.

²⁷ *Kingston* [1995] 2 AC 355.

criminal liability whatever the offence. The law was definitively settled in the case of *Kingston*²⁸ where, reversing the decision of the Court of Appeal,²⁹ the House of Lords rejected the argument that reduced inhibitions brought about by involuntary intoxication resulting from the secret acts of a third party could be a defence at common law. The defendant had committed an indecent assault on a fifteen-year-old boy with the fault required for liability. He was therefore liable to conviction of that offence even if it was accepted that he had abused the boy under the disinhibiting influence of a drug surreptitiously administered to him by his co-accused.³⁰

6.40 This rule operates well in those rare cases where the defendant has taken a substance which has resulted in a loss of capacity but the defendant was not even aware he or she was taking that substance. The case of the spiked drink is the obvious example.

- (1) A's lemonade is spiked with vodka without his knowledge. A murders V (specific intent offence). A is entitled to an acquittal, provided he lacked mens rea.
- (2) B's lemonade is also spiked. He commits an assault (basic intent offence). B is also entitled to an acquittal if he lacked mens rea.

We propose to make no change to these cases: they are squarely within the rules on involuntary intoxication.

6.41 However, a plea of involuntary intoxication can succeed in a broader range of circumstances than where the defendant's drink or food has been spiked. It also applies where the defendant becomes intoxicated through taking drugs in accordance with a medical prescription and, through no fault of his own, suffers a reaction which causes a loss of capacity.³¹ A further example of involuntary intoxication is where the defendant ingests a substance deliberately, but that substance is not commonly known to cause aggression or unpredictability, the defendant did not personally know that it might produce such effects, and it was reasonable for him or her to take it in the circumstances. In those cases the defendant is entitled to a complete acquittal provided he lacked the mens rea for the offence or lacked all capacity to commit the conduct element of the offence.³²

6.42 Under the present law an anomaly arises:

- (1) C, who has become involuntarily intoxicated by properly taking medication for a condition, would be found not guilty if he lacked capacity for the alleged crime irrespective of whether the crime charged was one of basic or specific intent.

²⁸ [1995] 2 AC 355.

²⁹ [1994] QB 81.

³⁰ As stated by the Court of Appeal in *Sheehan* [1975] 1 WLR 739, 744: "A drunken intent is nevertheless an intent".

³¹ See *Intoxication and Criminal Liability* (2009) Law Com No 314, para 2.88.

³² It does not apply where the accused knew he or she was drinking alcohol but did not realise how strong the drink was: *Allen* [1988] Criminal Law Review 698. This would equally apply to other intoxicating substances.

- (2) E with the same medical condition who did *not* take medication at the relevant time but had a reasonable excuse for not doing so,³³ and whose condition led to a loss of capacity, would be found insane irrespective of whether the crime charged was one of basic or specific intent.
- 6.43 As the intoxication rules stand, the same anomaly would arise when these rules are applied alongside our new defence; C would be acquitted while E would be found not criminally responsible by reason of a recognised medical condition.
- 6.44 We do not consider that there is any difference in moral culpability between these individuals, so there is no justification for treating them differently on that basis.
- 6.45 The primary rationale in the current law for treating E as “insane” is that there is a risk that his or her dangerous behaviour may recur and an unqualified acquittal is therefore inappropriate. This is clear from many of the leading cases. In *Sullivan* Lord Diplock stated that “The purpose of the legislation relating to the defence of insanity, ever since its origin in 1800, has been to protect society against recurrence of the dangerous conduct”.³⁴
- 6.46 On this basis, however, there is no reason to distinguish the two cases. It is just as likely that C will lose capacity again due to a reaction to his or her medicine as it is that E will lose capacity again due to his or her medical condition. In both cases the recognised medical condition is the underlying cause of the loss of capacity. In the case of C who has taken the medication, the only reason for his doing so is the recognised medical condition. Allowing inconsistent verdicts on the basis that in one instance, the defendant has ingested an intoxicating substance and in the other, he or she has failed to ingest a substance would be akin to the unsatisfactory internal/external distinction in the present law.³⁵ We believe that the two individuals therefore ought to be treated alike.
- 6.47 We think that it is appropriate to reflect that conclusion by treating both these cases as pleas of not criminally responsible by reason of recognised medical condition. We acknowledge that in doing so we are denying C the complete acquittal to which he or she is currently entitled, but we would emphasise that the verdict of not criminally responsible by reason of recognised medical condition to which he or she would be subject is a non-stigmatising verdict (unlike “not guilty by reason of insanity”). Furthermore, we believe that the application of the new defence in such cases provides more appropriate disposal powers.³⁶ Under the

³³ Such as where a person with diabetes had his or her insulin stolen or mistakenly locked in the hold of an aircraft rather than accessible in hand luggage.

³⁴ [1984] AC 156, 172. These comments have been echoed in the Supreme Court of Canada in *Parks* in which La Forest J said that “The continuing danger theory holds that any condition likely to present a recurring danger to the public should be treated as insanity. The internal cause theory suggests that a condition stemming from the psychological or emotional make-up of the accused, rather than some external factor, should lead to a finding of insanity. The two theories share a common concern for recurrence, the latter holding that an internal weakness is more likely to lead to recurrent violence than automatism brought on by some intervening external cause”. [1992] 2 SCR 871, 901.

³⁵ See paras 5.38 and following above.

³⁶ For other consequences of a special verdict as opposed to a conviction, see paras 1.15 to 1.22 in Part 1 of the Supplementary Material to the Scoping Paper.

present law, a simple “not guilty” verdict means the court has no choice but to let the defendant go free, even if there is a chance of recurrence and thus of the defendant being a danger to others. We think that it is important that the court has an appropriate range of disposal options to deal with this type of case. An absolute discharge would also be available for cases in which there is no such risk.

- 6.48 Under the new defence, therefore, our provisional view is that both of these situations should be treated alike and the involuntary intoxication rules disapplied, meaning that the new recognised medical condition defence would apply to both categories of case.
- 6.49 As an illustration of the way in which our proposal would operate, consider the case of a schizophrenic who complies with the instructions in taking his medication but who suffers an adverse reaction through no fault of his own (perhaps because of a change in the batch of drugs) which results in a total lack of capacity. If that individual was alleged to have committed a crime while in that state he would currently be acquitted of all charges. Under our proposals that person would, instead, be regarded as not criminally responsible by reason of recognised medical condition. This is a more appropriate verdict than an absolute acquittal since it accurately reflects the true underlying cause of the defendant’s conduct, namely the medical condition, and because it allows the court to address the risk of harm if he lost capacity again.
- 6.50 Another group affected by our proposals would be those with diabetes. Under the present law the outcomes in cases involving diabetic defendants who plead a lack of capacity are inconsistent. A diabetic who fails to take insulin and then commits an allegedly criminal act while totally incapacitated will be found not guilty by reason of insanity. This result flows from the fact that the incapacity had an “internal cause” (the diabetes). If, on the other hand, she took insulin in accordance with a medical prescription, but was unable to take it with food or had an unexpected reaction to it through no fault of her own, and committed an allegedly criminal act while lacking capacity, she would be entitled to a verdict of not guilty for all crimes since the loss of capacity was involuntary. We think that it is illogical that one blameless defendant should be entitled to a complete acquittal while the other is labelled insane, for the same reasons as explained above (at paragraphs 5.39 and following). Under our proposal, the verdict in both cases would be not criminally responsible by reason of a recognised medical condition.

Provisional proposal

- 6.51 **Proposal 14: We therefore provisionally propose that a person “D” shall be treated as pleading the recognised medical condition defence and not involuntary intoxication where:**
- (1) D suffered from a recognised medical condition, and**
 - (2) D took a properly authorised or licensed medicine or drug for the treatment of that condition, and**
 - (3) D took the medicine or drug in accordance with a prescription, with advice given by a suitably qualified person, or in accordance with**

the instructions accompanying the medicine or drug in the case of over-the-counter medicines, or, if D did not take it in accordance with instructions, it was nevertheless reasonable for D to take it in the way he or she did in the circumstances, and

- (4) D had no reason to believe that he or she would have an adverse reaction to that medicine which would cause him or her to act in that way, and**
- (5) the taking of that medicine or drug caused D totally to lack the relevant criminal capacity.**

6.52 At this stage, of course, we are merely setting out our provisional proposals and not drafting legislation, so the language used here is subject to refinement.

6.53 We recognise that this proposal departs from that in our intoxication report, which recommended that such instances be classed as involuntary intoxication.³⁷ However, the point of that recommendation was to avoid such people being classed as voluntarily intoxicated, which under the present law would lead to conviction. As we noted in that report, this would be very unfair on diabetics for whom “the maintenance of near normal blood glucose is very difficult”.³⁸ It would equally be unfair on those who have simply followed their doctors’ instructions with no knowledge that the medicine or drug could have such effects.

6.54 Our proposal here, on the other hand, would not put such people back into the category of voluntary intoxication leading to conviction. Rather, it would exclude them from the intoxication rules altogether, allowing them to rely on our proposed new defence of not criminally responsible by reason of recognised medical condition. As noted above, the label of recognised medical condition is not one carrying stigma. Categorising diabetics who have suffered a total loss of capacity and whose conduct is otherwise criminal as not responsible due to their medical condition would be far less objectionable than the current law’s approach.³⁹

6.55 It is worth emphasising that we are only making this change to one category of individuals who are relying on involuntary intoxication as the basis for their lack of capacity: those who took medication for a recognised medical condition. All others, such as those whose drinks are spiked, would continue to be dealt with under the rules governing involuntary intoxication as set out in *Kingston*.⁴⁰ Those individuals would be acquitted of any charge subject to them lacking capacity. We believe that this difference in outcome for cases of involuntary intoxication is entirely appropriate. If there is a complete loss of capacity but no underlying

³⁷ See Intoxication and Criminal Liability (2009) Law Com No 314, paras 3.125(4) and 3.128 to 3.136 where we recommended that “the situation where D took an intoxicant for a proper medical purpose” should be included in a statutory list of instances of involuntary intoxication.

³⁸ Intoxication and Criminal Liability (2009) Law Com No 314, para 3.135.

³⁹ Furthermore, the proposal in the intoxication report only examined diabetics who take insulin and then fail to eat, since this is an external cause which can give rise to a plea of sane automatism, while a diabetic who failed to take insulin at all would have to plead insane automatism. As we have explained, this is not a satisfactory distinction.

⁴⁰ [1995] 2 AC 355.

medical condition that caused the involuntary intoxication, an acquittal rather than a finding of not criminally responsible is the appropriate outcome.

Voluntary intoxication

- 6.56 Voluntary intoxication in itself is never a defence.⁴¹ If the defendant formed the necessary mens rea for the offence, it is irrelevant that his or her inhibitions were lowered or that he or she would not have acted in that way if sober.⁴²
- 6.57 Under the current law, voluntary intoxication describes the circumstance where:
- (1) The defendant intentionally or knowingly takes a substance which is commonly known to create a state of unpredictability or aggression. Generally this will be by drinking alcohol or taking prohibited drugs, but it can be as a result of taking any substance commonly known to have these consequences.
 - (2) The defendant intentionally or knowingly takes a substance which is not commonly known to create those consequences but he or she was aware that in taking the substance those consequences were likely to occur for him or her and it was not reasonable for him or her to take them in the circumstances.
 - (3) If the defendant knew that the substance he or she was consuming could cause unpredictability or aggression or loss of capacity, then it will be no excuse that he or she did not realise the strength of the substance.⁴³
- 6.58 The present rules governing the plea of voluntary intoxication or self-induced automatism are complex and heavily policy-laden. We have already described the prior fault principle that lies at the heart of the operation of the rules. Our aims, in making proposals to reform insanity, are not to introduce change to this discrete area of criminal law, but simply to guard against indefensible inconsistencies with the operation of the new recognised medical condition defence. We believe that we can best achieve this by adopting a policy of not permitting the recognised medical condition defence to be pleaded in any circumstances where the defendant's total lack of a relevant capacity at the time of the commission of the alleged offence has arisen from his or her prior fault.
- 6.59 We consider the various rules under the present law on intoxication and compare the outcomes in such cases with the outcomes of those who would plead the new defence of recognised medical condition. We acknowledge that the analysis that

⁴¹ See A Simester, "Intoxication is Never a Defence" [2009] *Criminal Law Review* 3, which argues that the criminal law doctrine of intoxication is in fact one of *inculcation*, not exculpation, which imposes constructive liability on defendants who are treated as though they acted with mens rea when in fact they did not.

⁴² If intoxication amounts to a recognised medical condition – which may be the case where a person suffers from alcoholism – then it can be a basis for the recognised medical condition defence. It may be that the drinking which led to the alcoholism was voluntary, but the common law takes the approach that the fault is too remote. We take the same view, and so avoid a potential conflict between the rules on self-induced intoxication and the recognised medical condition defence. See para 4.88 above.

⁴³ See n 6 above.

follows is complex and technical, but we think that this is unavoidable if we are to explain the state of the present law and the impact of the reform.

Voluntary intoxication leading to a specific intent offence

- 6.60 If, in a state of voluntarily intoxication, the defendant committed a crime which is one categorised as a specific intent offence, the defendant is entitled to an acquittal for that offence if he or she was so intoxicated that he or she did not form the mens rea.⁴⁴ Our proposals will make no change to this position. The defendant will not be relying on any recognised medical condition. He or she will usually be liable for a basic intent offence based on the same conduct.
- 6.61 Under the present law, the defendant who is diabetic and takes insulin, but who culpably fails to follow the prescription and who lacks all capacity at the time of the alleged offence will not be able to plead insanity. The diabetes is not the cause of the loss of capacity and, unlike the case of the involuntarily intoxicated diabetic above,⁴⁵ the defendant has been culpable in reducing himself or herself to the state where he or she lacks capacity. We believe that it is right to leave the culpability of this individual to be dealt with under the prior fault rules. In the case of someone charged with a specific intent offence⁴⁶ (for example, contrary to section 18 of the OAPA),⁴⁷ that would result in a not guilty verdict (as under the present law). It would, however, lead to a conviction for the basic intent offence under section 20 of the OAPA because, as we explain above, the prior fault in becoming voluntarily intoxicated will provide sufficient culpability for that basic intent offence.
- 6.62 There is a potential incongruity between this approach and that for our recognised medical condition defence.
- (1) F is charged under section 18 OAPA 1861 (a specific intent offence). He is a diabetic. He has become involuntarily intoxicated by taking medication in accordance with his prescription. F suffered a total loss of capacity and in that state caused serious injury to V. Under our proposals as set out above (see paragraph 6.51) F would be not criminally responsible by reason of recognised medical condition.
 - (2) G is charged under section 18 OAPA 1861. He is a diabetic. He has become voluntarily intoxicated by deliberately ignoring his prescription and taking too much insulin. G suffered a total loss of capacity (or merely a lack of mens rea) and in that state caused serious injury to V. G would be not guilty of the section 18 offence but would be guilty of a section 20 offence (a basic intent offence). Note that this is the same outcome as where the defendant does not have any recognised medical condition but has become voluntarily intoxicated with a dangerous drug; the defendant's prior fault means he cannot rely on his underlying condition to avoid responsibility for basic intent offences.

⁴⁴ *DPP v Majewski* [1977] AC 443.

⁴⁵ See para 6.50 above.

⁴⁶ See n 3 above for what is meant by an offence of specific intent.

⁴⁷ See n 16 above for a summary of the offences proscribed by ss 18 and 20 of the OAPA.

6.63 G is more culpable than F and ends up with a criminal conviction. This, we believe, is the correct outcome. However, in some instances the arbitrary way in which specific and basic intent offences are categorised will create undesirable outcomes:

(1) H is charged with theft. He is a diabetic. He has become involuntarily intoxicated by taking medication in accordance with his prescription. H suffered a total loss of capacity and in that state took some items from a shop he was passing. Assuming there was no criminal capacity H would be found not criminally responsible by reason of recognised medical condition.

(2) J is charged with theft. He is a diabetic. He has become voluntarily intoxicated by deliberately ignoring his prescription and taking too much insulin. J took some items from a shop he was passing and completely lacked capacity doing so. J would be found not guilty. There is no offence of basic intent with which he could be charged. Again, this is the same outcome as where the defendant does not have a recognised medical condition but has become voluntarily intoxicated with a dangerous drug.

6.64 J is more culpable than H but ends up with a complete acquittal. This incongruity only arises in cases where the defendant is charged with a specific intent offence for which no alternative basic intent offence is available. The obvious examples are offences under the Theft and Fraud Acts. Although this seems at first sight like a large category of offences, in practice the number of cases in which this incongruity will arise would be very small indeed since it would occur only where there was a total lack of capacity at the time of the offence. The situations in which voluntary intoxication lead to a total loss of capacity to steal or commit fraud are very rare and we have been unable to find any reported cases where this was pleaded.⁴⁸

6.65 We emphasise that this incongruity is not something created by our proposals but is a consequence of the unsatisfactory way in which specific and basic offences are defined in the existing law. We could recommend reform of the intoxication rules to remedy this anomaly, but this lies beyond the scope of the present project.

6.66 A further incongruity could arise where J did not have a *total* loss of a relevant capacity at the time of the alleged offence but simply lacked mens rea. Again, J is more culpable than H but ends up with a complete acquittal in cases where the defendant is charged with a specific intent offence for which no alternative basic intent offence is available. Again, reform to remove such an anomaly is beyond the scope of this project.

⁴⁸ For example, in *Cushion* (23 Oct 2000) (unreported) D pleaded guilty to theft so the issue of mens rea did not arise; other reported cases involving an alleged theft while D was intoxicated were decided before *Majewski* and therefore do not explicitly address the specific/basic intent distinction (see, eg, *Kindon* (1957) 41 Cr App R 208, *Ruse v Read* [1949] 1 KB 377).

Voluntary intoxication by a dangerous drug leading to a basic intent offence

6.67 Where the defendant is charged with an offence of basic intent, and because of his or her intoxicated state the defendant did not form the requisite mens rea, the current position is that where the defendant's lack of mens rea is due to his taking a dangerous drug (meaning one commonly known to create states of unpredictability or aggression), the defendant is treated as having been aware of any risk or circumstance of which he or she would have been aware if sober.

(1) K voluntarily consumes alcohol and LSD and suffers a loss of capacity or merely a lack of mens rea. He strangles his girlfriend believing she is a snake attacking him. He is not guilty of murder (a specific intent offence) because he lacks mens rea.

(2) L voluntarily takes alcohol and LSD and suffers a loss of capacity or merely a lack of mens rea. He strangles his girlfriend believing she is a snake attacking him. He is guilty of manslaughter even though at the time of the offence he lacked mens rea. L's prior fault inculcates him for that basic intent offence.

6.68 This is a clear application of the policy in relation to prior fault: where the defendant has voluntarily induced a state of intoxication, he or she should be held responsible for basic intent crimes committed while in that state and should not benefit, in terms of what the prosecution must prove against him or her, by reason of that state.⁴⁹ Our proposals will not alter that position.

6.69 Similarly, where the defendant has become an automaton as a result of taking, without reasonable cause, a substance commonly known to create states of unpredictability or aggression the defendant will not have an excuse to a basic intent offence. Our proposals will not alter this position.

6.70 The principle under discussion is clear from *Quick*.⁵⁰ In that case, the defendant had failed to manage his diabetes properly, had taken insulin, and suffered a hypoglycaemic episode during which he assaulted someone. Lord Justice Lawton commented that:

A self-induced incapacity will not excuse [in relation to a basic intent offence] ... nor will one which could reasonably have been foreseen as a result of either doing something, or omitting to do something, as for example taking alcohol against medical advice after taking certain prescribed drugs, or failing to have regular meals while taking insulin.⁵¹

⁴⁹ See C [2013] EWCA Crim 223 at [19]: "[In cases of voluntary intoxication with alcohol or illegal drugs] no further enquiry is needed into whether the consequences ought to have been foreseen. All of this is thus entirely consistent with the voluntary intoxication rule to which we have referred. Drugs or alcohol are an external factor. When voluntarily taken their acute effects are not treated by the law as a disease of the mind for the purposes of the M'Naghten rules. Such a case is governed by the law of voluntary intoxication".

⁵⁰ [1973] QB 910.

⁵¹ *Quick* [1973] QB 910, 922. See also C [2013] EWCA Crim 223 at [19].

- 6.71 This does not create any inconsistency with our recognised medical condition defence (nor with our reformed automatism defence).

Voluntary intoxication by a non-dangerous drug leading to a basic intent offence

- 6.72 So far we have considered the position where the defendant has taken substances commonly known to create states of unpredictability or aggression. The prior fault principles apply equally to cases where the defendant has taken substances that are not commonly known to create such states but this defendant is subjectively aware of that risk. We have explained the principle at 6.27 above.
- 6.73 Our proposals have no effect on this category of cases. The defendant will only be acquitted of the offence if he or she had no prior fault and lacked mens rea for the offence at the time.
- 6.74 Under the present law and under our proposals, a person who acts with prior fault will be convicted of a basic intent offence. In the case of a diabetic, the impact of this present rule and of our proposal is as follows:

- (1) G is an insulin dependent diabetic. He was aware of the risks of losing capacity unless he eats promptly after injecting insulin. He injects insulin and then fails to eat properly without reasonable cause. G loses capacity and in that state commits an assault. He will be convicted.
- (2) C is an insulin dependent diabetic. He was aware of the risks of losing capacity unless he eats promptly after injecting insulin. He injects insulin and eats properly, but because of some unforeseen reaction he suffers a total loss of capacity. There is no prior fault in inducing his lack of capacity. C will be entitled to a verdict of not criminally responsible by reason of medical condition.⁵²

Prior fault in causing a loss of capacity despite having a recognised medical condition

- 6.75 The discussion so far in this chapter has centred on the defendants who have committed alleged crimes while in intoxicated states caused either involuntarily or voluntarily. Our policy has been to make no change to the intoxication rules unless the proposal creates incoherence. We have sought to respect the prior fault principles which underpin the intoxication rules.
- 6.76 We have considered above the position of the individual who suffers from a recognised medical condition and who has, by his culpable conduct in *not* taking prescribed or authorised medicines at the appropriate time and/or in the appropriate dose, rendered him or herself completely lacking in a relevant capacity. Under the present law such a person would be treated as insane and liable to a not guilty by reason of insanity verdict. This seems to be out of step with the outcome in other cases in which the defendant has been at fault in bringing about his loss of capacity (whether he or she suffered from a medical condition or not).

⁵² See paras 6.46 to 6.47 above.

- (1) L suffers from no medical condition. He takes heroin and suffers a total loss of a relevant capacity. His prior fault in inducing that lack of capacity justifies his being held liable for all basic intent offences provided he would have had the relevant fault element for that offence if sober. (He would not be guilty of a specific intent offence: see K.)
- (2) G suffers from a recognised medical condition. He knowingly overdoses on his medication without any reasonable cause. He is aware of the likely consequences of doing so. He suffers a total loss of a relevant capacity. His prior fault in inducing that lack of capacity justifies his being held liable for all basic intent offences provided he would have had the relevant fault element for that offence if sober. (He would not be guilty of a specific intent offence: see J.)
- (3) N suffers from a medical condition. He is aware that he is due to take his medication and aware that a failure to do so is likely to result in his becoming aggressive or unpredictable. He knowingly fails to take his medication without any reasonable cause. He commits an offence while in a state where he suffers a total loss of a relevant capacity. At present he would be treated as insane and given a qualified acquittal.

6.77 N has a recognised medical condition and has a total loss of capacity but that total loss of capacity is caused by his own culpable fault. The only significant difference between N and L (who has unreasonably ingested a substance when he was aware, or ought to have been aware, of the likely consequences) is that N failed to do something he ought to have done and L did something he ought not to have done. We believe that the culpability is the same in this context and therefore the outcome should be the same. We therefore propose that the defence of recognised medical condition should not be available to any person who has culpably caused his complete loss of a relevant capacity, regardless of whether this is by ingesting a substance or failing to ingest a substance. Where such an individual is charged with a specific intent offence, to be coherent with the rules on intoxication he ought to be acquitted. Where in those circumstances he is charged with a basic intent offence he should be convicted. Thus under our proposals:

- (1) K does not suffer from a medical condition. He knowingly takes a dangerous drug and is aware of the likely consequences of doing so. He loses capacity. He would be acquitted of a specific intent offence, but convicted of a basic intent offence (as in L) on the basis of prior fault.
- (2) G suffers from a medical condition. He knowingly overdoses on his medication and is aware of the likely consequences of doing so. He loses capacity. He would be acquitted of a specific intent offence (as in J), but convicted of a basic intent offence on the basis of prior fault.
- (3) P suffers from a medical condition. He is aware that he is due to take his medication and aware that a failure to do so is likely to result in his becoming aggressive or unpredictable. He knowingly fails to take his medication without a reasonable cause and loses capacity. He would be acquitted of a specific intent offence (P), but convicted of a basic intent offence (as in N) on the basis of prior fault.

- 6.78 These outcomes are now consistent in two respects. First, the defendant's criminal liability depends on his or her culpability in inducing the incapacitated state, not on whether or not he or she had an underlying medical condition. This is the correct outcome because, in example 2, J's medical condition is not the cause of the intoxication. The fact that the defendant's drug of choice happens to be one prescribed to him or her for the treatment of a medical condition does not alter the fact that the defendant is at fault if he or she deliberately overdoses on that medication. Thus the outcome for example 1 in paragraph 6.77 ought to be the same as for example 2.
- 6.79 Secondly, the defendant is equally at fault in all three examples. The defendant's liability should not, therefore, depend on whether he or she ingested (as in examples 1 and 2 in paragraph 6.77) or failed to ingest (as in example 3 in paragraph 6.77) a substance. As discussed above at paragraph 5.38, this distinction, based on whether the cause of the incapacity is internal or external, is illogical and creates unjustifiable inconsistency. The defendants in all three examples ought to be treated alike, and that is the effect of our proposals.

No prior fault in causing a loss of capacity while having a recognised medical condition

- 6.80 For some people, the medical condition itself can lead to taking too much medication, or to the failure to take prescribed medication or to take it correctly. This may occur where, for example, a person suffering from schizophrenia lacks insight into his or her condition and consequently does not take the prescribed drugs.⁵³
- (1) Q suffers from a medical condition but a feature of the condition is that he does not accept that he has it. He has been prescribed medication which would control the symptoms, but he does not take it because of the lack of insight. Q is charged with wounding with intent contrary to section 18 of the OAPA and, in the alternative, with the basic intent offence of malicious wounding contrary to section 20 of the OAPA. Q could plead that he was not criminally responsible by reason of recognised medical condition in relation to both charges even though his own failure to take the medication precipitated his aggressive actions.
 - (2) R has recently been diagnosed with Alzheimer's. It affects her memory and cognitive abilities. She therefore fails to take the right dose of prescribed medication at the right times and her forgetfulness increases. She is charged with theft from a shop. She can plead the recognised medical condition defence.

In these examples, Q and R are not culpable and therefore, we would argue, should not stand to be convicted. The explanation for their behaviour lies in their medical condition, and the new special verdict would reflect that. The difference between Q and R as compared with G and P above is that Q and R are not culpable in inducing the loss of capacity whereas G and P are.

⁵³ We are grateful to Professor Ronnie Mackay for this point.

CONCURRENT AND SUCCESSIVE CAUSES OF LOSS OF CAPACITY

The current law

- 6.81 Different factors which cause a defendant to lack capacity may occur in succession or at the same time, but the law is unclear on how the rules should be applied to these sorts of complex scenarios. The rules seem to be as follows.⁵⁴
- 6.82 Successive causes:
- (1) Intoxication causes automatism (for example the defendant gets drunk, falls and is concussed before doing the allegedly criminal act): the Court of Appeal suggested in a non-binding part of the judgment in *Stripp*⁵⁵ that the defendant should be acquitted on the basis of automatism. It could also be argued that the intoxication is too remote from the final act.
 - (2) Automatism causes intoxication (for example the defendant is concussed and drinks vodka thinking it is water, then does the allegedly criminal act while intoxicated): the intoxication is involuntary, so if it prevented the defendant from forming the necessary mens rea then the defendant must be acquitted of basic and specific intent offences.
 - (3) Intoxication causes insanity (for example the defendant commits an allegedly criminal act while suffering from delirium tremens as a result of excessive drinking): as discussed above, the defendant has a disease of the mind and is therefore entitled to plead insanity in the same way as if it were a result of any other cause.⁵⁶
 - (4) Insanity causes intoxication (for example the defendant gets drunk because of a deluded belief caused by mental illness⁵⁷ and then commits an allegedly criminal act): if the defendant does not know the nature or quality of the act of becoming intoxicated then it is involuntary and, if it prevents the defendant from forming mens rea, he or she is entitled to be acquitted.⁵⁸
 - (5) Insanity causes automatism (for example the defendant bangs his head against a wall because of a deluded belief caused by mental illness, causing him to do an allegedly criminal act while concussed): the automatism appears to have been due to an internal cause (the defendant's underlying mental condition) and thus would amount to a plea of insane automatism.

⁵⁴ The examples given are adapted from those in *Smith and Hogan's Criminal Law* pp 327 to 330.

⁵⁵ (1979) 69 Cr App R 318, 323.

⁵⁶ *DPP v Beard* [1920] AC 479, 500 to 501, recently affirmed in C [2013] EWCA Crim 223 at [15].

⁵⁷ As in, eg, *Steel* (2012) British Court of Columbia Supreme Court 1821 where the accused drank 26 ounces of alcohol per day for two weeks, believing that the devil expected this of him.

⁵⁸ Note, however, that "insanity" strictly has no application here since it only applies in relation to a particular criminal act, and the act of getting drunk is not criminal.

- (6) Automatism causes insanity (for example the defendant's head injury leads to complications causing mental illness, and the defendant goes on to commit an allegedly criminal act): the immediate cause of the criminal act (the mental illness) is an internal factor and thus the defendant would be entitled to a plea of insane automatism.

6.83 Concurrent causes:

- (1) Intoxication and automatism (for example the defendant gets so drunk he commits an allegedly criminal act in an automatic state): this will depend on whether the intoxication was involuntary (the defendant has a defence to all crimes, including those with strict liability) or voluntary (the defendant has a defence to crimes of specific intent but not basic intent).⁵⁹
- (2) Intoxication and insanity (for example the defendant commits an allegedly criminal act while he both has a disease of the mind and is drunk): it seems that the magistrates or jury must make a decision as to which is the primary or predominant cause⁶⁰ and accordingly find the defendant either not guilty by reason of insanity, or guilty (unless the crime is one requiring specific intent). (Note, however, that doubt is cast on this approach by *Burns*⁶¹ in which the court held that the defendant was entitled to a complete acquittal if it could be shown that he did not know what he was doing, despite the fact that neither of the possible causes (insanity or voluntary intoxication) would entitle to an absolute acquittal. The decision can be explained only on the basis that it was an application of the principle, subsequently established in *Hardie*,⁶² that the defendant was not "reckless" in taking the "non-dangerous" medication with alcohol and his intoxication was therefore involuntary.)
- (3) Automatism and insanity (for example the defendant commits an allegedly criminal act while suffering from both a disease of the mind and concussion): as above, the court must determine the dominant cause and give the appropriate verdict accordingly.⁶³

Concurrent and successive causes under our proposals

6.84 Under our proposed new rules, situations in which automatism occurs together with a recognised medical condition or with intoxication, either in succession or concurrently, should occur rarely, if at all. This is because the category of automatism will be narrowed to cover only a very small number of situations; the examples given to illustrate the current law at paragraph 6.83(3) above which involve concussion would fall within our proposed recognised medical condition defence. It is difficult to imagine a plausible situation in which automatism could

⁵⁹ *DPP v Majewski* [1977] AC 443; see para 6.4 above.

⁶⁰ This was the approach taken in *Roach* [2001] EWCA Crim 2698, [2001] All ER (D) 98, though note that the case involved insanity and sane automatism, not intoxication.

⁶¹ (1973) 58 Cr App R 364.

⁶² [1985] 1 WLR 64.

⁶³ *Roach* [2001] EWCA Crim 2698, [2001] All ER (D) 98.

cause a recognised medical condition or vice versa, since any medical condition which might affect D's perception or understanding of events and thus previously might have founded a plea of automatism will now fall within the recognised medical condition category.

- 6.85 One example might be where the defendant, who is driving, lashes out reflexively having been stung by a wasp, or who jerks his hand on the steering wheel having been struck by a stone chip thrown up by a passing car which causes him or her to swerve and crash the car. The defendant sustains head injuries and then, as a result, assaults the paramedic who arrives on the scene. Here, the immediate cause of the criminal act would be the medical condition of post-concussion syndrome;⁶⁴ the automatism is too remote to be a significant cause. Under the present law, the cause is internal and the defendant would be entitled to the special verdict.
- 6.86 We think, however, that considering the events in this example as a succession of causes is unhelpful since it is obvious that the medical condition is not only the most proximate but also the most significant cause.
- 6.87 We think, therefore, that instead of analysing causes in terms of their remoteness, it makes more sense universally to adopt the approach taken for concurrent causes, that is to ask simply which cause was the most significant or prominent cause of the loss of capacity. We acknowledge that in some cases, discerning the predominant cause will be difficult. Mixed causes are simply a fact of life.
- 6.88 The rules would then apply as follows, whether the causes listed occurred in succession or concurrently:
- (1) Intoxication and automatism (for example the defendant gets so drunk he commits an allegedly criminal act in an automatic state): this will depend on whether the intoxication was involuntary (the defendant has a defence to all crimes) or voluntary (the defendant has a defence to crimes of specific intent but not those of basic intent).⁶⁵ If the defendant has a medical condition related to substance abuse, such as alcoholism, then the court will have to consider whether this was in fact the predominant cause of the defendant's incapacity.
 - (2) Intoxication and a recognised medical condition (for example the defendant commits an allegedly criminal act while he both has a mental illness and is drunk): the court must decide which was the predominant cause and accordingly find the defendant either not criminally responsible by reason of a recognised medical condition, or guilty (unless the crime is one requiring specific intent).
 - (3) Automatism and a recognised medical condition (for example the defendant commits an allegedly criminal act having been stung by a

⁶⁴ If a person who has suffered an injury to the brain, as a result of a blow to the head for example, exhibits specified symptoms consequently, then that may amount to post-concussion syndrome.

⁶⁵ *DPP v Majewski* [1977] AC 443; see para 6.4 above.

wasp and while suffering from a mental illness): as above, the court must determine the predominant cause and give the appropriate verdict accordingly.

- 6.89 It should also be noted that the examples involving intoxication would take account of our proposal to disapply the intoxication rules in specific circumstances (see paragraph 6.51 above). Thus where the defendant was both involuntarily intoxicated due to taking prescribed drugs in accordance with the prescription and had a recognised medical condition, it will not be necessary to consider whether the intoxication was the cause of the defendant's incapacity; the only verdict available would be not criminally responsible by reason of a recognised medical condition.
- 6.90 The table below brings together examples given above. It compares the outcomes for defendants according to whether they have or do not have a recognised medical condition; to whether they have ingested or not ingested a drug and whether it was "dangerous" or "non-dangerous"; whether the defendant showed prior fault; and whether the offence charged is one of specific or basic intent.

	Para in ch 6	RMC?	Ingested?	Fault?	Specific/basic?	Current verdict	New verdict
A	6.40	Not RMC	Dangerous drug	No	Specific	NG	NG
B	6.40	Not RMC	Dangerous drug	No	Basic	NG	NG
C	6.42 6.74	RMC	Dangerous/non-dangerous drug	No	Basic	NG	New special verdict
E	6.42	RMC	Nothing	No	Specific/basic	NGRI	New special verdict
F	6.62	RMC	Dangerous/non-dangerous drug	No	Specific	NG	New special verdict
G	6.62 6.74 6.76 6.77	RMC	Dangerous/non-dangerous drug	Yes	Basic	G	G
H	6.63	RMC	Dangerous/non-dangerous drug	No	Specific	NG	New special verdict
J	6.63	RMC	Dangerous/non-dangerous drug	Yes	Specific	NG	NG
K	6.67 6.77	Not RMC	Dangerous drug	Yes	Specific	NG	NG
L	6.67 6.76	Not RMC	Dangerous drug	Yes	Basic	G	G
N	6.76	RMC	Nothing	Yes	Basic	NGRI	G
P	6.77	RMC	Nothing	Yes	Specific	NGRI	NG
Q	6.80	RMC	Nothing	No	Specific/basic	NGRI	New special verdict
R	6.80	RMC	Nothing	No	Specific	G/NG depending on what is proved	New special verdict

Key: "RMC" in column 2 = recognised medical condition; "NGRI" = special verdict of "not guilty by reason of insanity"; new special verdict in column 7 = the new special verdict of "not criminally responsible by reason of recognised medical condition"; "G" = guilty verdict; and "NG" = not guilty verdict.

CHAPTER 7

PROCEDURAL QUESTIONS

7.1 In this chapter we address the following procedural questions:

- (1) Should the proposed special verdict of not criminally responsible by reason of recognised medical condition be available in the magistrates' courts?
- (2) If the special verdict is to be made available in the magistrates' courts, should the same disposals be available in the magistrates' courts as in the Crown Court?
- (3) Should the law require two expert reports to support a plea of not criminally responsible by reason of recognised medical condition?
- (4) Is it necessary and desirable for the special verdict to be returned by the jury/magistrates even where both prosecution and defence agree that the defendant satisfies the requirements of the proposed defence?

SUMMARY

7.2 We conclude that the new special verdict should be available in magistrates' courts in the same form as we propose for the Crown Court. We also conclude that the same disposals should be available in both courts except that there is no need for a new power to be given to magistrates to make a restriction order. If it seems to magistrates that a restriction order is likely to be necessary, they should be able to commit to the Crown Court for that court to impose a restriction order.

7.3 We conclude that there should continue to be a requirement for evidence from at least two experts in order to raise the defence before the court.

7.4 In some Crown Court cases the prosecution might be willing to accept the defendant's plea that he or she was not criminally responsible and no purpose would be served by putting evidence before a jury. In such a case, we provisionally propose that the court should be permitted to record the special verdict without the need for it to be returned by a jury, provided that:

the defendant is fit to plead and is represented,

the judge is satisfied that no reasonable jury would return a verdict other than not criminally responsible by reason of recognised medical condition, and

the judge records his or her reasons for accepting the plea.

- 7.5 We considered whether cases in which the recognised medical condition defence is raised should be reserved to specific judges.¹ We reject this as undesirable and unworkable.²
- 7.6 Finally, readers who accept that there should be a reformed mental disorder defence but disagree that it should extend as far as any “recognised medical condition” may note that the issues considered in this chapter apply equally to a mental disorder defence. In our view, the answers to these procedural questions are the same whichever defence is adopted.

SHOULD THE SPECIAL VERDICT OF NOT CRIMINALLY RESPONSIBLE BY REASON OF RECOGNISED MEDICAL CONDITION BE AVAILABLE IN THE MAGISTRATES’ COURTS?

- 7.7 We acknowledge that the term “verdict” is not entirely accurate to describe the determination made in a magistrates’ court: it is normally used to describe the finding of a jury. However, for convenience we use it in this chapter to include reference to a determination in magistrates’ courts.
- 7.8 As a matter of common law, the defence of insanity is available in both the magistrates’ courts³ and in the Crown Court, and the test of “insanity” is the same in both courts.⁴ There is, however, a difference in procedure: there is no “special verdict” available in the magistrates’ court.⁵ If the defence of insanity succeeds in the magistrates’ court, the defendant is simply acquitted and if it fails he or she may be convicted.
- 7.9 It follows that, unlike the position in the Crown Court, there are no disposal powers available to a magistrates’ court following such a verdict. If a distinct group of disposals is to be made available in the magistrates’ courts, those disposals ought to follow from a special verdict, as in the Crown Court. (Whether the same disposals should be made available is a distinct issue and is therefore dealt with separately from paragraph 7.19 below.)

¹ In the way that, following the Consolidated Criminal Practice Direction IV.33, cases falling into particular categories may only be tried by judges who have been authorised to try such cases, and as suggested by District Judges if a plea of unfitness to plead were introduced in the magistrates’ courts (see para 1.281 of the analysis of responses to CP 197).

² We note that recent research into magistrates’ courts practice found that policies tend to recommend that cases involving complex points of law, evidence or procedure are listed before District Judges (rather than lay magistrates), but that in fact there was no consistent approach to listing policies and practice across the 44 magistrates’ courts observed: Ministry of Justice, *Research Series 9/11* (Nov 2011).

³ The availability of the insanity defence in the magistrates’ court was established relatively recently: *R v Horseferry Road Magistrates’ Court, ex p K* [1996] 2 Cr App Rep 574 where the defence of insanity extended to offences heard in the summary jurisdiction.

⁴ Subject to *DPP v Harper* [1997] 1 WLR 1406 being wrongly decided, as we argue at para 1.55 above. (That decision is that the insanity defence may only be pleaded in the magistrates’ courts where the offence contains a mental element.) TV Edwards commented, in response to the Scoping Paper, that “In our experience when lecturing solicitors on representing mentally disordered offenders in the magistrates’ court and Crown Court, the majority of them do not know that insanity can be pleaded in the magistrates’ court”.

⁵ See para 1.54 above.

- 7.10 Previous reform bodies have concluded that the same verdict should be available in the Crown Court and the magistrates' courts. In 1975, the Butler Committee recommended that both the magistrates' courts and the Crown Court should be permitted to return the special verdict and that it is appropriate for both jurisdictions to have the same disposals.⁶ The Law Commission's report on the codification of criminal law in 1985 recommended that the procedure should be brought into line in both jurisdictions.⁷ The draft Criminal Code in 1989 also provided that the mental disorder verdict should be available in summary trials.⁸ Similarly, as a result of recent reforms to Scottish criminal law, the special defence will become available in both trials on indictment and in summary proceedings.⁹

Expert evidence on mental health in the magistrates' courts

- 7.11 Although the proposed defence of recognised medical condition is not limited to mental conditions, we anticipate that mental illness or learning disability will be the basis for raising the defence in some cases. Some have queried whether there is the necessary experience or expertise in mental disorder in magistrates' courts to justify having the same procedure. Arguably, it would be more efficient and appropriate to commit to the Crown Court for trial all those cases in which the defence is pleaded.¹⁰

Seriousness of offences

- 7.12 The non-availability of the special verdict in the magistrates' courts might be said to be justified because less serious cases are heard in the magistrates' courts. In such cases it will be more appropriate for the defendant to be diverted to the relevant mental health services if necessary.
- 7.13 This argument does not withstand scrutiny. While historically it may have been true that summary courts only dealt with less serious offences, currently they deal with a large range of offences that are serious. This is particularly true of the youth courts as they have jurisdiction to try offences that are more serious than those tried in the magistrates' courts.¹¹ The offences tried in the magistrates' courts might commonly be regarded as serious for the victims. Consider the offence of harassment: "stalking" can be an extremely serious offence in terms of

⁶ The Butler report, para 18.19. See Appx D to the Supplementary Material to the Scoping Paper, para D.25.

⁷ Law Com 143, para 11.12.

⁸ Law Com 177, para 11.12. See Appx D to the Supplementary Material to the Scoping Paper, para D.64.

⁹ Section 53E(3) of the Criminal Procedure (Scotland) Act 1995, as inserted by s 169 of the Criminal Justice and Licensing (Scotland) Act 2010.

¹⁰ While the insanity defence is available in the magistrates' court, if it appears that the defence is going to be raised on a charge of an offence that is triable either way, this may be a reason to commit the case to the Crown Court. In their response to CP 197, HM Circuit Judges wrote that consideration should be given to "providing that if a case raises an issue of unfitness to plead, it should be committed to the Crown Court for determination" because a hospital order is a serious deprivation of liberty.

its effect on the victim, but some stalking offences can only be tried in the magistrates' courts.¹²

- 7.14 In addition, the argument that a person who has committed a less serious offence poses a risk of less serious harm is highly speculative.
- 7.15 There is no reason to think that the defence is only relevant in serious cases, though it may be more significant in such cases. In recent years the insanity defence has been raised successfully where the offence is not necessarily one viewed as being very serious.¹³

Other available disposals

- 7.16 Another argument against the need for a special verdict in the magistrates' court is that magistrates' courts already have sufficient powers to deal with mentally disordered defendants.¹⁴ Magistrates have the power to make a hospital order under section 37(3) of the 1983 Act without convicting the accused (but where he or she is found to have done the act or made the omission charged). We are not persuaded by this argument. As we consider below,¹⁵ this still leaves a gap in the magistrates' powers of disposal where the defendant does not need hospitalisation, and some respondents to CP 197 thought that magistrates' powers to deal with mentally disordered defendants are not at all adequate. For example, HM Circuit Judges wrote:

The result [of the available procedures under s 37 of the 1983 Act] is that there are likely to be defendants who should not be standing trial but without a trial would be unlikely to be offered any assistance. This approach is inappropriate.

Conclusion

- 7.17 There does not seem to be any compelling logical reason why a special verdict should not be available in the magistrates' courts. Further, we suggest that a special verdict needs to be available in the summary jurisdiction, to act as a route through which a specific set of disposals can be made available to the court following a verdict of not criminally responsible by reason of recognised medical

¹¹ Defendants aged under 18 should be tried in a youth court except in limited circumstances – usually where the offence is considered very serious – where he or she may or must be sent to the Crown Court for trial. These exceptions are currently set out in Magistrates' Courts Act 1980, s 24: see *Blackstone's* para D24.7

¹² Contrary to s 2 or 2A of the Protection from Harassment Act 1997.

¹³ Drawing on the research on cases from 1975 to 1989, Mackay concluded that: "more often than not [the insanity defence] is used in cases of offences against the person, usually, but by no means always, of a serious nature": Mackay (1995) p 105. See para 3.43 of the Supplementary Material to the Scoping Paper.

¹⁴ This may go to explain the underuse of the insanity defence in magistrates' courts. There are no data available on how often the insanity defence is pleaded (successfully or otherwise) in the magistrates' courts, but discussions with criminal practitioners, district judges and psychiatrists, and responses to the Scoping Paper indicate that it is rare for the insanity defence to be raised.

¹⁵ See paras 7.29 and following below.

condition. **We therefore conclude that the special verdict should be available in magistrates' courts following a successful plea of the new defence of not criminally responsible by reason of recognised medical condition.**

IF THE SPECIAL VERDICT IS TO BE MADE AVAILABLE IN THE MAGISTRATES' COURTS, SHOULD THE SAME DISPOSALS BE AVAILABLE IN THE MAGISTRATES' COURTS AS IN THE CROWN COURT?

- 7.18 Currently, different disposals are available to the Crown Court from those available in the magistrates' courts. In the Crown Court, following a special verdict, the judge can make a hospital order (with or without a restriction order), a supervision order or an absolute discharge.¹⁶ If the insanity defence succeeds in the magistrates' court, however, what follows is a simple acquittal. In these circumstances, magistrates have no power to deal with an acquitted person. However, magistrates are able to make a hospital order under section 37(3) of the 1983 Act¹⁷ having found that the accused did the act or made the omission charged, but without making a determination of guilt.
- 7.19 There are several issues that need to be addressed relating to the discrepancy in the disposals.

Hospital orders with restriction order

Magistrates' current powers in relation to restriction orders

- 7.20 The magistrates' court can make a hospital order under section 37 but it cannot impose a restriction on the order. However, the magistrates' court may commit a convicted offender to the Crown Court for sentence (for a restriction order to be considered) in specified circumstances. Those circumstances are: where the defendant is 14 or older, has been convicted of an imprisonable offence, the court is satisfied that the conditions exist to make a hospital order, and it feels that a restriction order should also be made.¹⁸
- 7.21 This power is only available where the defendant has been *convicted* of an offence.¹⁹ If a defendant has been acquitted in the magistrates' court and the magistrates seek to make a hospital order under section 37(3), they do not have the power to attach a restriction nor to commit the person to the Crown Court for a restriction order to be considered. This is so even where the person is acquitted

¹⁶ Section 5 of the 1964 Act.

¹⁷ It is probable, though not certain, that a hospital order may be made after an acquittal. There are some grounds for thinking this point is not settled: compare *R v Horseferry Road Magistrates' Court, ex p K* [1997] QB 23 with *R v Kesteven Justices, ex p O'Connor* [1983] 1 All ER 901, 904 and see the commentary on *ex p K* at [1996] 3 *Archbold News* 1 and 3. It is less clear whether an acquittal may follow a hospital order. See *R (Singh) v Stratford Magistrates' Court* [2007] EWHC 1582 (Admin), 1 WLR 3119 at [37], by Hughes LJ.

¹⁸ Section 43 of the 1983 Act. If the magistrates do commit a defendant to the Crown Court for sentence under this provision, then they may direct him or her to be detained in hospital until the Crown Court deals with the case, instead of remanding the defendant into custody: s 44.

¹⁹ *R v Horseferry Road Magistrates' Court, ex p K* [1997] QB 23, 45.

by reason of insanity. Mr Justice Forbes has described this as an “obvious legislative lacuna”.²⁰

- 7.22 If a special verdict is introduced in the magistrates’ court, it would be possible to introduce a power for the magistrates to commit cases to the Crown Court for a restriction order to be attached where the person was found not criminally responsible by reason of recognised medical condition. This would reflect the magistrates’ committal power following the imposition of a hospital order after a conviction.

Magistrates’ powers if the special verdict were available

- 7.23 A more difficult question then follows: if the special verdict were to be available in the magistrates’ court, should magistrates be permitted to make a hospital order with a restriction order without committing the case to the Crown Court?
- 7.24 A hospital order with a restriction can be a more significant infringement on a person’s liberty than a short custodial sentence. It was said in *Birch* that “a patient subject to a restriction order is likely to be detained for much longer in hospital than one who is not, and will have fewer opportunities for leave of absence”.²¹ Given that a magistrates’ court cannot currently impose a custodial sentence longer than six months in respect of any one offence, it would be inconsistent to empower magistrates to make an order for detention for an indefinite period (namely, a hospital order with a restriction).
- 7.25 Another argument against extending the power to make restriction orders to magistrates’ courts is that magistrates deal with less serious offences. However, the seriousness of the offence is only one factor in deciding whether a restriction order should be made.²²
- 7.26 It would also be inconsistent to give magistrates the power to make a restriction order following a special verdict if they did not also have the power to make a restriction order following conviction. Suggesting that magistrates should have the power to make a restriction order under any circumstances would be extending the powers currently given to magistrates’ courts and would be beyond the scope of the present project.

Conclusion

- 7.27 **Proposal 15: We provisionally propose that magistrates’ courts should have the power to commit a person to the Crown Court for a restriction order following the special verdict.**

²⁰ *R v Horseferry Road Magistrates’ Court, ex p K* [1997] QB 23, 45.

²¹ (1989) 11 Cr App R (S) 202, 211. See also S P Sakar, “The addition of any type of restriction order means that [mentally disordered offenders] are likely to be detained longer in secure treatment than they would have spent in custody for the same offence”: “Mental Health Law and the Mentally Disordered Offender” in A Bartlett and G McGauley (eds) *Forensic Mental Health* (2010) p 269. For the differences between restricted and unrestricted hospital orders, see para A.51 in Appx A.

²² See para A.52 in Appx A to the Supplementary Material to the Scoping Paper.

- 7.28 **Conclusion 7: We conclude that it would not be appropriate to create a new power for magistrates to attach a restriction order to a hospital order.**

Supervision orders

The current (lack of) powers in the magistrates' court

- 7.29 Following a successful plea of insanity at the magistrates' court, there is currently no power to make a supervision order. Where appropriate, a hospital order can be made under section 37(3), but there is no power to make a supervision order for a person acquitted following a plea of insanity for whom a hospital order is inappropriate. Moreover, there is no other available disposal for a person who successfully pleads insanity.
- 7.30 Magistrates' courts currently have a wide range of sentencing options available following a conviction, including a guardianship order under section 37(2) of the 1983 Act or a community sentence with a mental health treatment requirement under section 177(1) of the Criminal Justice Act 2003.²³ It is illogical that at present the law provides a more appropriate disposal in the magistrates' courts to a mentally disordered offender following a conviction than following an acquittal as a result of a successful plea of the insanity defence.
- 7.31 As we have noted elsewhere in this paper, there is little information available on the use of the insanity defence in the summary jurisdiction. However, we have reason to believe that this gap in magistrates' powers can cause real problems in practice. We have been informed of one case in a magistrates' court in which the insanity defence was raised. The defendant was charged under section 2 of the Protection from Harassment Act 1997. Although the prosecution accepted that the defendant was "insane" at the time of the offence, the prosecution disputed the availability of the insanity defence to the charge. The court ruled that the defence of insanity was available and the prosecution offered no evidence. The defendant was acquitted, but the court considered it appropriate to make a restraining order following the acquittal.²⁴
- 7.32 In these circumstances, we think that a supervision order may have been a more appropriate disposal if it had been available because support to help the individual to adhere to the order would be available. A restraining order is not to be used "as if it were an adjunct to the Mental Health Act as a means of protecting the public against the possible effects of a possible recurrence of a mental illness".²⁵ From AR,²⁶ it is clear that a restraining order will not always be

²³ In the case of an offender under 18 years of age, the youth court has available a wide range of non-custodial sentencing options including youth rehabilitation orders (Criminal Justice and Immigration Act 2008, s 1).

²⁴ This is permitted under s 5A of the 1997 Act, inserted by s 12(5) of the 2004 Act, which was brought into force on 30 Sept 2009. The Court of Appeal considered the correct construction of s 5A in *Smith (Mark John)* [2012] EWCA Crim 2566, [2013] Criminal Law Review 250 and in AR [2013] EWCA Crim 591. In the former case the court said, at [27] and [28] that an order made under s 5A must identify the person or group of persons whom the order is intended to protect. In both cases the court held that, in order to make such an order, the court must be satisfied that the individual was likely to pursue a course of conduct amounting to harassment within s 1 of the 1997 Act.

²⁵ *Smith (Mark John)* [2012] EWCA Crim 2566, [2013] Criminal Law Review 250 at [34] by Toulson LJ.

appropriate to protect specified people against the risk of such a recurrence either.

- 7.33 There is currently no unfitness to plead procedure in the magistrates' courts to reflect the procedure that is available in the Crown Court.²⁷ Therefore, there is a similar gap in the magistrates' powers of disposal for persons who are not fit to plead but are found to have done the act alleged in the charge. Magistrates are only able to deal with such people by way of a hospital order under section 37(3) of the 1983 Act on conviction. This gap in disposal was raised by the Council of HM Circuit Judges, in their response to CP 197.²⁸
- 7.34 We think it would be sensible to make supervision orders available in the summary jurisdiction following a special verdict.

Provisional proposal

- 7.35 **Proposal 16: We provisionally propose that, following a special verdict of not criminally responsible by reason of recognised medical condition in the summary jurisdiction, the magistrates should have the power to make a hospital order, a supervision order or an absolute discharge and, if the accused is under 18, a non-penal Youth Supervision Order. In addition, we propose that where magistrates make a hospital order they should also have the power to commit the defendant to the Crown Court for that court to consider making a restriction order.**

SHOULD THE LAW REQUIRE TWO EXPERT REPORTS TO SUPPORT A PLEA OF NOT CRIMINALLY RESPONSIBLE BY REASON OF RECOGNISED MEDICAL CONDITION?

- 7.36 Currently, the special verdict can only be returned on the written or oral evidence of two or more "registered medical practitioners" at least one of whom is duly approved.²⁹ "Duly approved" means "approved for the purposes of section 12 of the 1983 Act by the Secretary of State as having special experience in the

²⁶ [2013] EWCA Crim 591.

²⁷ This is discussed in CP 197, Part 8.

²⁸ "At present save for the procedure under s 37(3) Mental Health Act 1983 there is no provision which attempts to consider the issue of unfitness to plead. Further, that provision builds upon the disposal of the case being by a Hospital Order under s 37(1). There are, however, many cases which do not require such an order but may be properly dealt with by a Community Order with an appropriate requirement. At present this would only be possible if there had been a conviction whether by plea or by trial. The result is that there are likely to be defendants who should not be standing trial but without a trial would be unlikely to be offered any assistance. This approach is inappropriate".

²⁹ Section 1(1) of the 1991 Act. The available empirical evidence on psychiatric reports in cases of insanity suggests that sometimes more than two reports are used: R D Mackay, B J Mitchell and L Howe, "Yet More Facts About the Insanity Defence" [2006] *Criminal Law Review* 399, 405.

diagnosis or treatment of mental disorder”.³⁰ In practice, they are usually psychiatrists.

- 7.37 We have provisionally proposed that the special verdict of not criminally responsible by recognised medical condition may only be returned where the court has received relevant evidence of the defendant’s medical condition from at least two experts (see paragraph 4.165 above).
- 7.38 As the new recognised medical condition defence can be raised on the basis of a physical disorder, a psychiatrist (or any section 12 approved medical practitioner) may not always be the appropriate expert, as we discuss in chapter 4 above. The requirement for one of the registered medical practitioners to be approved for the purposes of section 12 would therefore have to be changed in respect of the defence. However, psychiatrists would still have the relevant expertise in some cases where the new defence is raised on the basis of mental disorder existing at the time of the offence, and if a psychiatrist is the relevant expert, then he or she should still be subject to the requirement of section 12.
- 7.39 The 1991 Act introduced the requirement for medical evidence in order to “ensure greater congruence between the evidence necessary for a person to be found not guilty by reason of insanity and that necessary for long term detention under the Mental Health Act 1983 on grounds of mental disorder”.³¹ Historically, the requirement of two medical opinions acted as a safeguard against possible long periods of detention.³² However, the 1991 Act has since disconnected the verdict of not guilty by reason of insanity from the subsequent disposal by extending the range of possible disposals, so it could be argued that it is no longer necessary to have evidence from two medical practitioners to establish the defence.
- 7.40 The proposed new defence separates even more clearly the question of verdict and disposal. What is being considered here is whether one expert report is sufficient for the purposes of establishing whether the defence is available. We do not propose to consider reducing the requirement for two expert reports for the purposes of a hospital order – this requirement is clearly necessary to ensure compliance with article 5 of the ECHR.³³
- 7.41 It would be possible to retain the input of two experts in relation to disposal, whilst reducing the requirement to one expert in relation to the defence. This could be achieved by requiring only one expert report on the issue of the defendant’s condition at the time of the offence, and, if there is a verdict of not criminally responsible by reason of recognised medical condition and the court considers

³⁰ Section 6 of the 1991 Act. A “registered medical practitioner” is defined as a “fully registered person within the meaning of the Medical Act 1983 who holds a licence to practise”.

³¹ P Fennell, “The Criminal Procedure (Insanity and Unfitness to Plead) Act 1991” [1992] *Modern Law Review* 547, 548.

³² In relation to unfitness to plead, the Court of Appeal has observed that “it is perfectly understandable that Parliament should have required that a finding that a defendant is indeed unfit to plead should not be made except on substantial medical evidence, given the potential consequences for the defendant”: *Ghulam* [2009] EWCA Crim 2285, [2010] 1 WLR 891 at [18]. The same consequences follow a special verdict of not guilty by reason of insanity.

³³ See paras 4.146 to 4.147 above.

that a hospital order might be appropriate, then a second expert report could be ordered at that stage. Reducing the requirement to one report could therefore save public money in cases where a hospital order or supervision order is not being considered as a possible disposal.

- 7.42 There is some evidence which indicates that rates of agreement between psychiatrists are high and it could therefore be argued from that one report would be sufficient.³⁴ Against that, we would, however, expect that there would be more disagreement between psychiatrists in cases where the new defence does not succeed.

The reliability of psychiatric evidence

- 7.43 Whether two expert reports are necessary for the defence turns in part on whether one psychiatrist would necessarily be able to give reliable evidence of the accused's mental state at the time of the alleged offence. Rule 33.2 of the Criminal Procedure Rules 2011 provides that the expert owes a duty to the court which overrides any obligation owed to the party that instructed him or her. The expert must assist the court in giving an "objective, unbiased opinion on matters within his [or her] expertise".³⁵ However, "it is acknowledged that psychiatry, because of the subjectivity of much of the data on which psychiatric decisions must be based, is open to bias and influence in the context of the adversarial legal system".³⁶ Some potential sources of bias are indicated in the quote below:

A lawyer may be aware of the opinions expressed by several experts in previous matters and may choose the expert who is most likely to support the client's case. The lawyer selects the documents to be examined and can instruct the expert to limit evidence to specific areas. The expert may feel sympathy for the client and write a report that is helpful, and, in some jurisdictions, an unfavourable report does not have to be presented in court.³⁷

- 7.44 In an Australian study of psychiatric and psychological reports made in cases involving serious criminal offences where there were two or more reports, it was found that there was "good" agreement on the diagnosis of common psychiatric

³⁴ Given the nature of the evidence that is requested from experts – namely, an opinion on the mental state of the defendant at the time of the offence – it might be expected that there would frequently be contradictory opinions and it would therefore be dangerous to rely on only one. However, in a survey of psychiatric reports between 1997 and 2001 in cases where the insanity defence succeeded it was found that there were only six reports (in six cases) which said that the defendant was *not* insane at the time of the offence. R D Mackay, B J Mitchell and L Howe, "Yet More Facts About the Insanity Defence" [2006] *Criminal Law Review* 399, 405. The authors said, "Having regard to the fact there were 161 reports in the research sample it seems likely that cases giving rise to this type of disagreement are rare".

³⁵ Criminal Procedure Rules 2011, r 33.2(1).

³⁶ Irish Division of the Royal College of Psychiatrists, "Psychiatry and Court Procedures" (1989) 13 *Psychiatric Bulletin* 207, 208.

³⁷ O Nielssen, G Elliott and M Large, "The Reliability of Evidence About Psychiatric Diagnosis After Serious Crime: Part I: Agreement Between Experts" (2010) 38 *Journal of the American Academy of Psychiatry and the Law* 516.

disorders.³⁸ However, there were lower levels of agreement for certain categories of disorder, namely anxiety disorders and depressive disorders.³⁹

- 7.45 A related study in New South Wales considered the reliability of psychiatric evidence in relation to the defence of not guilty by reason of mental illness (as it is called there).⁴⁰ The study found that there was little evidence to suggest bias in expert opinions relating to this defence and that the agreement between experts on the availability of the defence was “moderate-good”.⁴¹ By contrast, there was only “fair-moderate” agreement in relation to assessments on a defendant’s unfitness to plead and stand trial.⁴² The authors considered this was a result of the way that unfitness is assessed.⁴³
- 7.46 These findings suggest that psychiatrists are able to make a reliable assessment of a defendant’s mental state. However, as the studies were conducted in a different jurisdiction with a different defence, their value may be limited for our purposes.

Arguments for requiring two expert reports to support the defence

- 7.47 We think that there remain compelling reasons for requiring two expert reports.
- 7.48 The expert is being asked to provide an opinion based on a retrospective assessment of whether the defendant had a recognised medical condition so that he or she lacked one or more of the relevant capacities. Some diagnoses are more problematic than others, as was found in the studies mentioned above. But it would not be workable to require different numbers of reports for different medical conditions.
- 7.49 An additional important reason is that it would be inappropriate to require only one report given the adversarial nature of criminal proceedings. Adrian Waterman QC has made the following observation:

The criminal – and for that matter the civil – trial process is adversarial. Dr Rix correctly points out that the court can direct that only one expert gives evidence on behalf of a number of accused persons. This is an example of financial expediency. The Rules are not always founded on principle. However, it is noteworthy that there is no provision in the Criminal Procedure Rules for the court to order that only one expert should be instructed on behalf of an accused and the prosecution. This would undermine the fundamentally adversarial nature of criminal proceedings, and it would put too much emphasis

³⁸ O Nielssen, G Elliott and M Large, “The Reliability of Evidence About Psychiatric Diagnosis After Serious Crime: Part I: Agreement Between Experts” (2010) 38 *Journal of the American Academy of Psychiatry and the Law* 516, 520.

³⁹ O Nielssen, G Elliott and M Large, as n 39.

⁴⁰ O Nielssen, G Elliott and M Large, “Reliability of Psychiatric Evidence in Serious Criminal Matters: Fitness to Stand Trial and the Defence of Mental Illness” [2009] 43 *Australian and New Zealand Journal of Psychiatry* 449.

⁴¹ O Nielssen, G Elliott and M Large, as n 41.

⁴² O Nielssen, G Elliott and M Large, as n 41.

⁴³ O Nielssen, G Elliott and M Large, as n 41.

on the opinion of a single expert. It would, in other words, run the risk of trial by expert. Although, as referred to above, experts must know their limitations and not exceed them, their evidence will additionally be subjected to the careful and critical scrutiny of the opposing party and the trial judge. The ultimate responsibility for ensuring the fairness of the trial process rests with the judge.⁴⁴

- 7.50 Finally, while the jury or magistrates will continue to decide on the ultimate issue, the psychiatric reports will provide evidence on issues which are likely to be significant in the case. Even though it is not a conviction, stigma attaches to a successful plea of insanity, and there may be some stigma attaching to the new special verdict. It may be dangerous to have only one expert provide evidence that, from the perspective of the defendant, would be evidence relating to such a significant determination. Similarly from the victim's perspective, it might be felt that the defendant would be absolved of responsibility too readily; especially as, if there is to be only one expert, that expert would probably be instructed by the defence.

Practical concerns

- 7.51 The arguments for reducing the requirement to one expert report are wholly pragmatic and economic. However, lowering the requirement to one expert report would almost certainly put pressure on the parties to rely on only one report in order to avoid extra costs. It is difficult to assess what practical impact such a change in the law would have.
- 7.52 We would expect any potential savings to be modest, especially given that two medical reports would always be required for the purposes of the hospital order. Where the defendant was most evidently suffering from a mental disorder at the time of the offence, he or she would probably require a hospital order, so there would be no savings at all in such cases. A second report would also always be necessary in all cases where there is not a "clear" case that the defence of medical condition is available.

Conclusion

- 7.53 It is clear that a decision by the court that a person should be detained in hospital requires important expert evidence from more than one expert. We have taken the view that the decision that a person is unfit to plead and to stand trial is also an important decision and duly requires the same weight of evidence to support it.⁴⁵ It seems to us that a verdict that a person was not criminally responsible is at least as important as those decisions. There should be substantial medical evidence before a special verdict can be returned. We do not think that the speculative potential savings on costs outweigh the need for substantial medical

⁴⁴ A Waterman, "Be the Expert You Are: Invited Commentary on ... The Psychiatrist as Expert Witness, Parts 1 and 2" (2008) 14 *Advances in Psychiatric Treatment* 119, 121. The reference to Rix is to K J B Rix, "The Psychiatrist as Expert Witness. Part 2: Criminal Cases and the Royal College of Psychiatrists' Guidance" (2008) 14 *Advances in Psychiatric Treatment* 109.

⁴⁵ See para 5.34 of CP 197.

evidence for determining the question of criminal responsibility. **We provisionally conclude that the requirement for two expert reports is necessary to safeguard the interests of the public and the defendant.**

IS IT NECESSARY AND DESIRABLE FOR THE VERDICT TO BE RETURNED BY THE JURY OR MAGISTRATES?

- 7.54 We now turn to an entirely different kind of question, namely whether there must always be a determination of the special verdict by the jury (or magistrates).
- 7.55 In the criminal law generally, the prosecution may accept a plea by the defendant, and a trial is then avoided. This is not the case for a plea of not guilty by reason of insanity: the verdict must be delivered by the jury or, in the magistrates' court, by the magistrates.⁴⁶ An obvious question is whether this is always necessary and desirable.
- 7.56 An alternative would be to provide that the prosecution could accept a plea of the special defence, and the verdict be entered by the court.⁴⁷ The Butler Committee made a recommendation to this effect,⁴⁸ as did the Law Commission in the draft Criminal Code.⁴⁹ The Scottish Law Commission said, in relation to this practice in Scotland, that they "could not identify any policy objective for the rule requiring a verdict of insanity at the time to be returned by a jury where the evidence has been agreed by the defence and the Crown", and none of their consultees suggested one.⁵⁰
- 7.57 We consider arguments for permitting the court to accept a plea to the new defence where the parties are agreed, without evidence being called for determination by the tribunal of fact. It is important to note that where a defendant pleads the defence, he or she is also accepting that he or she did what would have been an offence if not for his or her medical condition at the time of the offence.
- 7.58 We have already queried whether, in practice, the jury has any real deliberative role in many cases.⁵¹ If this is the situation, the argument for reform cuts both ways: on the one hand, there is no point in reform, because no significant change in practice will result; on the other hand, it is better if the law and practice match, and the practice would thereby be sanctioned by Parliament (or disapproved).

⁴⁶ *Maidstone Crown Court, ex p Harrow London Borough Council* [2000] QB 719.

⁴⁷ As with the procedure in Scottish courts set out in s 53E(1) of the Criminal Procedure (Scotland) Act 1995, inserted by s 169 of the Criminal Justice and Licensing (Scotland) Act 2010.

⁴⁸ The Butler report, para 18.50.

⁴⁹ Law Com No 177, cl 37.

⁵⁰ Scot Law Com 195, para 5.42.

⁵¹ The results from empirical studies suggested that, during the period studied, in over half of cases in which the insanity defence succeeded, the jury were directed by the judge to give a verdict of not guilty by reason of insanity: see para 3.54 in Part 3 of the Supplementary Material to the Scoping Paper.

Court time and cost considerations

- 7.59 An obvious benefit of permitting a court to accept a plea would be that the court would be able to deal with the case without empanelling a jury, which would save court time and, consequently, money.⁵²
- 7.60 For example, one judge has described to us a case before him at the Crown Court where the defence of insanity was undisputed between the parties. The case took a day in court and the jury returned the special verdict after a five-minute retirement. The judge suggested that this case could have been disposed of more efficiently if a plea could have been accepted. Another judge has described to us a similar case in which the defendant did not contest he had done the act and the prosecution conceded that the defendant was “insane” at the time of the offence in question:

So the trial was very short. No witnesses were called in person. The prosecution case was adduced by way of admissions; the relevant parts of the two defence psychiatrists’ reports were read; both counsel simply invited the jury to return a verdict of not guilty by reason of insanity; and I directed the jury that while ultimately it had to be their decision, any other verdict would, on the evidence, be perverse. The jury accordingly returned that verdict within a couple of minutes.

In these circumstances, the judge considered that “it was unnecessary and cumbersome to have a jury trial”.⁵³

The interests of justice

- 7.61 An objection to permitting the court to accept a plea without a jury verdict is that it might suit the defendant, and save courts time and money, but it would not satisfy public justice or the victim. It is likely that any mechanism that takes away decision-making from the jury would be thought of as undermining the institution of the jury trial and “there is little doubt that [the jury] is an institution that holds much public confidence”.⁵⁴ This is particularly relevant in relation to the insanity defence as the cases in which it is raised usually involve purposeful violence against a person.⁵⁵

⁵² It is unlikely there would be any savings in relation to the cost of the jury. Presumably, each Crown Court would have to have available a minimum number of jurors to be ready to sit on each trial that is listed for that Crown Court. Jurors do not sit during their whole period of service. Therefore, it would seem that the fact that juries would not be required for one trial would not necessarily reflect any significant savings on jury costs. This is particularly true where the facts are already agreed between the defence and the prosecution as it would be a shorter trial. (Between 2009 and 2010, jurors were sitting on trials for 67% of days during their period of service: *HMCS Annual Report and Accounts 2009-10*, <http://www.justice.gov.uk/downloads/publications/corporate-reports/hmcs/annual-reports/HMCS-Annual-Report2009-2010-web.pdf> (last visited 27 Jan 2012).

⁵³ See also the comments of D Wolchover and A Heaton-Armstrong in *Dumping Newton – Part 3* (2012) 176(25) *Criminal Law and Justice Weekly* 367, 752.

⁵⁴ A Ashworth and M Redmayne, *The Criminal Process* (4th ed 2010) p 325.

⁵⁵ See n 13 above.

7.62 As regards the victim’s perspective, one cannot make a uniform assumption that a complainant will (or will not) be satisfied by acceptance of a plea without the hearing of evidence. In response to CP 197, Victim Support pointed out that:

Very few victims who report crime see their cases come to court; those who do have a range of reactions, from fear of being cross-examined to exhilaration at the chance to take the stand.

7.63 Allowing a court to accept the plea might, however, “avoid the giving of unpleasant evidence that may cause grave distress to the witnesses their relatives, and to the defendant”.⁵⁶ Therefore an accepted plea would not necessarily be against the interests of the victim where a verdict of not criminally responsible by reason of recognised medical condition is the obvious result. The prosecuting authority should communicate with the victim about this aspect of the case.⁵⁷

7.64 On a charge of murder, a defendant may enter a plea of guilty to manslaughter by reason of diminished responsibility and that plea can be accepted by the court without a jury having to return the verdict.⁵⁸ Arguably, a plea of insanity (or of the new defence of recognised medical condition) should be treated no differently. A distinction might be that unlike a plea of diminished responsibility which leads to a manslaughter conviction, a successful plea of the new defence would, as with insanity, not result in conviction. In that sense, there may be public opposition to a mechanism by which a defendant might be perceived to “get off” lightly.

7.65 We therefore believe that the judge should have the power to accept the plea. However, this must be in circumstances in which it would be appropriate for the judge to accept a plea, as is the case with accepting pleas of guilty generally. The Practice Directions provide that certain facts must be stated on a guilty plea:

To enable the press and the public to know the circumstances of an offence of which an accused has been convicted and for which he is to be sentenced, in relation to each offence to which an accused has pleaded guilty the prosecution shall state those facts in open court before sentence is imposed.⁵⁹

7.66 The Practice Directions also set out the procedure to be followed for accepting a guilty plea in the Crown Court. Most importantly, there must be a written basis of plea between the prosecution and defence, which is subject to approval by the court.⁶⁰ We propose that the circumstances for accepting a plea of the new

⁵⁶ The Butler report, para 18.50.

⁵⁷ As the prosecutor would do in relation to decisions to drop a charge: see the Code of Practice for Victims of Crime, para 7.4.

⁵⁸ Cox [1968] 1 WLR 308.

⁵⁹ Criminal Procedure Rules 2011, Part III: Further Practice Directions Applying in the Crown Court and the Magistrates’ Courts, para 26.1.

⁶⁰ Criminal Procedure Rules 2011, Part IV: Further Practice Directions Applying in the Crown Court. See para 45.10 which provides that “the prosecution may reach an agreement with the defendant as to the factual basis on which the defendant will plead guilty, often known as an ‘agreed basis of plea’. It is always subject to the approval of the court, which will consider whether it is fair and in the interests of justice”. See further the procedure regarding agreed bases of plea in paras 45.10 to 45.12.

defence should follow the same procedure. Further, the judge should give a formal reasoned basis for accepting the plea. The judge could choose not to accept the plea on the basis that it would be in the public interest for the case to be tried before a jury.⁶¹

- 7.67 As mentioned above, it is open to the prosecution to accept a plea of guilty to manslaughter by reason of diminished responsibility to a charge of murder.⁶² It has been said that a plea to manslaughter by reason of diminished responsibility should only be accepted on clear evidence of mental imbalance and not on flimsy grounds.⁶³ *Blackstone's* provides some guidance which is worth setting out in full:

In a novel or borderline sort of case, the plea ought not to be accepted but the evidence presented to a jury for their determination. The public interest may demand this in a notorious case such as that of the "Yorkshire Ripper" (*The Times*, 23 May 1981). This was a striking case, in the sense that the prosecution were prepared to accept the plea in the light of unanimous psychiatric reports that the accused, Sutcliffe, was a paranoid schizophrenic, but the judge insisted that there should be a trial before a jury who convicted of murder. The nub of the problem is that, however unanimous the medical witnesses may be about there being an abnormality of mind, the question of whether that abnormality "substantially impaired responsibility"⁶⁴ is ultimately not a medical question but one for the jury. Thus, as a general rule, the prosecution should only accept a plea (and the judge should only approve that acceptance) where there is clear and convincing evidence of diminished responsibility. Of course, there may be exceptional cases where it is desirable to accept a plea on the basis of less convincing evidence because a trial is undesirable for other reasons, eg, the accused is himself seriously and terminally ill.⁶⁵

- 7.68 The same could be said for the acceptance of a plea of not criminally responsible by reason of recognised medical condition. Arguably, a higher threshold for the medical evidence should apply here as the defendant is not convicted if the plea is accepted.

⁶¹ This would seem to depart from the Scottish approach. The statute provides that "where the prosecutor accepts a plea (by the person charged with the commission of an offence) of the special defence ... the court *must* declare that the person is acquitted by reason of the special defence": s 53E(1) of the Criminal Procedure (Scotland) Act 1995, inserted by s 169 of the Criminal Justice and Licensing (Scotland) Act 2010 (emphasis added).

⁶² See para 7.64 above.

⁶³ *Vinagre* (1979) 69 Cr App R 104. In this case, the defendant killed his wife in a frenzied attack because of (allegedly unfounded or at least ill-founded) suspicions that she was having an affair. The medical evidence proffered by the prosecution said that the defendant was suffering from "Othello syndrome" (that is, morbid jealousy for which there was no cause) at the time of the offence. The trial judge accepted the plea of diminished responsibility.

⁶⁴ This was the test under the old law on diminished responsibility, which has been amended by s 52(1) of the Coroners and Justice Act 2009. The amended law is set out at para 4.46 above.

⁶⁵ *Blackstone's* para B1.32.

- 7.69 Those previous reports that have considered whether a plea of insanity ought to be capable of being accepted by the judge have not addressed the test the judge should apply in deciding whether to accept such a plea. The Butler report said that “the plea would naturally be accepted if the prosecution and the court were satisfied that the defendant would *be likely* to receive a special verdict from the jury”.⁶⁶ We think that this would be setting the threshold too low and would be inconsistent with our view that the question of responsibility is ultimately a moral question.
- 7.70 Judges currently guard against false convictions by ensuring that a weak case does not go before the jury.⁶⁷ Therefore, it is arguable that it would not be a significant extension of the current law to permit a judge to accept the plea if no reasonable jury, properly directed, would return a verdict other than not criminally responsible by reason of recognised medical condition.⁶⁸

The determination of the disposal

- 7.71 There is also a problem that where a guilty plea is accepted by the court, it may be difficult for a judge to decide on the most appropriate disposal. In *Birch*,⁶⁹ the Court of Appeal said that where a plea of guilty to manslaughter, on the grounds of diminished responsibility, is accepted by the court, there is no opportunity for the judge to form an impression of the defendant’s dangerousness as the case unfolds. The cases in which we would expect the mechanism to be used are those in which a jury verdict is currently merely a formality. As such, the opportunity to form an impression of the defendant’s dangerousness would not be greatly diminished in those circumstances.
- 7.72 Further, it is questionable whether it is proper for a judge to place much weight on the defendant’s behaviour at trial when deciding on the appropriate disposal. This is particularly important where the judge is considering whether to attach a restriction order to a hospital order in accordance with section 41 of the 1983 Act. Section 41 provides that if

it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section.

⁶⁶ The Butler report, para 18.50 (emphasis added).

⁶⁷ The defence can make a submission of no case to answer following the close of the prosecution case. If accepted by the judge, an acquittal follows.

⁶⁸ This would be similar to the second limb of the test as laid down in *Galbraith* [1981] 1 WLR 1039 which requires a judge to withdraw the trial from the jury “if the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it”: 1042B-D, by Lord Lane CJ.

⁶⁹ (1989) 11 Cr App R (S) 202, 213.

- 7.73 A judge is not bound by a medical recommendation in relation to the imposition of a restriction order,⁷⁰ but a qualitative study conducted on twelve Crown Court judges in England found that restriction orders were rarely made contrary to medical recommendations.⁷¹ All of those interviewed expressed reservations about imposing a restriction order without “sound, reasoned medical evidence”.⁷² Where a restriction order was made contrary to medical opinion, this was because, in the view of the judge, insufficient emphasis had been placed on the issue of public protection by the medical expert. Further, some judges thought a restriction order might be necessary to ensure compliance with medication, especially where non-compliance had previously been associated with serious harm to the public.⁷³
- 7.74 Notably, while some of the judges interviewed considered the severity of the illness to be relevant, “the offender’s presentation during the trial had little to no bearing on the final outcome”,⁷⁴ although one judge commented that:

Everything informs the judge’s decision but there are cases when you get a gut feeling that somebody is dangerous which can be achieved because of the behaviour of the person during the course of the three day trial. On paper he may not present as a significant risk but you may find him a chilling person because of his presentation and so on which may inform you as to whether you think he is a risk in the future.⁷⁵

The defendant’s interests

- 7.75 Although the defendant pleading insanity can be assumed to be “fit to plead” (because if he or she is not fit to plead, then a different procedure will be followed) he or she might nevertheless be suffering from a disorder at the time of trial. It would then be in the defendant’s interest to avoid the ordeal of a longer trial and to receive treatment as early as possible.
- 7.76 However, it is necessary to guard against the risk that a defendant would plead the special defence when he or she should not do so, such as when the alleged criminal act could not be proved and there should be a simple acquittal. There is some evidence to suggest that some people with mental disorder – particularly

⁷⁰ *Birch* (1989) 11 Cr App R (S) 202. It has been suggested that the judgment implies that a judge is bound by the medical evidence with regards to the s 37 hospital order: E Baker, “Human Rights, M’Naghten and the 1991 Act” [1994] *Criminal Law Review* 84.

⁷¹ I Quarashi and J Shaw, “Sections 37/41 Mental Health Act 1983: A Study of Judges’ Practice and Assessment of Risk to the Public” (2008) 48 *Medicine, Science and the Law* 57. However, in an earlier study conducted on 97 forensic psychiatrists throughout mainland UK and Northern Ireland, nearly a quarter had experienced this: M Humphreys, J Kenny Herbert and C Gray, “Restricted Hospital Orders: A Survey of Forensic Psychiatrists’ Practice and Attitudes to their Use” [1998] 9 *Journal of Forensic Psychiatry* 173.

⁷² I Quarashi and J Shaw, “Sections 37/41 Mental Health Act 1983: A Study of Judges’ Practice and Assessment of Risk to the Public” (2008) 48 *Medicine, Science and the Law* 57, 59.

⁷³ I Quarashi and J Shaw, as n 73 above, at p 60.

⁷⁴ I Quarashi and J Shaw, as n 73 above, at p 60.

⁷⁵ I Quarashi and J Shaw, as n 73 above, at p 60.

those with learning difficulties and/or personality disorders – might be especially prone to accept responsibility⁷⁶ when they should not.

- 7.77 This is of particular concern considering the current failings of the law on unfitness to plead. We have already argued elsewhere⁷⁷ that the current test for “unfitness”, also referred to as the *Pritchard* criteria,⁷⁸ is set too high and fails to take all aspects of the modern trial process into account. As a result, a significant number of mentally disordered defendants are being tried when they should not be because of their mental condition.⁷⁹ In particular, we are concerned that the current test focuses disproportionately on cognitive deficiencies and fails to take account of a defendant’s capacity to make decisions.⁸⁰
- 7.78 The requirement for a jury verdict mitigates this risk because it ensures that there is an objective finding at least that the accused did what is alleged in the charge. Requiring a verdict to be delivered by the jury does not, however, necessarily entail genuine consideration of the evidence in these cases.⁸¹
- 7.79 This objection might be overcome by sufficient safeguards to ensure that the defendant does not enter such a plea as a result of a mental disorder. First, the judge could be required to reject a plea of not guilty by reason of insanity if he or she has reason to believe that the defendant may be unfit to plead.⁸² Secondly, the judge could be required to give a formal reasoned ruling.

Unrepresented defendants

- 7.80 Permitting a court to accept a plea without a trial is more problematic where the defendant is unrepresented. With the likely introduction of a financial eligibility threshold for legal aid for defendants in the Crown Court,⁸³ (replacing the recent introduction of means-testing in the Crown Court) and a financial eligibility threshold for legal aid in the magistrates’ courts, the numbers of unrepresented defendants are likely to increase. In these instances, our provisional view is that the trial should proceed with a jury, or, in the case of a magistrates’ court, the magistrates should proceed to hear the evidence.

⁷⁶ Although the plea is one of *not* guilty, by the plea, the accused would be accepting that he or she did the act while stating that his or her medical condition should absolve the accused from criminal responsibility.

⁷⁷ CP 197, paras 2.60 and onwards.

⁷⁸ *Pritchard* (1836) 7 C & P 303.

⁷⁹ T P Rogers, N J Blackwood, F Farnham, G J Pickup, and M J Watts, “Reformulating Fitness to Plead: A Qualitative Study” (2009) 20(6) *Journal of Forensic Psychiatry and Psychology* 815, 817.

⁸⁰ CP 197, paras 2.69 to 2.87.

⁸¹ Such as in the case described in para 7.60 above in which the evidence was presented to the jury by way of admissions.

⁸² In which case, the issue of fitness should be determined in accordance with s 4 of the 1964 Act. This was considered necessary by the Butler Committee: para 18.50 of the Butler report.

⁸³ See pages 22 to 26 of Ministry of Justice “Transforming legal aid: delivering a more credible and efficient system” CP14/2013.

- 7.81 Alternatively, the court could be given a power to appoint a legal representative for the defendant where he or she would otherwise be unrepresented. A procedure for appointing a representative for the accused is currently available where he or she is unfit to plead.⁸⁴ This is not, however, to ensure that the accused has representation, but rather that he or she should have “the best person to put the case for the defence”.⁸⁵
- 7.82 Those seeking to rely on the new defence, despite being fit to plead, might be vulnerable as a result of a persisting mental disorder. It seems inappropriate for the plea of such a defendant to be accepted without legal representation. We would expect, in any event, that the prosecution would be unwilling to accept a plea of the recognised medical condition defence where the defendant is unrepresented.

Magistrates’ courts

- 7.83 In the summary jurisdiction, magistrates decide on issues of both fact and law. Consequently, we would imagine that allowing a plea to be accepted by the court would not have any substantial impact on the current procedure in magistrates’ courts.

Conclusion

- 7.84 On balance, we conclude that there should be a mechanism by which a court can accept a plea of not criminally responsibly by reason of recognised medical condition from the defendant where the prosecution agrees. However, there would need to be procedural safeguards in order to ensure a defendant does not enter the plea *due to* his or her mental disorder. The court would need to consider the case against the defendant and the medical evidence in order to be satisfied that no reasonable jury would return a verdict other than not criminally responsibly by reason of recognised medical condition.
- 7.85 If the defendant is unrepresented, we do not think it should be open to the court to simply accept the plea.
- 7.86 Where the plea is accepted and entered by the court, it should have the same effect as a special verdict delivered by the jury or magistrates after hearing evidence.

⁸⁴ Section 4A(2)(b) of the 1964 Act.

⁸⁵ *Norman* [2008] EWCA Crim 1810, [2009] 1 Cr App R 13 at [34].

Provisional proposal

7.87 **Proposal 17: We provisionally propose that, unless the defendant is unfit to plead or is unrepresented, the court should be able to accept a plea of not criminally responsible by reason of recognised medical condition provided that:**

the prosecution consents,⁸⁶

the court is satisfied that no reasonable jury would return a verdict other than not criminally responsible by reason of recognised medical condition, and

the judge records his or her reasons for accepting the plea.

⁸⁶ It would be for the CPS to formulate their policy on this matter, and not for us.

CHAPTER 8

THE BURDEN OF PROOF

- 8.1 The burden of proof is “the obligation imposed on a party by a rule of law to prove (or disprove) a fact in issue to the requisite standard of proof”.¹ It is also referred to as the persuasive burden. The evidential burden is an obligation on a party to “adduce sufficient evidence for the issue to go before the tribunal of fact”.² In this chapter we consider these two burdens in relation to the defences of insanity and automatism. From paragraph 8.46 onwards we state our provisional proposals as to the burden of proof and evidential burden in relation to the defences proposed in this paper.

THE CURRENT LAW

Automatism

- 8.2 If the defendant pleads not guilty on the grounds of automatism, he or she bears an evidential burden in relation to that defence, as would be the case for other defences such as self-defence. In other words, it is necessary for the defence to introduce “only such evidence as would, if believed and uncontradicted, induce a reasonable doubt in the mind of a reasonable jury as to whether [the accused’s] version might be true”.³ If the defendant fails to discharge the evidential burden, then the issue is not a live issue for the jury (or magistrates) to consider.
- 8.3 If the defendant pleads not guilty on the grounds of sane automatism then, once the defendant has satisfied the evidential burden, it is for the prosecution to disprove the issue beyond reasonable doubt (otherwise known as “to the criminal standard”).

Insanity

- 8.4 In the M’Naghten Rules, the judges stated that the accused’s sanity may be presumed:

The jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction.⁴

¹ H M Malek QC (ed), *Phipson on Evidence* (17th ed 2009) para 6-02.

² H M Malek QC (ed), *Phipson on Evidence* (17th ed 2009) para 6-02; C Tapper, *Cross and Tapper on Evidence* (12th ed 2010) p 128. Or, as Lord Bingham put it, “It is a burden of raising, on the evidence in the case, an issue as to the matter in question fit for consideration by the tribunal of fact. If an issue is properly raised, it is for the prosecutor to prove, beyond reasonable doubt, that that ground of exoneration does not avail the defendant”. *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 246 at [1].

³ C Tapper, *Cross and Tapper on Evidence* (12th ed 2010) p 152, relying on *A-G’s Reference (No 2 of 1992)* [1994] QB 91 and *Bratty v A-G of Northern Ireland* [1963] AC 386.

⁴ *M’Naghten’s Case* (1843) 10 Clark and Finnelly 200, (1843) 8 ER 718, [1843-60] All ER Rep 229.

- 8.5 It would, of course, be ridiculous if the prosecution had to prove in each case that the person accused was sane at the time of the alleged offence. There is, in that sense, no difficulty with the presumption of sanity.
- 8.6 If the prosecution alleges that the defendant was insane, then both the evidential and the persuasive burden fall on the prosecution, and the criminal standard of proof applies. This situation presents no controversy.
- 8.7 If the defendant claims that he or she was insane, the position is more complicated as the defendant must go further than satisfying the evidential burden. He or she bears the burden of proof as well as the evidential burden, and this means that the jury or magistrates must be satisfied on the balance of probabilities that the defendant is not guilty by reason of insanity.
- 8.8 In that event, if the tribunal of fact is sure beyond reasonable doubt of the elements of the offence which the prosecution must prove, and satisfied on the balance of probabilities that the accused was insane, then the correct verdict is not guilty by reason of insanity. If the tribunal of fact is sure beyond reasonable doubt of all the elements of the offence which the prosecution must prove and sure also that the accused was not insane, then it should convict. The troublesome case is where the tribunal of fact is sure beyond reasonable doubt of all the elements of the offence, but not satisfied that it is more likely than not that the accused was insane. It is troublesome because the accused will be convicted though the tribunal of fact is not sure of his or her guilt in the sense of not having been satisfied to the criminal standard to reject the insanity defence.

The presumption of innocence

- 8.9 The allocation of the burden of proof is important as a matter of principle because, to require the state to prove that the accused has committed the crime as alleged, gives effect to the presumption that everyone is innocent until the contrary is proved.⁵ It is a “prime example of the constitutional protection of the accused”.⁶ As Lord Bingham has said:

It is repugnant to ordinary notions of fairness for a prosecutor to accuse a defendant of crime and for the defendant to be then required to disprove the accusation on pain of conviction and punishment if he fails to do so.⁷

- 8.10 The position is stated even more strongly by Ashworth:

Being wrongly convicted is a deep injustice and a substantial moral harm. It is avoidance of this harm that underlies the universal

⁵ The presumption is stated at art 6(2) of the ECHR (see para 5.42 and following of the Supplementary Material to the Scoping Paper) and has long been a part of English common law.

⁶ C Tapper, *Cross and Tapper* (12th ed 2010) p 148.

⁷ *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 246 at [9].

insistence on respect for the right to a fair trial, and with it the presumption of innocence.⁸

- 8.11 The presumption of innocence is an important part of the checks and balances in the criminal justice system, as Roberts has written:

The burden of proof checks and constrains the power of the state to intervene in the lives of individuals and their families in the far-reaching and sometimes catastrophic ways sanctioned by the machinery of criminal justice.⁹

- 8.12 The presumption applies not only to elements of an offence, but also to defences. In *Whyte* the Canadian Supreme Court rejected an argument that as a matter of principle a constitutional presumption of innocence only applies to elements of the offence and not excuses.¹⁰ Giving the judgment of the court, Chief Justice Dickson observed:

The real concern is not whether the accused must disprove an element or prove an excuse, but that an accused may be convicted while a reasonable doubt exists. When that possibility exists, there is a breach of the presumption of innocence.¹¹

- 8.13 Commenting on Chief Justice Dickson's dictum, Lord Nicholls of Birkenhead has said:

This consequence of a reverse burden of proof should colour one's approach when evaluating the reasons why it is said that, in the absence of a persuasive burden on the accused, the public interest will be prejudiced to an extent which justifies placing a persuasive burden on the accused.¹²

- 8.14 The placing of the burden of proof on the prosecution has famously been said to be a "golden thread" running through English criminal law, but in the same breath, Viscount Sankey made an exception for the defence of insanity.¹³ We now examine that exception.

⁸ A Ashworth, "Four Threats to the Presumption of Innocence" (2006) 10(4) *International Journal of Evidence and Proof* 241, 247.

⁹ P Roberts, "Taking the Burden of Proof Seriously" [1995] *Criminal Law Review* 783, 785.

¹⁰ The Court of Appeal in *Foye* [2013] EWCA Crim 475 at [29] noted that the distinction between offences where the accused has to disprove an element of the offence, and offences where the accused has to prove a defence "is sometimes difficult to discern".

¹¹ *Whyte* (1988) 2 SCR 3, (1988) 51 DLR (4th) 481, 493.

¹² *Johnstone* [2003] UKHL 28, [2003] 1 WLR 1736 at [50].

¹³ "Throughout the web of the English criminal law one golden thread is always to be seen, that it is the duty of the prosecution to prove the prisoner's guilt subject to what I have already said as to the defence of insanity and subject also to any statutory exception". Viscount Sankey LC in *Woolmington v DPP* [1935] AC 462, 481. His comments on insanity were not part of the binding element of judgment because, as Viscount Sankey himself commented, M'Naghten had nothing to do with the case of *Woolmington*.

DISCUSSION

Arguments for placing the burden of proof on the prosecution

- 8.15 Our first argument for the prosecution to bear the burden of disproving the defence follows from the nature of the defence itself. Some argue that the “defence” of insanity is simply about whether the accused had mens rea as required for proof of the offence charged. If that argument is correct, it seems evident that the burden of proving mens rea should be on the prosecution as for any element of an offence.
- 8.16 We have argued in chapter 2¹⁴ that the defence of insanity is not simply about mens rea, and is not a true excuse-type defence, but is a denial of responsibility.¹⁵ One consequence of that conceptualisation of the defence is that the prosecution ought to have to prove that the defendant *should* be held responsible in criminal law.¹⁶
- 8.17 As Sir John Smith pointed out,¹⁷ if the accused relies on the *first* limb of the M’Naghten test (that is, not knowing the nature and quality of the act) he or she is in effect obliged to prove absence of mens rea. That is contrary to general legal principle. If the accused is to bear the legal burden of proof on that issue a different rationale must be found.¹⁸
- 8.18 A second, practical argument, for the accused to bear only an evidential burden is that it avoids overly complex jury directions. As noted above,¹⁹ the burden of proof lies on the prosecution if the defence is automatism but on the defendant if the defence is insanity. The direction to the jury can therefore be complicated if both defences are in issue. We do not consider this to be a particularly strong argument because cases where defences of automatism and insanity are pleaded together are rare.
- 8.19 A third, far more important argument, is the presumption of innocence. It can be argued that for the persuasive burden of a defence to be on the defendant

¹⁴ See paras 2.18 and following.

¹⁵ In this respect, the defence of insanity can be distinguished from the partial defence of diminished responsibility.

¹⁶ See D Husak, “Answering Duff: R A Duff’s Answering for Crime” (2010) 29(1) *Law and Philosophy* 101, 112:

[Duff’s] categorization of exemptions as denying responsibility creates a powerful reason to allocate the burden of proof on states to prove sanity in cases in which defendants (through their agents) deny that they are able to answer for their conduct. Constitutional law in the United States currently imposes no such burden on states, and thus is deficient according to Duff’s model.

Justice McLachlin argues that putting the burden of proof on the accused does not violate the presumption of innocence because a finding of insanity does not go to guilt or innocence. Brudner describes this argument as “ingenious” but “mistaken” in “Guilt under the Charter: The Lure of Parliamentary Supremacy” (1998) 40(3 and 4) *Criminal Law Quarterly* 287, 307.

¹⁷ J C Smith, *Smith and Hogan: Criminal Law* (10th ed 2002) pp 226 to 227.

¹⁸ In *Simester and Sullivan’s Criminal Law* the authors comment that “no English court has addressed the tension between the burden of proof in insanity and the usual requirement for the prosecution to prove a voluntary act and mens rea attributable to D”: p 706.

¹⁹ See paras 8.2 and following and paras 8.4 and following. See eg *Burns* (1973) 58 Cr App R 364.

unjustifiably contravenes the presumption of innocence. It is consistent with legal principle for the prosecution to have to prove all elements of an offence: this principle aims to reduce the risk of innocent people being convicted. The prosecution should not be absolved from having to prove mens rea where there is evidence that the accused was unable to form mens rea.

The presumption of innocence in the ECHR

- 8.20 The European Commission of Human Rights considered the burden of proof in the insanity defence in *H v United Kingdom*.²⁰ The Commission concluded that the insanity defence raised the issue of the presumption of sanity, not the presumption of innocence, and in any event, placing the burden on the accused was not unreasonable or arbitrary. We consider the reasoning in this judgment to be unsound because the Commission seemed to confuse an evidential burden with a requirement to prove a fact,²¹ extrapolated too much from *Salabiaku*,²² and did not explain how it thought the rights of the defence are adequately preserved. It failed to provide an answer to the fundamental point that, with the burden of proof on the defendant, there remains the possibility that a defendant will be convicted even though there is a reasonable doubt about his or her sanity at the time of the offence.²³
- 8.21 We note also that the Commission did not ask itself the right questions. Infringement of article 6 is not prohibited by the ECHR in all circumstances. Rather, following case law of the European Court, the presumption of innocence “may be confined within reasonable limits which take into account the importance of what is at stake and maintain the rights of the defence”.²⁴ It has been held in the domestic courts that derogation may be justified where it is necessary and proportionate in fulfilment of a legitimate objective.²⁵ The Commission should therefore have asked itself whether the infringement of the presumption of innocence was justifiable in that it was necessary and proportionate in fulfilment of a legitimate aim. We conclude that the views of the Commission and the Court should not be regarded as conclusive, and the better view is that the placing of the burden on the defendant is in breach of article 6(2).

²⁰ *H v UK* App No 15023/89 (Commission decision) (unreported).

²¹ See B Emmerson, A Ashworth, and A Macdonald, *Human Rights and Criminal Justice* (2nd ed 2007) para 11–30, where the authors argue that the reasoning in *H* is flawed and confuses the obligation to present evidence of D’s insanity with the obligation to prove insanity on the balance of probabilities.

²² *Salabiaku v France* (1988) 13 EHRR 379 (App No 10589/83).

²³ See paras 5.51 to 5.52 in the Supplementary Material to the Scoping Paper.

²⁴ *Salabiaku v France* (1988) 13 EHRR 379 (App No 10589/83).

²⁵ See *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 264 at [80].

Historical accident

- 8.22 The last aspect to note is that the placing of the burden of proof on the defendant may only be “an exceptional historical accident”²⁶ and that in itself is not a reason for the burden to remain on the defendant. The distinction between an evidential burden and a persuasive burden was not always clearly drawn in nineteenth century case law.²⁷ It is important to bear this in mind when questioning why the burden of proof should not be on the prosecution as it is with any other defence.²⁸ It was suggested by Williams that the placing of the burden of proving insanity on the defendant is an accident of history “explicable only as a survival from a time before the present rules of burden of proof were established”.²⁹ Jones’ view is that the words in M’Naghten “to establish a defence on the ground of insanity, it must be clearly proved that ...” were not conceived of as laying down a special rule for the insanity defence.³⁰

Arguments for placing the burden of proof on the defendant

- 8.23 The essence of the principal arguments for the burden of proof being on the defendant is that it is necessary, and so we turn to those arguments now.
- 8.24 There are two linked arguments for putting the burden of proof of insanity on the defendant. First, it is argued that if the burden were on the prosecution, then it would be impossible for the prosecution to disprove an assertion of insanity, resulting in unmeritorious acquittals.³¹ The argument continues that in consequence some of the most heinous acts would go unpunished, and it is therefore safer to put the burden on the accused. Secondly, it is argued that it will be easier for the defendant to adduce evidence of his or her mental state than it would be for the prosecution to do so.
- 8.25 There is no doubt that across the criminal law, there are some situations in which placing the burden of proof on the defendant is appropriate. For example, where an enactment prohibits the doing of an act subject to a proviso, an exemption or similar, it may be appropriate to require the accused to bring himself or herself within the proviso or exemption. An example given by Lord Woolf is that of an

²⁶ P Roberts, “Taking the Burden of Proof Seriously” [1995] *Criminal Law Review* 783, 789. See G R Williams, “Offences and Defences” (1982) 3 *Legal Studies* 233, 235. Conversely, maybe it was “an instance of the general practices of English courts” at the time of M’Naghten: see A Loughnan, “Manifest Madness” (2007) 70(3) *Modern Law Review* 379, 398, citing G Fletcher, “Two Kinds of Legal Rules: A Comparative Study of Burden-of-Persuasion Practices in Criminal Cases” (1968) 77 *Yale Law Journal* 880 and T H Jones, “Insanity, Automatism and the Burden of Proof on the Accused” (1995) 111 *Law Quarterly Review* 475.

²⁷ G Fletcher, *Rethinking Criminal Law* (1978) p 528.

²⁸ Of course, as insanity is not, strictly speaking, a defence it does not follow necessarily that the burden should be on the prosecution to disprove it.

²⁹ G Williams, “Offences and Defences” (1982) 2 *Legal Studies* 233, 235.

³⁰ T H Jones, “Insanity, Automatism, and the Burden of Proof on the Accused” (1995) 111 *Law Quarterly Review* 475, 477.

³¹ For example, Morse’s view is that a reverse burden of proof is justified because it “minimise[s] the risk of success of insanity defences in questionable cases” while allowing deserving cases to win through: S J Morse, “Excusing the Crazy: The Insanity Defense Reconsidered” (1985) 58 *Southern California Law Review* 777, 824.

offence of performing some act without the appropriate licence.³² Requiring the prosecution to prove an absence of a licence could be onerous, as compared with requiring the defendant to produce it.³³

- 8.26 Some take the view that leaving the legal burden on the prosecution to disprove insanity would set the bar at an impossibly high standard.³⁴ This was part of the majority reasoning of the Supreme Court of Canada in *Chaulk*, as summarised recently by the Court of Appeal:³⁵

The court held by a majority of 6:3 that the reverse onus provision did impinge on the presumption of innocence, but that it served a legitimate objective which justified overriding a constitutionally protected right and moreover satisfied the additional test of proportionality; thus it was not invalid under the [Canadian Charter of Rights and Freedoms].³⁶

- 8.27 The Court of Appeal has recently made just this point:³⁷

The law does not in any way inhibit a defendant from demonstrating that in his case this ordinary assumption [of sanity] cannot be made, but it is entirely reasonable that a matter so personal to the defendant should be for him to prove, albeit only on the balance of probabilities. For the same reason, the position is identical if the defendant asserts not diminished responsibility but the greater mental disability of insanity in law: that is likewise for him to prove on the balance of probabilities.

...

In the case of both insanity and diminished responsibility, the issue depends on the inner workings of the defendant's mind at the time of the offence. It would be a practical impossibility in many cases for the Crown to disprove (beyond reasonable doubt) an assertion that he was insane or suffering from diminished responsibility.

³² See s 101 of the Magistrates' Courts Act 1980 which states that the burden of proving an exception, exemption, proviso, excuse or qualification falls on a defendant to a statutory summary offence. And see *Hunt* [1987] AC 352.

³³ *A-G of Hong Kong v Lee Kwong-Kut* [1993] AC 951, 969. Lord Woolf took the same view of the defence of insanity but without argument, as insanity was not in issue.

³⁴ An "unworkable burden", in the words of Lamer CJ of the Canadian Supreme Court in *Chaulk* [1990] 3 SCR 1303.

³⁵ *Foye* [2013] EWCA Crim 475 at [38], referring to *Chaulk* [1990] 3 SCR 1303.

³⁶ Not all the Supreme Court judges took this view. Wilson J, dissenting from the majority judgment, thought that the burden of proving sanity was not unduly onerous, drawing on experience in the United States. Critical analysis of the decision of the Supreme Court can be found in D B Deutscher, "*R v Chaulk and R v Swain: Insanity and the Constitution*" (1991) 2(4) *Constitutional Forum* 99, 101; D M Tanovich, "The Unravelling of the Golden Thread: The Supreme Court's Compromise of the Presumption of Innocence" (1993) 35(2) *Criminal Law Quarterly* 194, 194; and P Healy, "Automatism Confined" (2000) 45(1) *McGill Law Journal* 87, 103.

³⁷ *Foye* [2013] EWCA Crim 475 at [33] and [35].

8.28 Jones, by contrast, has written that:

There is no convincing explanation offered as to what it is about the defence of insanity which sets it apart in this respect from other legally recognised defences. A prosecutor can be faced with equal difficulties of proof in cases of, for example, sane automatism or voluntary intoxication.³⁸

8.29 Under the existing law, cases of sane automatism can indeed require the prosecutor to be faced with the challenge of proving a negative. For example, it may be necessary to prove that the defendant did not black-out when driving as he or she claims. There is sometimes public disquiet when the prosecutor is unable to do this and the accused is acquitted.³⁹ As Stumer writes:

If the prosecution is able to overcome the evidential problems in cases on [non-insane] automatism there is no reason to think it could not overcome those problems in cases of insanity.⁴⁰

8.30 Jones asks whether it is “any easier for an accused to make a bogus claim of insanity than one of, say, duress”.⁴¹ We doubt it, given that it would probably be easier to prove duress by threats because another individual is involved and evidence of his or her threats can be adduced.⁴² In contrast, expert evidence from two registered medical practitioners is required to support a defence of insanity.

8.31 In attempting to identify what sets the defence of insanity apart, we suggest that it is the internal nature of mental illness or disorder and the criteria used for judging whether a person has such an illness or disorder. Evidence of a specified illness or disorder is not always as clear-cut as evidence of a physical illness such as a broken limb which can be verified by an X-ray. Mental illness or disorder may be diagnosed as a result of observed behaviours and self-reports of how a person is thinking and feeling, and there is a general suspicion that these can be faked in a way that, say, a fracture cannot.

8.32 This brings us to the second argument: that it is easier for the defendant to adduce evidence about his or her mental state than it is for the prosecution to do

³⁸ T H Jones, “Insanity, Automatism, and the Burden of Proof on the Accused” (1995) 111 *Law Quarterly Review* 475, 492 referring to Davis AJA in *Kaukani* [1947] (2) SA 807, 814. D Hamer comments that the claim as to the “impossibly onerous burden” “does not withstand examination”: “The Presumption of Innocence and Reverse Burdens: A Balancing Act” (2007) 66(1) *Cambridge Law Journal* 142, 162.

³⁹ As in the case at Leeds Crown Court in Feb 2007 before HHJ Norman Jones (then Recorder of Leeds). The accused was charged with causing death by dangerous driving. He killed two people. The accused raised the defence of sane automatism, which the prosecution felt they could not disprove. The accused was acquitted.
<http://www.dailymail.co.uk/news/article-437471/Death-driver-walks-free-automatism-condition.html> (last visited 9 Mar 2012).

⁴⁰ A Stumer, *The Presumption of Innocence: Evidential and Human Rights Perspectives* (2010) p 186.

⁴¹ T H Jones, “Insanity, Automatism, and the Burden of Proof on the Accused” (1995) 111 *Law Quarterly Review* 475, 492.

⁴² The hearsay rule is not engaged and any evidence of the threatening party’s bad character can be adduced: Criminal Justice Act 2003, s 100 or s 101(1)(e).

so.⁴³ In practice, this is not necessarily the case. A defendant might be able to say what was going through his or her mind at the time, but for those with a mental disorder that disorder may make it far harder to do so.

8.33 We do not consider that it is always easier for the accused to obtain evidence of his or her mental condition than it would be for the prosecution to do so. Even if it was easier, it is still not clear what makes the insanity defence distinct from any other element of an offence or defence about which the defendant may know more, such as intention. Although a defendant may be in a privileged position of knowledge as to what his or her intention was, the law does not (generally) place the burden of proof of intention on him or her,⁴⁴ so there needs to be a different justification for the case of insanity.

8.34 As Mr Justice Jack noted in a discussion of the reversal of the burden of proof in a different context:

I accept that, where the matters raised by a defence are solely within the defendant's knowledge, in some situations this may be a factor in establishing that a legal burden on the defendant is necessary and so proportionate. On the other hand, in the criminal law there are very many situations where the prosecution has to prove something which is not within its knowledge. Intent is a primary example. The prosecution commonly overcomes the difficulty by reliance on the circumstances to establish intent or whatever other matter it may be that is in issue.⁴⁵

8.35 Even if it were the case that evidence of the accused's mental disorder may much more easily be produced by the defence than by the prosecution, this still does not amount to good reason for placing the persuasive burden of proof on the defendant. It amounts only to a good reason for placing an *evidential* burden on the defendant.⁴⁶ Several commentators on the Canadian Supreme Court case of *Chaulk* have made this point: that even if the accused can more easily produce the relevant evidence, the burden placed on the accused should be an evidential burden, not a persuasive burden.⁴⁷ Williams also drew attention to the

⁴³ For example, "Insanity, diminished responsibility and coercion fall into the category of cases where the basis of the defence is *peculiarly* within the accused's knowledge ..." P W Ferguson, "Reverse Burdens of Proof" (2004) 22 *Scots Law Times* 133, 138 (emphasis in original).

⁴⁴ Lord Bingham commented, in *Kebilene*, that "Whenever a criminal intention is an essential ingredient of a crime the defendant is better placed to prove his intention than anyone else, but this does not relieve the prosecution of the need to prove criminal intention against him in the overwhelming majority of cases". *DPP ex p Kebilene* [2000] 2 AC 326, 345. Roberts has commented that "ease of proof is, of itself, no reason whatsoever to depart from *Woolmington* by requiring a defendant to prove his innocence": P Roberts, "The Presumption of Innocence Brought Home? *Kebilene* Deconstructed" [2002] 118 *Law Quarterly Review* 41, 66.

⁴⁵ *Sheldrake v DPP* [2003] EWHC 273 (Admin), [2004] QB 487 at [152]. The Divisional Court judgment was overruled by the House of Lords.

⁴⁶ I Dennis, "Reverse Onuses and the Presumption of Innocence: In Search of Principle" [2005] *Criminal Law Review* 901, 915.

⁴⁷ See, eg, D M Tanovich, "The Unravelling of the Golden Thread: The Supreme Court's Compromise of the Presumption of Innocence" (1993) 35(2) *Criminal Law Quarterly* 194, 200.

significance of the difference between an evidential burden and a persuasive burden.⁴⁸ To put it another way, it is a good reason for requiring the defendant to call evidence to displace the presumption of sanity.

- 8.36 Brudner supports the placing of the burden of proof on the accused on a different basis. He writes that presuming sanity and requiring the accused to prove his or her insanity “reflects respect for the human person”. He continues:

Respect for persons here requires that we be reasonably persuaded that this individual *is* insane before we subject him to measures that for a sane person would amount to a serious indignity. We cannot do this simply because we have a reasonable doubt about his sanity. We have to be more certain than that. Accordingly, the presumption of sanity is a reasonable limit on the right to be presumed innocent because it is needed to further the very values that underlie the presumption of innocence, namely, respect for the autonomy of the person.⁴⁹

In our view, this argument is not persuasive because, in the kinds of cases in view, it is almost always the accused who claims to be “insane”, and because there are appropriate safeguards in the conditions necessary for a hospital order. His argument supports the presumption of sanity but not placing the burden of proof of sanity on the accused.

- 8.37 As it is, a defendant cannot simply assert “insanity” without any medical evidence in support. Section 1 of the 1991 Act requires there to be evidence from at least two medical practitioners (one of whom must have expertise in mental health) before there can be a verdict of not guilty by reason of insanity. Given this heavy evidential requirement, it may be asked whether it matters whether the accused bears the burden of proving the defence.
- 8.38 The answer is that it matters for reasons of principle as explained above, but also in practice in cases where the evidence is finely balanced. A consequence of a party bearing the burden of proving an issue is that, in the event that that party fails to prove it (to whichever standard applies), the tribunal of fact finds against him or her on that element. Thus, if the other elements of the offence charged are proved, the tribunal of fact will convict unless satisfied that it is more probable than not that the defendant was “insane” at the time of the offence. If, on the other hand, the prosecution cannot make the tribunal of fact sure that the accused was not “insane” at the time of the offence, then the accused is entitled to the special verdict.

The views of other bodies and jurisdictions

- 8.39 In many jurisdictions⁵⁰ the defence of insanity involves a presumption of sanity which may be rebutted by the accused if he or she can prove insanity on the

⁴⁸ G Williams, *The Proof of Guilt* (3rd ed 1963) p 184.

⁴⁹ A Brudner, “Guilt under the Charter: The Lure of Parliamentary Supremacy” (1998) 40(3 and 4) *Criminal Law Quarterly* 287, 308 (emphasis in original).

⁵⁰ Scotland, Canada, the Code jurisdictions in Australia, New Zealand, South Africa, Hong Kong and India.

balance of probabilities. In some jurisdictions (such as Canada) the prosecution may raise the issue, in which case it bears the burden of proving it.

- 8.40 Reform bodies which have examined this issue before have come to differing conclusions. Whereas the Criminal Law Revision Committee would have placed the burden of disproving the defence on the prosecution,⁵¹ the Scottish Law Commission and the Law Reform Commission of Western Australia were content to leave the burden of proof on the defendant.⁵²
- 8.41 The Butler Committee criticised the placing of the burden of proof on the defendant, although its own recommendations produced a complicated scheme.⁵³ In its Fourteenth report, the Criminal Law Revision Committee thought that the burden of disproving the defence of diminished responsibility should fall on the prosecution.⁵⁴
- 8.42 The Code team, in their report to the Law Commission in 1985, thought that the burden should lie on whichever party sought to prove the issue, on the balance of probabilities, and the draft Code of 1989 took the same view.

Conclusion

- 8.43 It is not necessary for the accused to bear the burden of proving a defence based on his or her mental (or physical) condition; justice can be served by an evidential burden on the defence. In addition, if it is not necessary, then in our view, placing the burden of proof of the defence on the accused is in breach of article 6(2) of the ECHR.
- 8.44 Such an approach is consistent with an understanding of the defence as a denial of responsibility, it accords with general principle, and it avoids complicated explanations of which party bears the burden of proof where automatism and recognised medical condition are both in issue.
- 8.45 We now apply these conclusions to the defences proposed in this paper.

THE DEFENCES PROPOSED IN THIS PAPER

The defence of recognised medical condition

- 8.46 Our provisional view is that the prosecution should bear the burden of proof even where the accused pleads the defence we propose of “not criminally responsible by reason of recognised medical condition”. However, we also think that the evidential burden should be greater in these circumstances than is ordinarily the case. It should not be sufficient, for example, for the defendant to claim, without

⁵¹ 11th Report Evidence (General) (1972) Cmnd 4991, para 140.

⁵² The Law Reform Commission of Western Australia, *The Criminal Process and Persons Suffering from Mental Disorder* (1991) para 2.25. See Part 5 of Scot Law Com 195. The Scottish Law Commission had taken the opposite view in its discussion paper. In its final report, however, it left the burden on the defendant in their recommendations, and said also that the issue can only be raised by the defence.

⁵³ See para D.40 in Appx D to the Supplementary Material to the Scoping Paper.

⁵⁴ Criminal Law Revision Committee, Fourteenth Report, Offences Against the Person (1980) Cmnd 7884.

any supporting evidence, that he or she has this or that recognised medical condition.

- 8.47 By its nature, the defence will depend on expert evidence, and our provisional view is that the requirement for expert evidence is appropriate. This in itself means that the burden on the defendant to raise the defence is more demanding than the usual evidential burden. The current insanity defence in the Crown Court requires expert evidence from two recognised medical practitioners, and so applying that requirement to the defence of recognised medical condition, and to the magistrates' courts, is an approach familiar to courts and practitioners.⁵⁵
- 8.48 Although one of the experts should be a registered medical practitioner, we do not think it is appropriate or necessary for one of the experts to be a psychiatrist (as the law currently requires): the nature of the expertise will depend on the nature of the condition. We discuss this more fully in chapter 7 above.
- 8.49 The issue of whether a particular medical condition is a qualifying recognised medical condition is one of law,⁵⁶ and therefore if that issue is in dispute the accused will have to adduce evidence to satisfy the court. If the court rules that the condition in question does satisfy that legal test, then the accused will have to adduce evidence before the tribunal of fact as to each element of the defence in order to put the defence in issue.
- 8.50 **Conclusion 9: We conclude that where the accused pleads the defence of recognised medical condition, he or she should bear an elevated evidential burden – meaning that the accused must adduce evidence from two experts – but that the prosecution should bear the burden of disproving the defence once it has been raised. These conclusions are reflected in our proposals for the recognised medical condition defence.**⁵⁷
- 8.51 We accept that the direction to the jury could be complex if a defendant charged with murder pleads either the partial defence of diminished responsibility or the partial defence of loss of control together with the defence of recognised medical condition.

The practicability of putting the burden of proof on the prosecution

- 8.52 We wrote in our work on the partial defence of diminished responsibility that “a contested case would become impossible to prosecute” if the burden of disproving that defence fell on the prosecution.⁵⁸ It may be helpful here to illustrate why we do not think this would be the result in the context of the recognised medical condition defence.
- 8.53 The new recognised medical condition defence requires a total loss of one of the relevant capacities, due to a qualifying recognised medical condition.⁵⁹ The

⁵⁵ In ch 7 we discuss whether there should still be a need for expert evidence from two people, and conclude that there should.

⁵⁶ See para 4.63 above.

⁵⁷ See paras 4.160 and 4.163 above.

⁵⁸ *Murder, Manslaughter and Infanticide* (2006) Law Com No 304, para 5.105.

⁵⁹ See para 4.8 and following above.

potential outcomes are a hospital order, a supervision order, or an absolute discharge as opposed to the penalties that follow a conviction for manslaughter.

- 8.54 For those whose medical condition could be seen, in lay terms, as a mental illness, there is a disincentive to pleading the recognised medical condition defence because the prospect of a hospital order will be real.⁶⁰ Under the current law defendants are deterred from pleading the insanity defence because, if they are likely to be given a custodial sentence, they prefer the certainty of a release date to the uncertainty as to release from a hospital, and the same effect would apply in relation to pleading the recognised medical condition defence. Placing the burden of proving the defence on the accused makes no difference to this.
- 8.55 From the point of view of the public, if D raises the recognised medical condition defence and the prosecution is unable to disprove it, the public may well be protected from harm by a hospital order.
- 8.56 The category of case which might cause most concern is that where the medical condition is not the kind of condition which could or would result in a hospital order. There, the incentive to plead the recognised medical condition defence could be much greater. An example might be the case of D who is charged with rape and who pleads recognised medical condition on the basis of parasomnia (sleepwalking).
- 8.57 If the prosecution is able to prove the offence and to disprove the defence, then D is likely to face a significant prison term, whereas if the prosecution proves the offence but cannot disprove the recognised medical condition defence, D is likely to avoid the stigma of a conviction for rape and to receive a supervision order. In such a case, D might wish to make it as difficult as possible for the prosecution to obtain expert evidence and refuse to submit to expert examinations other than with experts chosen by the defence. The prosecution would no doubt make the point that the credibility of the defence was undermined by D's refusal to cooperate, but it is conceivable that the point would not carry a great deal of weight.
- 8.58 In fact, our provisional proposals would make it harder for D to run such a defence than under the current law because D who relies on sane automatism is not required to adduce evidence from two experts. It is also the case that if D succeeds, the public is better protected by our provisional proposals than under the current law because D would at least be (probably) subject to a supervision order rather than simply acquitted as now.

Automatism

- 8.59 The evidential burden of proving sane automatism currently rests on the accused. Once the accused adduces evidence which puts the voluntariness of his or her act in question, the prosecution must ultimately prove to the ordinary criminal standard that the act was willed. This approach is followed in the criminal codes in Australia, and in Scotland and New Zealand. In Canada, by contrast, if the

⁶⁰ Contrast the position with a person who stands to be convicted of murder: the diminished responsibility verdict offers an outcome which is clearly preferable to a mandatory life sentence.

accused pleads the defence of automatism, he or she bears both the evidential burden and the burden of proof for this defence.⁶¹

- 8.60 Under our proposed defence of automatism, the defendant would have to adduce credible evidence which would make the defence a reasonable possibility. For example, if the accused's case was that he or she reacted in a reflex way to a wasp sting while driving, a passenger could give evidence of the incident and the accused's reaction, and that would suffice to raise the defence. It would then be for the prosecution to disprove it.
- 8.61 **Proposal 18: Although we provisionally propose a reformed defence of automatism, described in chapter 5 above, we are not proposing a change in the burden of proof in relation to this defence.**

⁶¹ Part of the reason for this decision by the Supreme Court in *Stone* [1999] 2 SCR 290 was the need to be consistent with the allocation of the burden of proof in two other defences: in the plea of insanity, and in the plea of extreme intoxication producing a state akin to automatism (*Daviault* (1994) 93 CCC (3d) 21). The burden falls on the defendant in all three cases. The decision in *Stone* was a majority decision, with strong dissent. This aspect of *Stone* has been criticised by Brudner: "Insane Automatism: A Proposal for Reform" (2000) 45(1) *McGill Law Journal* 65, 84, and by Healy: P Healy, "Automatism Confined", (2000) 45(1) *McGill Law Journal* 87, 92.

CHAPTER 9

A NEW DEFENCE OF “NOT CRIMINALLY RESPONSIBLE BY REASON OF DEVELOPMENTAL IMMATURITY”?

- 9.1 In this chapter we raise the issue of whether a defence of “not criminally responsible by reason of developmental immaturity” merits further consideration in a separate paper.
- 9.2 This issue arises naturally, both from the foundation of the defences proposed in this paper and from our earlier work on the partial defence of diminished responsibility.

LACK OF CAPACITY

- 9.3 The foundation of the defences proposed in this paper is, as discussed in Appendix A, a person’s lack of capacity to regulate his or her conduct to comply with the criminal law. One of the reasons a person may lack capacity in this sense is that he or she has not developed the relevant capacities of understanding and self-control.
- 9.4 In light of this, it is arguable that a person should not bear criminal responsibility for what would otherwise be an offence when he or she *wholly* lacked the relevant capacities by virtue of developmental immaturity. The relevant capacities could be those which apply in our proposed defence of “not criminally responsible by reason of recognised medical condition”, namely,
- (1) rationally to form a judgment in relation to what he or she is charged with having done;
 - (2) to appreciate the wrongfulness of what he or she is charged with having done; or
 - (3) to control his or her physical acts in relation to what he or she is charged with having done.

OUR RECOMMENDATIONS ON DEVELOPMENTAL IMMATURITY IN RELATION TO THE PARTIAL DEFENCE OF DIMINISHED RESPONSIBILITY

- 9.5 In considering reform of diminished responsibility, we were concerned that that defence, in its original form, was not available to a developmentally immature person unless that immaturity amounted to an “abnormality of mind”. Medical experts reported how difficult, or impossible, it could be to assess the impact of a person’s abnormality of mind while disregarding any effects of developmental immaturity.¹
- 9.6 We recommended reforming the defence so that the “abnormality of mind” criterion was replaced with a requirement that the defendant had an abnormality of mental functioning arising from a recognised medical condition. We also

¹ Murder, Manslaughter and Infanticide (2006) Law Com No 304 para 5.128.

recommended that the diminished responsibility defence should be available to a person aged under 18 at the time of the murder who was developmentally immature, even though that developmental immaturity did not constitute a recognised medical condition. Ashworth described this approach as “a significant step forward”.²

- 9.7 We acknowledged that the recommendation was potentially controversial,³ and it was not carried through into reform of the defence of diminished responsibility implemented by the Government in the Coroners and Justice Act 2009. The omission of a “developmental immaturity limb” from the new diminished responsibility defence was criticised by Lord Phillips:

It is surely offensive to justice that a child whose brain has not yet developed to the extent necessary to provide the self-control that is found in an adult should be unable to pray this fact in aid, at least as a partial defence. Children develop at different speeds. If (and it may be a big if) some are sufficiently mature at the age of 10 to have full criminal responsibility, those who are not should, I feel, be entitled to pray this in aid.⁴

- 9.8 Both our thinking at the time of our recommendation on the reform of diminished responsibility, and the reasoning behind the proposal of a recognised medical condition defence have led us to pay special attention to the issue of developmental immaturity.

WHAT IS DEVELOPMENTAL IMMATURITY?

- 9.9 As a matter of medical fact, children are immature as compared with adults:

There is now a significant body of research evidence indicating that early adolescence (under 13-14 years of age) is a period of marked neurodevelopmental immaturity, during which children’s capacity is not equivalent to that of an older adolescent or adult.⁵

² Though he thought that our view that some ten-year-old killers might fairly be convicted “rather alarming”. He supported our earlier argument in *A New Homicide Act for England and Wales? (2005) Law Commission Consultation Paper No 177* para 6.84 for a partial defence to a charge of murder for very young offenders as “surely compelling”: A Ashworth, “Child Defendants and the Doctrines of the Criminal Law” in J Chalmers, F Leverick and L Farmer (eds), *Essays in Criminal Law in Honour of Sir Gerald Gordon* (2010) pp 38, 41.

³ *Murder, Manslaughter and Infanticide* (2006) Law Com No 304 para 5.129.

⁴ Lord Phillips of Worth Matravers, “Reforming the Law of Homicide”, Essex University/Clifford Chance lecture (6 Nov 2008) p 15. Lord Carlile of Berriew spoke for the inclusion of developmental immaturity in the House of Lords: *Hansard* (HL), 30 June 2009, vol 712, col 173, as did Baroness Butler-Sloss: *Hansard* (HL), 30 June 2009, vol 712, col 184. The omission was also criticised by the Standing Committee on Youth Justice (a coalition of interested bodies) in *Briefing on Coroners and Justice Bill* (2009) p 2, and by J R Spencer, “Response to Ministry of Justice Consultation Paper Murder, Manslaughter and Infanticide: Proposals for Reform” at para 34.

⁵ Centre for Social Justice, *Rules of Engagement: Changing the Heart of Youth Justice* (Jan 2012) p 201. “Scanning adolescent brains has (perhaps unsurprisingly) shown them to be under-developed when contrasted with adults”: C Walsh, “Youth Justice and Neuroscience: a Dual-use Dilemma” (2011) 51(1) *British Journal of Criminology* 21, 22.

9.10 This much is uncontroversial, but it is not the basis for a possible criminal defence. A person's developmental maturity can be classified with some degree of objectivity by comparing him or her to other children of the same chronological age. Some individuals will have a level of developmental maturity that is much lower than the norm for a person of their age, albeit that their level of immaturity is not so extreme as to constitute a recognised medical condition. The question is whether such individuals ought to have available to them a separate defence to criminal charges, to reflect the fact that their level of maturity was so far below the norm and that it caused a lack of a relevant capacity on their part.

9.11 This was an issue that was brought to our attention by responses to our consultation paper on the partial defences of diminished responsibility and provocation. The Royal College of Psychiatrists wrote that:

Biological factors such as the functioning of the frontal lobes of the brain play an important role in the development of self-control and of other abilities. The frontal lobes are involved in an individual's ability to manage the large amount of information entering consciousness from many sources, in changing behaviour, in using acquired information, in planning actions and in controlling impulsivity. Generally the frontal lobes are felt to mature at approximately 14 years of age.⁶

9.12 Developmental immaturity may be more than simply a matter of biological development. The same paper from the Royal College of Psychiatrists noted that "It is generally agreed that child development can be described across several categories and these include: physical, intellectual, emotional and social development".⁷ Development is assessed in a multi-faceted way, as appears from the approach to assessment proposed by Bailey in child homicide cases.⁸ As we mentioned in our report on Murder, Manslaughter and Infanticide, a defendant may wish to rely on either biological factors or social or environmental influences, or all of these⁹ to support a claim of developmental immaturity.

9.13 This kind of multiple, persistent developmental immaturity is not uniform across all children and young people.¹⁰ It may be particularly relevant to children and

⁶ Royal College of Psychiatrists, *Child Defendants* (Occasional Paper OP56, March 2006) p 38.

⁷ Royal College of Psychiatrists, *Child Defendants* (Occasional Paper OP56, March 2006) p 31.

⁸ Law Com No 304, Appx F which included a template, prepared by Professor Sue Bailey, which is a guide to the ways in which the nature and degree of developmental immaturity can be assessed by experts. It is a template for assessments of young defendants which includes assessment of cognitive functioning, mental state, needs, risk of violence, behavioural analysis of problems and multi-axial diagnosis of psychiatric syndrome, specific disorders or psychological development, intellectual level, medical conditions, associated psychosocial situations, and global assessment of functioning.

⁹ Law Com No 304 para 5.132 and Appx F.

¹⁰ "While it has long been understood that components of adolescent development, such as puberty, cognition and social skills develop at different speeds in each individual, we now understand that brain development is not identical for each individual adolescent": M Moreno and M Trainor, "Adolescence Extended: Implications of New Brain Research on Medicine and Policy" (2013) 102 *Acta Paediatrica* 226, 228.

young people who appear before the criminal courts. As has been noted in a recent report:¹¹

Young people drawn into the criminal justice system typically have additional vulnerabilities, for example learning disabilities and mental health problems, stemming from adverse developmental experiences.¹² These vulnerabilities serve, “in addition to developmental immaturity, to constrain the ability to act freely and maturely, raising further questions about culpability”.¹³

What capacities does developmental immaturity affect?

- 9.14 There are particular areas of developmental delay that are relevant to the question of capacity and criminal responsibility, as described in a recent review:

One of the key distinctions they draw is between cognition (generally present in adolescents) and judgment (often considered to be lacking), with the latter taken to include the ability to “imagine alternative courses of action, think of potential consequences of these hypothetical actions, estimate probabilities of their occurrence, weigh desirability in accordance with one's preferences, and engage in comparative deliberations about alternatives and consequences”.¹⁴

- 9.15 The developmental delays have been summarised as the following specific incompetencies:

“defective risk assessment”;

“vulnerability to peer influence”;

“distorted temporal perspective”: adolescents are more likely to think in terms of short-term consequences. “This may be due to their more limited life experiences or cognitive limitations that inhibit their ability to fully understand future consequences”.

¹¹ Centre for Social Justice, *Rules of Engagement: Changing the Heart of Youth Justice* (Jan 2012) p 202.

¹² Examples of developmental adversity include abuse, neglect and exposure to violence. Young people in the youth justice system are more likely than other children to experience abuse and neglect. (footnote in original)

¹³ E Farmer, “The Age of Criminal Responsibility: Developmental Science and Human Rights Perspectives” (2011) 6(2) *Journal of Children's Services* 86. (footnote in original)

¹⁴ C Walsh, “Youth Justice and Neuroscience: a Dual-use Dilemma” (2011) 51(1) *British Journal of Criminology* 21, 23, citing P Kambam and C Thompson “The Development of Decision-Making Capacities in Children and Adolescents: Psychological and Neurological Perspectives and their Implications for Juvenile Defendants” (2009) 27(2) *Behavioral Sciences and the Law* 173, 174. For other sources for this conclusion see n 61 in S J Morse, “Immaturity and Irresponsibility” (1997-1998) 88 *Journal of Criminal Law and Criminology* 15 and E S Scott and L Steinberg, “Blaming Youth” (2002-2003) 81 *Texas Law Review* 799, cited at J Carbone, “Neuroscience and Ideology: Why Science Can Never Supply a Complete Answer for Adolescent Immaturity” in M Freeman (ed), *Law and Neuroscience, Current Legal Issues, Volume 13* (2011). For a discussion of the insights of development psychology in 1997 see E S Scott and T Grisso, “The Evolution of Adolescence: A Developmental Perspective on Juvenile Justice Reform” (1997-1998) 88 *Journal of Criminal Law and Criminology* 137.

“difficulty with self-management”: in other words, difficulty in regulating their moods and in controlling impulsive behaviour.

“As a result of these deficiencies, adolescents not only ‘make bad decisions’, they ‘make decisions badly’”.¹⁵

Developmental immaturity and age

- 9.16 There is clearly an important age-related element to developmental maturity. Scott and Grisso have written, “If these [influences of developmental factors] on decision-making are developmental and not simply reflective of individual idiosyncratic preferences for risk-taking, they should abate with maturity”. The evidence indicates that this is what happens: it has long been recognised that of those adolescents who commit offences, most will “grow out of it”.¹⁶
- 9.17 It does not necessarily follow, however, that a developmental immaturity defence would be relevant only to those under 18. In its response to our consultation paper on reform of the law of homicide,¹⁷ the Criminal Bar Association thought that restricting the proposed extension to the diminished responsibility defence to children and young people would be illogical. There is evidence that physiological development is not complete by 18: neurological research identifies that brain development continues into early adulthood and that “the human brain is not ‘mature’ until the early to mid-twenties”.¹⁸ The Independent Commission on Youth Crime and Antisocial Behaviour observed that:

The age thresholds relating to the youth justice system cannot constitute an accurate guide to an individual child or young person’s level of maturity and understanding. Recent evidence concerning brain development during adolescent and early adult life provides scientific support for the view that young people deserve to be treated

¹⁵ L S Miller-Wilson, “Law and Adolescence: Examining the Legal and Policy Implications of Adolescent Development Research for Youth Involved in the Child Welfare, Juvenile Justice, or Criminal Justice Systems” (2006) 79(2) *Temple Law Review* 317, 321 to 322. Footnotes and emphasis omitted.

¹⁶ E S Scott and T Grisso, “The Evolution of Adolescence: A Developmental Perspective on Juvenile Justice Reform” (1997-1998) 88 *Journal of Criminal Law and Criminology* 137, 166. And later in the same article at p 172: “the fact that delinquent behaviour desists for most adolescents as they approach adulthood strongly suggests that criminal conduct, for most youths, is associated with factors peculiar to adolescence”. Walsh comments that neuroscientific research supports an approach which assumes that for most young offenders, their offending is “adolescence-limited”: C Walsh, “Youth Justice and Neuroscience: a Dual-use Dilemma” (2011) 51(1) *British Journal of Criminology* 21, 24. It is still criminal conduct, however.

¹⁷ A New Homicide Act for England and Wales? (2005) Law Commission Consultation Paper No 177.

¹⁸ One of the key findings of a report for T2A (Transition to Adulthood Alliance): D Prior and others, *Maturity, Young Adults and Criminal Justice: A Literature Review* (2011). See also M Moreno and M Trainor, “Adolescence Extended: Implications of New Brain Research on Medicine and Policy” (2013) 102 *Acta Paediatrica* 226, 230; T A Maroney, “Adolescent Brain Science and Juvenile Justice” in M Freeman (ed), *Law and Neuroscience, Current Legal Issues 2010* (vol 13, 2011) p 273: “Developmental neuroscience consistently indicates that structural brain maturation is incomplete at age 18”; and a recent report by the Royal Society which stated that “changes in important neural circuits underpinning behaviour continue until at least 20 years of age”: *Brain Waves Module 4: Neuroscience and the Law* (Dec 2011) p 13.

differently by the criminal law.¹⁹ These developments have been linked to a reduced capacity among adolescents to control impulse.²⁰

Reviews of the scientific evidence coincide with our instinctive view that while some children may understand from quite an early age that certain types of behaviour are socially unacceptable and harmful, others reach adolescence with much less sense of where the boundaries lie. In addition, we have heard from experts, including professionals working with young adult offenders, about the marked differences they encounter in maturity among older teenagers to which physical age offers no guide.²¹

WHY THIS ISSUE IS DISTINCT FROM THE PROPOSED RECOGNISED MEDICAL CONDITION DEFENCE

- 9.18 Defendants under 18 rarely rely on the insanity defence. We understand that this is in part due to the kinds of disposals that are available following a verdict of not guilty by reason of insanity, but also because practitioners do not usually think of the insanity defence as being applicable in the youth courts.²² A further reason is that mental illness is less likely to be diagnosed in someone aged under 18 than in an adult.²³
- 9.19 The proposed recognised medical condition defence would, we think, be more accessible to young defendants than the insanity defence is. For example, it would be available to a person with a learning disability which meant that he or she wholly lacked a relevant capacity. It would not, however, be available to a child or young person who did not have a diagnosis.
- 9.20 What we are highlighting here is the possibility of a different defence applicable where someone did not have a recognised medical condition. There is an important difference between a recognised medical condition and developmental immaturity: youth is not a pathological condition equivalent to a medical condition. Though a developmental immaturity defence is related to the “recognised medical condition” defence because they both depend on lack of the same specified capacities, it is clearly not within it.

¹⁹ M Rutter, “Causes of Offending and Antisocial Behaviour” in D J Smith (ed), *A New Response to Youth Crime* (2010) (footnote in original).

²⁰ S-J Blakemore and S Choudhury, “Brain Development During Puberty” (2006) 9 *Developmental Science* 11 to 14 (footnote in original).

²¹ Independent Commission on Youth Crime and Antisocial Behaviour, *Time for a Fresh Start* (2010) p 90.

²² See the comments of the CPS at para B.160 in Appx B.

²³ Royal College of Psychiatrists, *Child Defendants* (Occasional Paper OP56, March 2006) p 51: “The majority of child defendants are unlikely to show signs of serious mental illness such as schizophrenia; rather, they are likely to present with a severe, childhood-onset conduct disorder with a wide range of additional contextual psychosocial problems, which should be assessed in a methodical and forensically oriented manner”.

CONCLUSION

- 9.21 The fact that understanding and control develop through childhood and adolescence is one of the reasons why the law sets an age below which a person is not held criminally responsible. Many readers will be familiar with the arguments for raising the age of criminal responsibility in England and Wales. We are also mindful that the Government has repeatedly declined even to review the question of the age of criminal responsibility.²⁴ We are not addressing that issue.
- 9.22 It used to be that children had the doctrine of *doli incapax* as an additional protection from punishment under the criminal law. That doctrine required that in every charge against a defendant aged 10 to 13, in addition to the elements of the offence, the prosecution proved that the child knew that what he or she had done was seriously wrong. But this doctrine has been discarded.²⁵ We do not seek the reintroduction of that doctrine here.
- 9.23 Leaving those two issues to one side, it seems to us that there is nevertheless a discussion to be had about a defence for those who lacked the capacity to avoid committing the crime in question due to their developmental immaturity. There are many aspects to this discussion – legal, psychological, social policy – and it is part of a far wider debate about how our society deals with children and young people who break the law.
- 9.24 It also seems to us that, although this possible defence has clear connections with the defences we are proposing in this paper, it has different ramifications from those defences. In order to explore the various aspects of the possible defence, this paper would have to cover a range of issues which are not relevant to the rest of this paper, particularly various aspects of the youth justice system. We do not think we can do the possible defence justice in this paper, but we do think that it merits separate, full, treatment.

²⁴ In 2010, the Earl of Listowel tabled a question in the House of Lords on the Government's plans to review the age of criminal responsibility: *Hansard* (HL), 20 Dec 2010, vol 723, col 815. This followed the publication of a report on youth justice by the All-Party Parliamentary Group for Children: *Children and Young People in the Youth Justice System* (2010). Lord McNally, for the Government, said that "the Government have no current plans to review the age of criminal responsibility. ... For the moment, we hold firm that, although the age of criminal responsibility is 10 years, the thrust of the policy when children come into the care of the authorities is not to feed them into the criminal justice system but to apply as vigorously and ... holistically as possible responses to their needs to try to avoid them reoffending": *Hansard* (HL), 20 Dec 2010, vol 723, cols 815 to 816.

²⁵ Crime and Disorder Act 1998, s 34, as confirmed in *JTB* [2009] UKHL 20, [2009] 1 AC 1310. It has been suggested that the doctrine was flawed in that it permitted a defence "for reasons which were not at the heart of why criminal responsibility was inappropriate for many children" and "this gap between the legal requirements for the defence and the reason for denying criminal responsibility ultimately meant the defence became disengaged from reality and lost the support of the judges and practitioners...": C Elliott, "Criminal Responsibility and Children: A new Defence Required to Acknowledge the Lack of Capacity and Choice" (2011) 75(4) *Journal of Criminal Law* 289, 290.

CHAPTER 10

OUR PROVISIONAL CONCLUSIONS AND PROPOSALS

SHOULD THERE BE A MENTAL DISORDER DEFENCE?

Conclusion 1

- 10.1 We provisionally conclude that there should be a defence which allows for a special verdict where the case is not proved against the accused because of his or her mental disorder as well as where it is proved because of the mental disorder. [2.34]

Conclusion 2

- 10.2 We provisionally conclude that there should be a special verdict in those cases of total lack of criminal capacity resulting from a recognised medical condition (provided the other criteria of the defence are met) without limiting it to mental disorders. [2.63]

A NEW DEFENCE AND SPECIAL VERDICT

The relevant capacities

Conclusion 3

- 10.3 We take from the civil law, and from our previous examinations of the issue, that one of the relevant capacities is the capacity for practical reasoning, and for the purposes of the new defence this is best expressed as the capacity rationally to form a judgment about the relevant conduct or circumstances. [4.14]

Conclusion 4

- 10.4 We conclude that if a person did not have the ability to conform to the law because he or she could not understand that the conduct was something he or she ought not to do, and that incapacity was because of a qualifying recognised medical condition, then that person should not be held criminally responsible. Therefore, one aspect of capacity to conform to the law should be the capacity to understand the wrongfulness of the act or omission, and that wrongfulness should not be limited to illegality. [4.33]

Conclusion 5

- 10.5 Some recognised medical conditions are capable of depriving a person of control of his or her bodily actions. They produce, in that sense, involuntary actions. We accept that as a matter of practice, it can be difficult, particularly in the case of mental disorders, to discern when a person has genuinely lost the power to control his or her physical acts (such as may be the case for a person with a sleep disorder). We nevertheless think that in some cases it is possible for a medical condition to deprive a person of the power to control his or her actions, and that it is right in principle for the law to allow a defence in such cases. [4.53]

A new defence and special verdict

Proposal 1

- 10.6 We provisionally propose that the common law rules on the defence of insanity be abolished. [4.158]

Proposal 2

- 10.7 We provisionally propose the creation of a new statutory defence of not criminally responsible by reason of recognised medical condition. [4.159]

Proposal 3

- 10.8 The party seeking to raise the new defence must adduce expert evidence that at the time of the alleged offence

the defendant wholly lacked the capacity:

(i) rationally to form a judgment about the relevant conduct or circumstances;

(ii) to understand the wrongfulness of what he or she is charged with having done; or

(iii) to control his or her physical acts in relation to the relevant conduct or circumstances

as a result of a qualifying recognised medical condition. [4.160]

Proposal 4

- 10.9 We provisionally propose that certain conditions would not qualify. These include acute intoxication or any condition which is manifested solely or principally by abnormally aggressive or seriously irresponsible behaviour. [4.161]

Proposal 5

- 10.10 We provisionally propose that if there is a dispute as to whether the medical condition which the accused claims to have had is a recognised medical condition and/or whether it is a qualifying condition, then this shall be a question of law and not one for the tribunal of fact. [4.162]

Proposal 6

- 10.11 We provisionally propose that if sufficient evidence is adduced on which, in the opinion of the court, a properly directed jury could reasonably conclude that the defence might apply, the defence should be left to the tribunal of fact to consider. The prosecution then bears the burden of disproving the defence beyond reasonable doubt. [4.163]

Proposal 7

- 10.12 The jury (or magistrates) shall return a special verdict of “not criminally responsible by reason of recognised medical condition” unless satisfied beyond reasonable doubt that the accused did not suffer a complete loss of capacity by reason of a qualifying recognised medical condition. [4.164]

Proposal 8

- 10.13 We provisionally propose that the special verdict of “not criminally responsible” may only be returned where evidence on the accused’s medical condition has been received from two or more experts, one of whom is a registered medical practitioner. [4.165]

Proposal 9

- 10.14 We provisionally propose that whether a person has been or is going to be held not criminally responsible by reason of recognised medical condition shall not affect the criminal liability of any other person. [4.166]

Disposal following the new special verdict

Proposal 10

- 10.15 We provisionally propose that the following disposals should be available following a special verdict of “not criminally responsible by reason of recognised medical condition”: a hospital order (with or without a restriction), supervision order, or an absolute discharge. [4.167]

Proposal 11

- 10.16 We provisionally propose that in respect of a defendant who is under 18, the court should also have the power to make a non-penal Youth Supervision Order following a special verdict of “not criminally responsible by reason of recognised medical condition”. [4.168]

A REFORMED DEFENCE OF AUTOMATISM

Proposal 12

- 10.17 We provisionally propose that the common law rules on the defence of automatism be abolished. [5.123]

Proposal 13

- 10.18 We provisionally propose that where the magistrates or jury find that the accused raises evidence that at the time of the alleged offence he or she wholly lacked the capacity to control his or her conduct, and the loss of capacity was not the result of a recognised medical condition (whether qualifying or non-qualifying), he or she shall be acquitted unless the prosecution disprove this plea to the criminal standard. [5.124]

RELATIONSHIP TO PRIOR FAULT AND INTOXICATION

Application of the intoxication rules in the common law

Proposal 14

- 10.19 We provisionally propose that a person “D” shall be treated as pleading the recognised medical condition defence and not involuntary intoxication where:

- (1) D suffered from a recognised medical condition, and
- (2) D took a properly authorised or licensed medicine or drug for the treatment of that condition, and

- (3) D took the medicine or drug in accordance with a prescription, with advice given by a suitably qualified person, or in accordance with the instructions accompanying the medicine or drug in the case of over-the-counter medicines, or, if D did not take it in accordance with instructions, it was nevertheless reasonable for D to take it in the way he or she did in the circumstances, and
- (4) D had no reason to believe that he or she would have an adverse reaction to that medicine which would cause him or her to act in that way, and
- (5) the taking of that medicine or drug caused D totally to lack the relevant criminal capacity. [6.51]

PROCEDURAL QUESTIONS

Availability of the special verdict in the magistrates' courts

Conclusion 6

- 10.20 We conclude that the special verdict should be available in magistrates' courts following a successful plea of the new defence of not criminally responsible by reason of recognised medical condition. [7.17]

Magistrates' powers of disposal

Proposal 15

- 10.21 We provisionally propose that magistrates' courts should have the power to commit a person to the Crown Court for a restriction order following the special verdict. [7.27]

Conclusion 7

- 10.22 We conclude that it would not be appropriate to create a new power for magistrates to attach a restriction order to a hospital order. [7.28]

Proposal 16

- 10.23 We provisionally propose that, following a special verdict of not criminally responsible by reason of recognised medical condition in the summary jurisdiction, the magistrates should have the power to make a hospital order, a supervision order or an absolute discharge and, if the accused is under 18, a non-penal Youth Supervision Order. In addition, we propose that where magistrates make a hospital order they should also have the power to commit the defendant to the Crown Court for that court to consider making a restriction order. [7.35]

The number of experts from whom evidence is required to support a plea

Conclusion 8

- 10.24 We provisionally conclude that the requirement for two expert reports is necessary to safeguard the interests of the public and the defendant. [7.53]

Court's power to accept a plea

Proposal 17

10.25 We provisionally propose that, unless the defendant is unfit to plead or is unrepresented, the court should be able to accept a plea of not criminally responsible by reason of recognised medical condition provided that:

the prosecution consents,

the court is satisfied that no reasonable jury would return a verdict other than not criminally responsible by reason of recognised medical condition, and

the judge records the reasons for accepting the plea. [7.87]

BURDEN OF PROOF

The defence of recognised medical condition

Conclusion 9

10.26 We conclude that where the accused pleads the defence of recognised medical condition, he or she should bear an elevated evidential burden – meaning that the accused must adduce evidence from two experts – but that the prosecution should bear the burden of disproving the defence once it has been raised. [8.50]

Automatism

Proposal 18

10.27 Although we provisionally propose a reformed defence of automatism, we are not proposing a change in the burden of proof in relation to this defence. [8.61]

APPENDIX A

THE QUESTION OF CRIMINAL RESPONSIBILITY

A.1 Criminal law is generally thought to be founded on the principle that a person must have been responsible for his or her actions in order to be held culpable and to be punished.

A.2 It would be unfair for those whose serious disorders caused them to lack criminal responsibility at the time of an alleged offence to be at risk of the same outcome (criminal conviction) as people without that serious condition.¹ As Lord Chief Justice Bingham put it in the Court of Appeal:

It would be offensive to visit the full rigour of the law on those who are not mentally responsible ...²

A.3 In this Appendix we address the concept of responsibility as part of the essential inquiry: when does the fact that a person has a particular condition make it unfair to hold him or her responsible for his or her otherwise criminal conduct?

A.4 What is meant by this concept of responsibility is a philosophical question, yet we are not philosophers. Inevitably therefore, in this Appendix we draw on the work of those who have thought from that theoretical angle at greater length than we have about these issues. We do not claim to be presenting all the interpretations of any particular theoretical stance. Nevertheless, because they inform our proposals for reform, we consider that it is important to set out the theoretical justifications in broad terms for not finding a person culpable in law.

A.5 Our principal conclusion is that people should not be held criminally responsible for their conduct if they lack the capacity to conform their behaviour to meet the demands imposed by the criminal law regulating that conduct. This lack of capacity might consist in an inability to think rationally, or in an inability to control one's actions. The reason for that lack of capacity might lie in a mental disorder, or in a physical disorder.³

THE SCOPE OF THIS APPENDIX

A.6 We start by examining different explanations for the foundation of responsibility in criminal law theory: that a person is to be held responsible because he or she

¹ The verdict of "guilty but insane" used to be available in England and Wales under the Trial of Lunatics Act 1883. It was later recognised that it was, in substance, an acquittal, and so various bodies recommended that it was recast "so that the verdict may again be one of acquittal in language as well as in substance". Royal Commission on Capital Punishment report, para 459, endorsing a recommendation made by the Atkin Committee of 1923. The recommendation was again endorsed by the Criminal Law Revision Committee in 1963, and became law in 1964. If the mental condition of the accused is such as to absolve him or her from criminal responsibility then it is wrong to convict the accused of the offence, even if a tag of explanation is added. The verdict is used in some of the United States.

² *Antoine* [1999] 3 WLR 1204, 1208.

³ See paras 2.53 onwards where we discuss the reasons not to draw a distinction in this context between physical and mental conditions.

made a choice, or because of what an act reveals about his or her character. We conclude that the theory of responsibility based on a person's *choices* does not fully answer the question of responsibility. This is because in the case of a mentally disordered person a bad choice does not necessarily prevent him or her being excused criminal liability. Similarly, we find that the theory which bases responsibility in *character* is not workable in the field of criminal law. We conclude that capacity is the key to criminal responsibility. Where a person is unable to refrain from performing the proscribed conduct and has not culpably produced the loss of capacity, it is fair to say that he or she lacks responsibility.

- A.7 We then discuss the concept of involuntary behaviour. There is often an assumption that an act must have been voluntary in order to hold a person responsible for it, but there are limitations to the understanding of responsibility if approached through voluntariness. Similarly, there are limits to the understanding of responsibility if approached through the concept of consciousness. However, in our view a solid foundation for explaining a defence to what would otherwise be criminal actions lies in the concept that a person is not responsible for involuntary behaviour. This is because he or she lacked the capacity to do otherwise, in other words he or she lacked the ability to control him or herself.
- A.8 We then seek to apply the concept of lack of capacity to the kinds of capacity which are relevant to criminal liability. Up to this point, we suspect that most of what we say is not controversial: there is a consensus amongst writers on the subject that lack of capacity of some kind justifies treating some people as non-responsible.⁴ It is also non-controversial to take the capacity for rational thought as a relevant criminal capacity, though it might be hard to be precise about what rationality means in the context of criminal law.
- A.9 Controversy does, however, attach to one aspect of the capacity to make one's behaviour conform to the criminal law. Not engaging in criminal conduct requires, first, some measure of cognitive ability, but it also requires an ability to make one's behaviour conform to one's values. We discuss the theoretical difficulties with a defence based on lack of capacity for self-control, and conclude that this aspect of lack of capacity does make sense at a theoretical level. (Whether it can be translated into a criminal defence which will be capable of practical application in the courts is an issue we discuss in Part 8.)
- A.10 Lack of responsibility due to lack of a relevant capacity depends on the accused not being culpably responsible for that lack of capacity, and this is something we refer to briefly at paragraph A.43.
- A.11 There are some who argue that there should be a distinct exempt category for those who will always lack criminal capacity. We do not agree, and explain why at paragraphs A.94 to A.103.
- A.12 Having explained our reasoning and conclusions on the foundations for the lack of criminal responsibility, we discuss the more theoretical question of what kind of

⁴ As Lacey writes, it is "generally agreed among theorists of criminal responsibility in England [that] ... responsibility for crime is founded in a certain set of capacities": N Lacey, "Responsibility and Modernity in Criminal Law" (2001) 9(3) *The Journal of Political Philosophy* 249, 255, referring to H L A Hart, *Punishment and Responsibility* (1968).

defence a lack of capacity plea amounts to. It is not a justification. We conclude it is not an excuse, but is a denial of responsibility at a more fundamental level, and the same is true of a defence of automatism.

“COULD NOT HAVE DONE OTHERWISE”

- A.13 The classic statement of the foundation of criminal responsibility is that made by Hart:

What is crucial is that those whom we punish should have had, when they acted, the normal capacities, physical and mental, for doing what the law requires and abstaining from what it forbids, and a fair opportunity to exercise these capacities. Where these capacities and opportunities are absent, as they are in different ways in the varied cases of accident, mistake, paralysis, reflex action, coercion, insanity, etc, the moral protest is that it is morally wrong to punish because “he could not have helped it” or “he could not have done otherwise” or “he had no real choice”.⁵

- A.14 It is immediately helpful to explain why we reject a deterministic interpretation of this statement. The determinist might argue that everything has a cause, and therefore, if you unpick the causes of the accused’s act, you will find that events could not have unfolded differently, and the accused should not therefore be held responsible.⁶ On this view of the world a person, as a physical being, is subject to the laws of nature and of causation, as is any other thing, and every human act is therefore determined. The determinist then works backwards from the act which is being judged, and establishes the causes of that act, and then the causes of those causes, and so on. Because the act can be explained in terms of its causes, it follows, on this view, that the agent was not really “free” at all. Further, if the act was not the result of free will, then the agent should not be held morally responsible for it.
- A.15 We do not accept this denial of free will because to do so would undo the whole foundation of the criminal justice system, but also because it confuses causation with compulsion. Rather, we agree with Moore when he writes that “to explain an act, a choice, or a willing, in terms of its causal antecedents, is not to explain it

⁵ H L A Hart, *Punishment and Responsibility* (1968) p 152. The context is an argument about whether strict liability is fair.

⁶ There is a great deal of literature on this topic. On the problem as it arises in the legal context, see J Horder, “Criminal Law: Between Determinism, Liberalism and Criminal Justice” (1996) 49(1) *Current Legal Problems* 159; M S Moore, “Causation and the Excuses” (1985) 73(4) *California Law Review* 1091; S J Morse and M B Hoffman, “The Uneasy Entente between Insanity and Mens Rea: Beyond *Clark v Arizona*” (2007) *Scholarship at Penn Law*, Paper 143; H Howard “Reform of the Insanity Defence: Theoretical Issues” (2003) 67(1) *Journal of Criminal Law* 51.

out of existence”⁷ and that “persons can be agents who act for reasons even in a world in which all mental states and all physical events are caused”.⁸

- A.16 Moreover, causation is not the point at issue, as Howard explains: “if causation were an excuse in itself, none of us would be responsible for anything. Causation is not the issue with which we should be dealing; all behaviour is caused, the issue is a non-culpable lack of rationality or compulsion.”⁹ The issue is that of assigning responsibility: as Horder has written, “our system of criminal law ... presupposes that to become criminals people must be responsible for harm, and not just cause it.”¹⁰

THEORIES OF RESPONSIBILITY

- A.17 The three main competing theories of responsibility¹¹ are summarised by Tadros as follows:

For choice theorists, an agent cannot be criminally responsible for his action unless he had choices. For the capacity theorist, he cannot be criminally responsible unless he had some kind of capacity in relation to his action. For the character theorist, he cannot be criminally responsible unless his action was properly related to his character.¹²

- A.18 The capacity theory (see Hart’s statement cited above) is the most generally accepted basis for responsibility, and we are content to adopt the wealth of academic support expressed for this approach. However, we acknowledge that others seek to base criminal responsibility in a person’s character, or in his or her choices, and we deal with those theories very briefly here to explain our preference for the capacity theory.

⁷ M S Moore, “Causation and the Excuses” (1985) 73(4) *California Law Review* 1091, 1133. See S J Morse, “Common Criminal Law Compatibilism” in N A Vincent (ed) *Neuroscience and Legal Responsibility* (2013).

⁸ M S Moore, “Causation and the Excuses” (1985) 73(4) *California Law Review* 1091, 1127.

⁹ H Howard, “Reform of the Insanity Defence: Theoretical Issues” (2003) 67(1) *Journal of Criminal Law* 51.

¹⁰ J Horder, “Pleading Involuntary Lack of Capacity” (1993) 52(2) *Cambridge Law Journal* 298, 299. See also S J Morse, “Lost in Translation? An Essay on Law and Neuroscience” in M Freeman (ed) *Law and Neuroscience, Current Legal Issues 2010* (2011) and Horder who writes that the “laws of the universe” are distinct from reasons: the latter are subject to evaluation and “determinism cannot challenge the existence of and need for evaluation of beliefs and of conduct, in the light (inter alia) of reasons as well as causes.” J Horder, “Criminal Law: Between Determinism, Liberalism and Criminal Justice” (1996) 49(1) *Current Legal Problems* 159,165.

¹¹ Though Duff says that capacity theories of responsibility “do not compete with ‘choice’ and ‘character’ theories”. Duff argues that choice and character theories concern the objects of responsibility, whereas capacity theories concern the conditions of responsible agency. R A Duff, *Answering for Crime* (2007) p 39.

¹² V Tadros, *Criminal Responsibility* (2005) p 45.

Character-based criminal responsibility¹³

- A.19 In general terms, the theory that a person's character provides the basis for his or her criminal responsibility can be summarised as follows: "criminal liability is properly grounded where D's action manifests an undesirable character trait that requires correction".¹⁴ A modern version of the theory has been advanced by Tadros as follows:

An agent is responsible for an action ... insofar as that action reflects on the agent *qua* agent. In relation to action performed for a reason, [the action will only reflect on the agent *qua* agent] insofar as the desire that motivated the action is appropriately connected to the system of values of the agent ... and that value of the agent is accepted [by the agent] in the light of the agent's system of values.¹⁵

- A.20 The character theory of responsibility has been the subject of potent criticism.¹⁶ We note here a summary of some obvious criticisms that may be made of it.
- A.21 The character theorist may argue that the accused should not be held responsible for conduct if it does not reflect on his or her character. So, for example, even if the accused acts dishonestly, it could nevertheless be argued that the conduct does not reveal the accused to have a dishonest character, in which case he or she should not be punished. This theory does not explain why the state should not give priority to enforcing the law, even if that means punishing a person for conduct which is contrary to the law irrespective of whether it was typical of the person or not. Secondly, one could say that dishonest conduct does itself show that the accused has a dishonest character and nothing more is needed.¹⁷
- A.22 Brudner attacks the theory on the basis that there is:

¹³ The assumption that criminal responsibility resided in a person's bad character held sway in eighteenth century England: N Lacey, "Psychologising Jekyll, Demonising Hyde" (2010) 4 *Criminal Law and Philosophy* 109, 117. A person's character may, in the current law, play a part in pre-prosecution decisions, at trial in generating incriminating evidence of previous offending, and then again at the sentencing stage, when it may be shown that the act for which the person has been convicted is typical of him or her as demonstrated by his or her criminal history, or as a deviation from previous good character.

¹⁴ C Crosby, "Culpability, *Kingston*, and the Law Commission" (2010) 74(5) *Journal of Criminal Law* 434, 447. "Manifest criminality" is Fletcher's term: G Fletcher, *Rethinking Criminal Law* (1978). Hume proposed that "blame and punishment are not directly for acts but for character traits ..." (M D Bayles, "Character, Purpose and Criminal Responsibility" (1982) 1 *Law and Philosophy* 1, 7 cited by C Crosby, "Culpability, *Kingston*, and the Law Commission" (2010) 74(5) *Journal of Criminal Law* 434, 447) but it can be traced before Hume to Spinoza and Aristotle.

¹⁵ V Tadros, *Criminal Responsibility* (2005) p 44.

¹⁶ See, eg, J Horder, *Excusing Crime* (2004) p 118 and following, and A Brudner, *Punishment and Freedom* (2009) p 69.

¹⁷ This is Duff's argument: R A Duff, *Criminal Attempts* (1996) p 188.

The [faulty] assumption ... that we are responsible for our characters and can thus be appropriately blamed for vicious traits, dispositions, habits, and attitudes ... [and] that character theorists can demarcate with some precision the borders of the character for which we are responsible ... so that judgments of actions as “in character” or “out of character” can be analytical and disciplined rather than subjective and result-driven.¹⁸

- A.23 A further problematic feature of character-based theory of responsibility is that it assumes a fixed sense of a person’s character. Even if it is accepted that a fifty-year-old does have a character settled in all relevant respects, which is disputable, it is even less certain that an eleven-year-old’s character is fixed. It would therefore be difficult for the prosecution to go about showing that young people had acted “out of character”.¹⁹
- A.24 A further difficulty is that, taken to its logical conclusion, a person can be punished for his or her character, irrespective of whether the character has manifested itself in conduct. Furthermore, if it is believed that character persists over time, then character theory would allow or promote preventive detention. It does not help to argue that it is the actions which are reflective of a person’s character which are the subject of punishment and not his or her character. As Brudner puts it, if an action is punished because it reflects character, then it is still the person’s character that is being punished, and he or she will still be vulnerable to pre-emptive punishment.²⁰
- A.25 For character theorists, “insanity” distorts a person’s “true character”.²¹ This idea reflects general perceptions of some mentally disordered people some of the time (for example, we may say of a person with dementia that “she is no longer herself”) but it is limited as an explanation of why mental disorder should exculpate a person. Brudner offers a forceful criticism of the notion of true character being distorted by disorder:

Where mental disorder is not genetic or biologically caused, it comprises a set of character vices (megalomania, paranoia, narcissism, lack of conscience, etc) for which agents are as much or as little responsible as they are for any other formation of character ... Accordingly, the character theory would seem to be committed to eliminating or drastically reducing the scope of the defence of mental disorder ...²²

- A.26 Lacey’s description of the distorting effect of insanity is also interesting in this context. She refers to the cutting of the link between a person and his or her actions, though she says this is not about altered capacity:

¹⁸ A Brudner, *Punishment and Freedom* (2009) p 65.

¹⁹ See J Horder, *Excusing Crime* (2004) pp 122 to 123.

²⁰ A Brudner, *Punishment and Freedom* (2009) p 68.

²¹ “It is implicit in the medical conception of insanity that the actor’s true character is distorted by his mental illness”. G Fletcher, *Rethinking Criminal Law* (1978) p 800.

²² A Brudner, *Punishment and Freedom* (2009) pp 66 to 67.

We cannot take it, in the case of insane persons, that their actions do in fact manifest settled dispositions, character traits, in any real sense, or at least anything like the sense we take non-insane persons' actions to do so. The link between disposition and action seems to be severed by insanity, not because it alters the capacities of the insane person, but because it involves disordered thought and behaviour which is not patterned by the structure of thought (both in terms of reason and emotion) by which we normally communicate and interpret each other's actions.²³

A character-based M'Naghten test

A.27 Building on the concept of criminal responsibility as based in a person's character, Tadros has proposed a refinement of the M'Naghten test along the following lines:

It must not only be the case that the defendant's mental disorder resulted in the defendant failing to appreciate the nature and quality of the act or that it was wrong. The defect must be such that the failure to appreciate those things could not be attributed to the agent. And that will be true only if the mental disorder was such that the belief formed was radically disconnected from the background beliefs of the defendant. Hallucinations are the most obvious example of when this will be the case. But they need not be the only example.²⁴

A.28 This suggestion is vulnerable to some of the general criticisms made of the character theory. We have considered the extent to which Tadros' suggestion might be workable in practice. We can identify the following obvious difficulties.

A.29 Tadros's test would require reliable evidence of the accused's general mindset over a long period of time prior to the alleged disorder which affected him or her at the time of the crime. This would have to show that an accused's belief at the time of the alleged criminal conduct was radically disconnected from her background beliefs, or that it was not truly reflective of the accused, taking a long-term view of his or her character.

A.30 An example of a practical difficulty that would create is that any psychiatric evidence would most likely relate to periods when the accused had been unwell. Therefore evidence of the accused's real "background beliefs" would have to come from people who had known the accused and his or her beliefs over time. That would be unlikely to involve expert opinion and be likely to be unreliable.

A.31 If this model were to be adopted, it is also unclear what should happen to the person whose criminal conduct is in accordance with his background beliefs. What is the law to do, for example, with the racist who commits a racially aggravated assault but in fact was psychotic at the time of the assault. Tadros' model would indicate that he should be convicted, even though he acted as a

²³ N Lacey, *State Punishment* (1988) p 74, cited by Mackay (1995) p 78.

²⁴ V Tadros, *Criminal Responsibility* (2005) p 339.

result of serious mental illness, because he did in fact act in accordance with his background beliefs.

- A.32 We do not pursue the character theory or this suggested revision of the M'Naghten test any further.

Choice-based responsibility

- A.33 Respect for a person's autonomy leads to the idea that he or she is responsible for his or her own choices. It is because the accused makes a choice that he or she is or is not culpable. It follows from this theory that if a choice is made which results in criminal conduct, that is sufficient to ground criminal responsibility, even where the accused in fact had no other options.²⁵

- A.34 This theory of responsibility is vulnerable to challenge on numerous bases. Tadros writes that:

Choice ... plays no central role in determining whether an agent is responsible for his action. An agent need not have had a choice, nor need he have had a perception of choice, about his action, nor need his action to have been chosen for him properly to be held responsible for that action.²⁶

- A.35 Similarly, Horder argues that "the choice to do wrong is not an essential element of criminal liability and the fact that wrongdoing was not chosen does not necessarily excuse".²⁷ One example that he gives to illustrate this point is that of the person who acts without making a considered choice:

If I lose my self-control and kill my rival upon some trivial provocation, I may be rightly convicted of his murder, even though it would be bizarre to speak of me as having "chosen between options" when intentionally killing him. One is just as responsible for spontaneously committed wrongdoing as one is for wrongdoing preceded by deliberation: the freedom to "choose between options" is neither here nor there.²⁸

- A.36 Horder notes that Hart himself was clear that choice is not essential to criminal responsibility, as demonstrated by his acceptance that criminal responsibility may arise out of merely negligent behaviour.

²⁵ H Frankfurt, "Alternate Possibilities and Moral Responsibility" 66 *Journal of Philosophy* (1969) 829, 835 cited by M S Moore, "Causation and the Excuses" (1985) 73(4) *California Law Review* 1091, 1141. This could also be described as a situation in which the person had no choice: V Tadros, *Criminal Responsibility* (2005) p 65. Brudner offers a more sophisticated model of this theory by expanding a culpable choice into one which interferes with another's liberty: A Brudner, *Punishment and Freedom* (2009).

²⁶ V Tadros, *Criminal Responsibility* (2005) p 100.

²⁷ J Horder, *Excusing Crime* (2004) p 128.

²⁸ J Horder, "Criminal Law: Between Determinism, Liberalism and Criminal Justice" (1996) 49(1) *Current Legal Problems* 159, 163.

- A.37 Horder also points out that in the case of a person treated as insane in the criminal law, it is simply irrelevant to ask what alternatives she had, to doing as she did: “it is her lack of capacity that brings her insanity into play... and not a lack of options to do otherwise.”²⁹
- A.38 It may be that the culpability of the choice of the mentally disordered offender is beside the point. Whereas a bad choice could indeed spell criminal liability for a person without mental disorder, the issue for us is whether a culpable choice should lead to criminal responsibility where mental disorder (or physical disorder) is at the root of that bad choice. And that issue leads us to conclude that it is not choice which is significant here, but whether D had the *capacity* to choose.

Capacity-based responsibility

- A.39 To be criminally responsible, the person must have had “the capacity to do otherwise”. This justification for punishment goes back to Hart.³⁰ In his recent searching analysis, Brudner teases out of Hart’s statement an element of consciousness, in the sense that a human being must have some awareness of him or herself as a being that can reflect and act in order to be a moral agent: “a capacity to have done otherwise in this sense belongs to any human being that is aware of itself as an ‘I’ or subject”.³¹ We agree that this must indeed be a primary condition, one which is usually taken for granted when discussing criminal responsibility. The point may be illustrated by the example of an animal, which does not possess any idea of itself as an actor. Most would agree it does not make sense to fix an animal with legal responsibility.³²
- A.40 Given this initial ability to be aware of oneself as an agent, and an ability to evaluate one’s conduct,³³ discussions of capacity come back to the same two fundamental capacities: of rationality, and of control over one’s actions.³⁴ This may entail a capacity to choose freely whether to act on an inclination,³⁵ but, as we have noted above, responsibility cannot be explained solely in terms of capacity to make a choice.

²⁹ J Horder, “Criminal Law: Between Determinism, Liberalism and Criminal Justice” (1996) 49(1) *Current Legal Problems* 159, 168.

³⁰ “Fairness require[s] that a man should not be punished ... unless he had the capacity and a fair opportunity to avoid doing the thing for which he is punished.” H L A Hart, *Punishment and Responsibility* (1968) pp 190 to 191.

³¹ A Brudner, *Punishment and Freedom: A Liberal Theory of Penal Justice* (2009) p 72.

³² Compare the practice in the Middle Ages: W Woodburn Hyde, “The Prosecution and Punishment of Animals and Lifeless Things in the Middle Ages and Modern Times” (1916) 64(7) *University of Pennsylvania Law Review and American Law Register* 696. Compare also the practice in English law of imposing a fine on an inanimate object (deodand) which persisted into the nineteenth century.

³³ Horder writes persuasively that if an agent has this ability then it is fair to treat him or her as a person with “moral capacity”, in other words, to hold him or her responsible: J Horder, “Pleading Involuntary Lack of Capacity” (1993) 52(2) *Cambridge Law Journal* 298.

³⁴ N Lacey, “Psychologising Jekyll, Demonising Hyde: The Strange Case of Criminal Responsibility” (2010) 4 *Criminal Law and Philosophy* 109, 117. Different writers express these capacities in various ways: eg, Morse writes that “responsibility is based on minimal cognitive and volitional competence”: S J Morse, “Excusing the Crazy: The Insanity Defence Reconsidered” (1985) 58 *Southern California Law Review* 777, 783.

³⁵ A Brudner, *Punishment and Freedom: A Liberal Theory of Penal Justice* (2009) p 71.

A.41 A lack of capacity to control one's actions can account for non-responsibility where a person lacked self-control (discussed at paragraphs A.74 to A.88 below) but also where his or her actions are said to be "involuntary". Before examining the capacities of rationality and control in detail, we therefore look at what is often said to be a fundamental condition of responsibility: that the agent acted *voluntarily*.

LACK OF CAPACITY: INVOLUNTARY BEHAVIOUR

A.42 As in the rest of this Appendix, we are not seeking to develop a novel theory but to establish a working basis for the law which is sufficiently coherent. We remind ourselves that the central issue is where criminal responsibility should lie and where it should not. For example, a deliberate assault should entail criminal responsibility, but an "assault" committed by someone in the throes of an epileptic fit should not. The person who is hit hard on the head and is concussed should not be punished for pushing someone while still dazed, but ordinarily, pushing someone else is an act for which a person will fairly be held criminally responsible.

A.43 It is worth noting that behaviour which would otherwise be blameless will be regarded as sufficiently blameworthy to attract criminal liability if the accused culpably took the risk of that loss of capacity. For example if the accused crashed having fallen into a coma when driving, it will be fair to hold him or her responsible for the crash if he or she foresaw the risk of slipping into a coma and did not take avoiding action. Though the conduct which caused the harm was itself involuntary, there was some prior fault, and the person will still be found criminally responsible.

A.44 It is also worth noting that in offences where liability as to one or more elements of the offence is strict, mens rea is irrelevant as to that element, so "involuntariness" may be all that stands between the accused and a conviction. If an act (or omission) is involuntary then the consequent lack of responsibility is more fundamental than a lack of mens rea.

A.45 We can assert that *involuntary* acts or omissions should not lead to criminal responsibility, and we can give examples of such behaviour. We now need to identify what it is about the involuntary actions that preclude responsibility.

"Voluntary"

A.46 A standard explanation of criminal responsibility often starts with the idea that an act or omission must have been voluntary.³⁶ Some of the terms used in developing arguments from that starting point to explain when criminal responsibility is present or absent have a variety of meanings.

A.47 The term "voluntary" is open to misunderstanding. It might be used to describe conduct which is accompanied by a particular attitude, desire, intention or simple awareness, but whether conduct is "voluntary" in that sense will not always tell us

³⁶ As expounded by J Stephen, G E Moore, and J L Austin. For references see, eg, Mackay (1995) p 8, *Principles of Criminal Law* ch 4, W Wilson, *Central Issues in Criminal Theory* (2002) p 103.

whether it is conduct for which the agent is to be held responsible. There are some situations in criminal law where a defendant will be at risk of conviction even though the conduct was not voluntary in this sense. For example, the accused need not have acted voluntarily in this sense to be guilty of a strict liability offence.³⁷

- A.48 Again, “voluntary” may not be the opposite of “involuntary” when it is used to mean “willed”. Behaviour may be unthinking or automatic in the sense of habitual, without being involuntary in the sense that a sneeze is involuntary.

Lack of consciousness is not the issue

- A.49 Some have sought to argue that consciousness is the foundation of voluntariness, and thus of responsibility.³⁸ We reject this approach. If the agent is not conscious then movements will be involuntary, but lack of consciousness does not cover the whole ground of involuntary behaviour.³⁹ For example, the person who coughs as a reflex action is just as conscious as the person who coughs deliberately, but his or her reaction is involuntary.
- A.50 Furthermore, an explanation of voluntary behaviour in terms of consciousness has to take account of the important difference between being in a state of consciousness and being conscious *of* something (as in, aware of what one is doing). The two are connected, naturally, because whether a person is said to be conscious or not will be ascertained in part by whether he or she is aware of the surroundings and of his or her actions, but the concepts are not necessarily interchangeable. In fact, it is because there are degrees of consciousness that founding responsibility on consciousness or lack of consciousness will not be wholly satisfactory.⁴⁰

Authorship

- A.51 Ashworth has described the defence of automatism as a denial of authorship.⁴¹ Although in practice a clear distinction between an excuse and a denial of authorship cannot always be clearly drawn,⁴² there is an important feature of culpability at work in the idea of authorship. It establishes a connection between what happened and the person in such a way that the person is the subject of the action, not a person to whom something happened:

³⁷ Eg, where a defendant is convicted of driving without insurance, contrary to s 143(1)(a) of the Road Traffic Act 1988, there is no requirement for the act of driving without insurance to have been voluntary or even for the driver to be aware that he or she was uninsured.

³⁸ See para 5.2 above.

³⁹ S Yeo, “Putting Voluntariness Back into Automatism” (2001) 32 *Victoria University of Wellington Law Review* 387.

⁴⁰ See the comments in *Simester and Sullivan’s Criminal Law* cited at para 5.2 above.

⁴¹ *Principles of Criminal Law* p 87.

⁴² W Wilson, “Impaired Voluntariness: The Variable Standards” (2003) 6(2) *Buffalo Law Review* 1011,1029.

At its most basic to act voluntarily – to be an author of a criminal wrong – means that the relevant event can be attributed to something the individual has done rather than, say, to someone else or to a natural occurrence.⁴³

Voluntariness and “willed” actions

- A.52 As we have noted above, it is often written that a basic condition of criminal responsibility is that the agent must have acted voluntarily. This statement is vulnerable to misunderstanding. Where it serves to distinguish situations in which a person may be justifiably absolved from responsibility because the act was the result of reflex behaviour, then it is valid. However, if it is interpreted to mean that there must always be some willed act on the part of the agent, then that interpretation is mistaken. For example, many actions are “unwilled” in the sense that we are not thinking about them and not consciously aware of making them, but they are still our actions.
- A.53 More than one writer has noted that “judgments of moral responsibility are judgments about a *connection* between an agent and his action”.⁴⁴ Involuntary actions⁴⁵ may be conceived of as actions where the connection with the agent has been severed. Some have described this in terms of a mind/body distinction, but this line of thought is of limited use. A satisfactory explanation of how thought translates into action is not necessarily possible and, even if it were:

Although neuroscience may help to explain some of the mechanics of voluntary action, this in itself will do little to assist us in our quest for a satisfactory legal analysis of automatism. There are two obvious problems. The first is theoretical and concerns the fundamental difficulty that although neuroscience may be able to produce an adequate physiological account of a particular movement, this is not the same as providing “an explanation of that movement *as an action*”.⁴⁶

- A.54 Wilson highlights another fundamental difficulty with the idea that responsibility lies only in “willed” actions, which is that it does not quite capture the difference between being the agent of an action, and being the object of something that happens. For example, if person A pushes person B into C, B is not an agent and is not responsible. That remains the case irrespective of whether B was willing, hoping or wishing that C would come to some harm or even that A would push B into C. The reasons, motivations and desires for acting are irrelevant to an explanation of whether the agent was an agent.

⁴³ W Wilson, “Impaired Voluntariness: The Variable Standards” (2003) 6(2) *Buffalo Law Review* 1011,1012 to 1013.

⁴⁴ C Elliott, *The Rules of Insanity* (1996) p 123 (emphasis in original).

⁴⁵ Involuntary actions, such as blinking, may be distinguished from non-voluntary actions, where the agent’s will has collapsed and the action is dictated by someone else: J Horder, *Excusing Crime* (2004) p 85.

⁴⁶ Mackay (1995) p 27, referring to D Noble, “Biological Explanation and Intentional Behaviour” in K A Mohyeldin Said and others, *Modelling the Mind* (1990) p 98 (emphasis in original).

Hart's thesis

- A.55 Hart convincingly criticised the argument that voluntariness was at the root of responsibility.⁴⁷ He himself proposed that involuntary actions are “bodily movements [which] occurred though the agent had no reason for moving his body in that way”,⁴⁸ but his proposal has been subject to persuasive criticisms in turn. As Wilson writes, “a basic difficulty with Hart’s approach is that it implies that if the accused had such a reason then he would be unable to claim he was acting involuntarily *even though he was unable to prevent it happening*.”⁴⁹ Wilson then gives examples which undermine Hart’s idea. These include where moral responsibility is lacking even though the actor did exactly what he wanted to do, as in the footballer who fends off a ball about to strike his face (analogous to the driver who tries to brush bees away from his face). So whether or not the actor had a reason to do what he or she did will not necessarily tell us whether the actor is to be held responsible.

Is it about control?

- A.56 In the draft Criminal Code, a test based on lack of effective control was used as one of the indicators that the act in question was involuntary and therefore non-blameworthy.⁵⁰ Indeed, lack of total control by the accused over his or her behaviour can be discerned as the factor identified in some cases that makes the difference between behaviour for which the accused is held responsible (as in *Broome v Perkins*)⁵¹ or not held responsible (as in *Charlson*).⁵² Lack of control is another aspect of a lack of capacity, and it seems to us that this is key.
- A.57 This has been acknowledged before. Williams emphasised the uncontrollable nature of the behaviour: action is voluntary “[if] the person in question could have refrained from it if he had so willed: that is, he could have acted otherwise or kept still”.⁵³ An example, though not one given by Williams, would be the person with Tourette’s Syndrome, who has a tic which she cannot stop.
- A.58 In the draft Criminal Code the “governing principle” was taken to be:
- That a person is not guilty of an offence if, without relevant fault on his part, he cannot choose to act otherwise than as he does.⁵⁴
- A.59 And so we return to the principle that blame does not attach where the person “cannot choose to act otherwise”.

⁴⁷ H L A Hart, *Punishment and Responsibility* (1968) p 98 and following.

⁴⁸ H L A Hart, *Punishment and Responsibility* (1968) p 256.

⁴⁹ W Wilson, *Central Issues in Criminal Theory* (2002) p 112 (emphasis added).

⁵⁰ Law Com 177, para 11.3.

⁵¹ [1987] *Criminal Law Review* 271.

⁵² [1955] 1 WLR 317, 1 All ER 859. The judgment in *Charlson* was subsequently disapproved on another point: see para 2.67.

⁵³ G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 148.

⁵⁴ Law Com 177(2), para 11.3.

Conclusion: the lack of capacity to control

- A.60 We conclude that a person is not to be held criminally responsible for an act or omission where, for reasons beyond his or her control, he or she lacked the capacity to control his or her conduct. This echoes the conclusion reached by Husak: “persons are responsible and deserve punishment only for those states of affairs over which they exercise control”.⁵⁵ That lack of capacity may be due to being in a state of unconsciousness, but it may not be.⁵⁶ Wilson writes that involuntary actions which excuse the accused “encompass cases where the physical cause of a person’s behaviour is an event outside that person’s control ...”.⁵⁷

The connection between involuntary actions and a lack of capacity for self-control

- A.61 Wilson goes on to say that involuntary actions also excuse “where there is an interference with those mental processes which enable a person to identify and follow rules”.⁵⁸ By defining voluntariness of action “in terms of a person’s capacity to conform, it becomes clear how close a claim of automatism is to other excuses ... Literal involuntariness is simply the extreme case on this spectrum which incorporates also less direct claims of involuntariness such as duress, provocation, diminished responsibility and mistake.”⁵⁹ He writes also that:

Behaviour is involuntary where, under some description or other, the actor lacked the capacity to have acted otherwise either because of an absence of physical control or because of a failure of those cognitive and other processes which enable people to act systematically in accordance with rules.⁶⁰

- A.62 The concept of inability therefore provides a common thread between a defence of involuntary behaviour and a defence of mental disorder (in the current law, the defences of sane automatism and insanity respectively): that the agent could not have done otherwise. Wilson pinpoints this connection when he describes a spectrum of involuntary behaviour from the literally involuntary (as in the case of automatic behaviour) to the metaphorically involuntary (such as where a person

⁵⁵ D Husak, “Does Criminal Liability Require an Act?” 60, 75 in R A Duff (ed), *Philosophy and the Criminal Law* (1998).

⁵⁶ A P Simester, “On the So-called Requirement for Voluntary Action” (1998) 1 *Buffalo Criminal Law Review* 403, 416.

⁵⁷ W Wilson, “Impaired Voluntariness: The Variable Standards” (2003) 6(2) *Buffalo Law Review* 1011, 1027.

⁵⁸ W Wilson, “Impaired Voluntariness: The Variable Standards” (2003) 6(2) *Buffalo Law Review* 1011, 1027.

⁵⁹ W Wilson, “Impaired Voluntariness: The Variable Standards” (2003) 6(2) *Buffalo Law Review* 1011, 1034, citing K J M Smith and W Wilson, “Impaired Voluntariness and Criminal Responsibility” (1993) 13 *Oxford Journal of Legal Studies* 69.

⁶⁰ W Wilson, “Impaired Voluntariness: The Variable Standards” (2003) 6(2) *Buffalo Law Review* 1011, 1034 to 1035.

acts under duress).⁶¹ Kadish also questions whether the legal excuse of involuntariness is fairly limited to movements produced by external physical force and internal physiological reactions “or whether it should be extended to include conduct produced by psychological forces”.⁶²

LACK OF CAPACITY

A.63 Having explored how the concept of a “voluntary” act or “involuntary” behaviour relates to the understanding of responsibility, we return to the issues of the kinds of capacity which are relevant to criminal responsibility.

A.64 “Enforcing rules, in any rule-system, pre-supposes a basic ability to follow them”.⁶³ This simple statement by Wilson draws on the concept of the law as a collection of rules, and derives from that concept the rightfulness of punishment (only) where a person could follow the rules. Eminent writers distil from the ability to conform to the law two capacities: the capacity to be rational, and the ability to control oneself. For example, as Cane has written:

It is generally agreed that a minimum level of mental and physical capacity is a precondition of culpability. A person should not be blamed if they lacked basic understanding of the nature and significance of their conduct, or basic control over it, unless their lack of capacity was itself the result of culpable conduct on their part.⁶⁴

A.65 Tadros sums the position up like this:

There are two important components to capacity-responsibility in the criminal law. These are the capacity to be rational and the capacity for self-control. This is because these two capacities are fundamental to the capacity of the agent to restructure their behaviour in a way that has a sufficient degree of sensitivity to the wrongfulness of actions. Consequently, it is precisely insofar as insanity deprives the agent of these components that they ought to be given the insanity defence.⁶⁵

A.66 Hart refers to capacities “of understanding, reasoning and control of conduct: the ability to understand what conduct legal rules or morality require, to deliberate

⁶¹ W Wilson, *Central Issues in Criminal Theory* (2002) p 113 to 114. This kind of involuntariness is sometimes called “moral involuntariness”: see, eg, *Perka* [1984] 2 SCR 232.

⁶² S H Kadish, “Excusing Crime” (1987) 75(1) *California Law Review* 257, 266 to 267.

⁶³ W Wilson, *Central Issues in Criminal Theory* (2002) p 115.

⁶⁴ P Cane, *Responsibility in Law and Morality* (2002) p 65. Eg, Horder puts the question in terms of whether D has the capacity to make her conduct accord with her values: J Horder, “Criminal Law: Between Determinism, Liberalism and Criminal Justice” (1996) 49 *Current Legal Problems* 159, 172, and J Horder, *Excusing Crime* (2004).

⁶⁵ V Tadros, “Insanity and the Capacity for Criminal Responsibility” (2001) 5 *Edinburgh Law Review* 325, 347.

and reach decisions concerning these requirements, and to conform to decisions when made”⁶⁶.

- A.67 We now turn to the two components of an inability to conform to the law: rationality, and self-control. The second of these is the more controversial.

Lack of capacity: rationality

- A.68 “One is a moral agent only if one is a rational agent.”⁶⁷ We now need to explore what is meant by “rational” in this context. We accept that concepts of rationality are normative as well as descriptive,⁶⁸ but do not think they should be avoided for that reason. We acknowledge also that the idea of rationality must incorporate some notion of intelligibility,⁶⁹ but it cannot be expressed purely in terms of intelligibility or it becomes simply a matter of whether it can be understood by others.⁷⁰

- A.69 Fingarette and Hasse write that the insanity defence consists in asking whether the defendant was “incapable of rational conduct in regard to the criminal significance of the conduct”.⁷¹ Mackay’s preferred meaning of “irrational” in this context is “when an agent’s normal mental functioning is interfered with to such an extent that he no longer possesses his normal critical powers of practical reasoning”⁷² There is a useful emphasis in this formulation on “mental functioning” which can, we would say, encompass something more than a cognitive grasp of the world. One of the criticisms made of the M’Naghten test is that it depends on a compartmentalised view of the human mind, separating off reason from other aspects of what it is to be human, such as emotion.⁷³ The capacity to be rational needs to be understood as encompassing all that goes on in the mind, incorporating the interplay between the abilities to think, to believe and to experience feelings.

- A.70 Several writers emphasise the importance of a capacity for practical reasoning,⁷⁴ meaning a reasoning process which leads to and supports action. Gardner refers to “the incapacity to reason intelligibly through to action”,⁷⁵ and Schopp describes it as the “process by which the individual reasons from wants and beliefs about

⁶⁶ H L A Hart, *Punishment and Responsibility* (1968) p 227.

⁶⁷ M S Moore, *Law and Psychiatry* (1984) p 244.

⁶⁸ T Szasz, *Law, Liberty, and Psychiatry* (1963) p 127.

⁶⁹ “It is... a defining feature of mental disorder that it involves *non-rational*, or rationally unintelligible, patterns of thought, feelings, and motivation.” R A Duff, *Criminal Attempts* (1996) p 180 (emphasis in original). See also M S Moore, *Law and Psychiatry* (1984) pp 244 to 245.

⁷⁰ C Elliott, *The Rules of Insanity* (1996) p 118.

⁷¹ H Fingarette and A F Hasse, *Mental Disabilities and Criminal Responsibility* (1979) p 199. See also the other references given at Mackay (1995) p 75.

⁷² Mackay (1995) p 79.

⁷³ See para 4.8 above and para 4.51 in Part 4 of the Supplementary Material to the Scoping Paper.

⁷⁴ See M S Moore, *Law and Psychiatry* (1984) pp 48 to 49 and p 100 and R F Schopp, *Automatism, Insanity and the Psychology of Criminal Responsibility* (1991) pp 108 to 131.

the acts that will serve as means to fulfilling those wants to a conclusion that takes the form of a want or decision to perform those acts.”⁷⁶

A.71 Elliott gives this simple example of practical reasoning: “if I desire X and believe that action A will lead to X, then to A is rational, and not to A is irrational (assuming, of course, no other competing desires or beliefs that might interfere, and so on)”.⁷⁷

A.72 Duff thinks in terms of a person’s ability to respond. As Husak explains:

At the most general level, a person is a responsible agent if he possesses the capacities upon which participation in the range of responsibility-ascribing practices depends. The relevant capacities presupposed by any such practice involve responsiveness to reasons. Duff claims no special originality in this particular account of responsibility – an account that has been endorsed by a number of prominent contemporary philosophers. According to this conception, an agent is responsible if he has the capacity to recognize and respond to the various reasons that bear on his situation.⁷⁸

A.73 Duff writes that “rationality in this context involves more than purely intellectual capacities: a rational agent is one whose emotions and desires or other conative⁷⁹ dispositions, as well as her beliefs, are responsible (sic) to reasons.”⁸⁰ Responsibility follows from rationality where the individual is able to recognise and respond to reasons.

Lack of capacity: self-control (could not have acted otherwise if he had willed)

A.74 Hart clearly included in his concept of criminal responsibility a person’s lack of capacity to conform to a decision to act or not act, and it is to this aspect of capacity that we now turn. We have already established (in our discussion of involuntariness) that responsibility will not lie where a person could not have

⁷⁵ J Gardner, “The Gist of Excuses” in *Offences and Defences* (2007) p 132.

⁷⁶ R F Schopp, *Automatism, Insanity and the Psychology of Criminal Responsibility* (1991) p 188. Mackor writes, “The aim of practical reason is ... to answer the question ‘What should I do?’” A R Mackor, “What Can Neurosciences say about Responsibility?” 62 in N A Vincent (ed) *Neuroscience and Legal Responsibility* (2013). Other accounts of practical reasoning are possible, but we are not able to go into them here.

⁷⁷ C Elliott, *The Rules of Insanity* (1996) p 117.

⁷⁸ D Husak, “Answering Duff: R A Duff’s Answering for Crime” (2010) 29(1) *Law and Philosophy* 101, 105.

⁷⁹ Conation: “The power or act which directs or impels to effort of any kind, whether muscular or psychological”. Webster’s online dictionary <http://www.webster-dictionary.org/definition/Conation>.

⁸⁰ R A Duff, *Answering for Crime* (2007) p 39. This notion of the ability to respond to reasons, including moral reasons, forms part of the argument why children under a specified age should not be held criminally responsible: P Arenella, “Character, Choice and Moral Agency: The Relevance of Character to our Moral Culpability Judgments” in E F Paul and others (eds) *Crime, Culpability and Remedy* (1990) p 68.

controlled his or her physical actions: that action might be said to be involuntary or not really his or her action. These literal instances of inability to control one's actions are fairly obvious instances of non-responsibility. It is in cases where the reason for the inability to control physical actions lies in the person's mental or physical state that matters become more contentious. It is to this kind of inability to control one's actions that we turn now.

- A.75 The problem is sometimes referred to as that where an accused person should be excused because of "irresistible impulse". We think this is an unhelpful label because it gives the impression that whatever the accused did was done as impulsively in the sense of "on the spur of the moment". This may not be the case. It may not be that if only the accused had just paused to reflect he would not have done whatever he did. In fact, cases of compulsive behaviour might often be ones of action even though the agent has frequently reflected on the action and wished very much not to do it.
- A.76 The problem is also sometimes referred to as one of "volition". Again, we do not find that a very helpful term, partly because it is not a term in general use. We understand it to mean the general power that leads a person to act, or the will. This could also be expressed as the translation of a decision or choice into action. There may be, theoretically speaking, a distinction between a volition and the act of self-control. That is to say, it might mean something different to say that a person decides to refrain from a particular act, from saying that she exercises self-control, but we have some doubt about that.
- A.77 In any event, whether one describes this state as a case of "willing" an action, or choosing to do or not do something, it amounts to the same thing as exercising control over one's actions or inactions. We prefer therefore to put it in terms of control of one's physical actions. This provides the right point of focus because it is the conduct – usually the harmful conduct – which is the interest of the criminal law, rather than the mental act of willing or not willing.
- A.78 The relevant question for our purposes is whether there is anything in the idea that a person can (non-culpably) lack the capacity to control his or her physical actions.

It means only that the accused failed to resist a strong desire

- A.79 Some argue that the idea of lack of capacity to control oneself amounts merely to saying that the agent acted on the strongest motivation or desire:

For there to be an action, it must be possible to identify the desire that motivated it. When an agent acts, he always acts on his strongest desire. That means that his action is caused by his strongest desire. Consequently, the argument goes, there is no distinction to be made between irresistible impulse cases and ordinary cases of action: in both cases the agent merely acts on his strongest desire.⁸¹

⁸¹ V Tadros, *Criminal Responsibility* (2005) p 340. Tadros is here merely expressing an argument put by others, not necessarily agreeing with it. We agree with Tadros that impulse and desire are equivalent for these purposes (see Tadros p 342).

- A.80 It is not, however, always the case that a person acts in response to his or her strongest desire, unless the strongest desire is defined in a circular way as the one which constitutes the motivation for the action. McAuley gives a persuasive example of the person who compulsively washes her hands, not because it is what she most wishes to do, but even though she does not wish to do it.⁸² (We do not think it is an answer to his example to say that she must “really” want to wash her hands.) Other examples would be of the compulsive hoarder, who acquires and keeps things to the point where it interferes with his or her ability to live the life he or she would choose, or a person who compulsively and repeatedly harms him or herself.
- A.81 Slobogin answers that “the subjectively experienced urges of a person with mental illness are not provably greater than the urges of people we would never think of excusing.”⁸³ Morse and Hoffman would add, “why should we ever excuse someone who acts wrongly in response to a very strong desire, whether that desire is normal or abnormal?”⁸⁴ Morse and Hoffman’s argument does not truly reflect the compulsive element of some mental disorders and it seems to confuse desire with the ability to choose not to do something.
- A.82 As Wilson has argued, there is a significant difference in culpability between those who fail to resist an impulse upon which they desire to act, and those whose condition caused them to fail to resist an impulse “upon which they desired not to act”.⁸⁵

The concept is actually another aspect of a lack of rationality

- A.83 McAuley writes that in many cases which are put forward as instances of a person who could not help doing what they did, an accurate analysis would show that the person could help it but his or her thinking was disordered as a result of psychosis or addiction.⁸⁶
- A.84 Morse and Hoffman go further and argue that the inability-to-control test adds nothing: “If the person is having difficulty conforming to law because he is irrational, then irrationality is doing the potentially excusing work and there is no

⁸² McAuley p 50. He describes such cases as ones “where a person’s beliefs and desires all support one course of action and yet the person persistently does another...”. A different way of looking at this is to say that the desire to wash one’s hands is a first-order desire and the other a second-order desire, and a person acts freely when he or she is able to choose whether to act on the first-order desire: H Frankfurt, “Freedom of the Will and the Concept of a Person” (1982) in G Watson (ed) *Free Will* (1982).

⁸³ C Slobogin, “The Integrationist Alternative to the Insanity Defense” (2003) 30 *American Journal of Criminal Law* 315, 322.

⁸⁴ S J Morse and M B Hoffman, “The Uneasy Entente between Insanity and Mens Rea: Beyond *Clark v Arizona*” (2007) *Scholarship at Penn Law*, Paper 143, p 30.

⁸⁵ W Wilson, *Criminal Law Doctrine and Theory* (4th ed 2011) p 208.

⁸⁶ McAuley pp 46 to 52.

need for a separate control test”.⁸⁷ Kadish has also argued that “the proper ground of excuse” in such cases is the irrationality of the behaviour.⁸⁸ There is, we believe, some force in this argument, in part because irrationality is used as the measure of disordered behaviour.

- A.85 A man who says the devil implants in him a desire to kill and it is a desire that must be acted on for the devil to go away is, we suggest, a person who can be said not to understand what he is doing or to be out of touch with reality to the point where he should not be held criminally responsible. This conclusion can be reached without resorting to any statement about whether he can control himself.⁸⁹ McAuley gives an example to similar effect of the depressed man who kills his family “because of a pathological belief that it was necessary to do so in order to save them from penury”.⁹⁰ Again, this is a person whom it might well not be fair to hold responsible, but that is because of the delusional belief arising out of his mental illness, not because he could not stop himself.
- A.86 But we do not agree that it is always the case that irrational thinking and beliefs are all that lie behind a lack of control. In the examples of compulsive behaviour above, there may be no consciously-held irrational belief. The compulsive hoarder may well recognise that he does not “need” all the things that fill up the floors in his home, but that recognition will not in itself release him from the compulsive hoarding.

Conclusion

- A.87 It is not illogical to allow for the possibility that a person cannot, because of mental disorder, control his or her behaviour. If a person cannot choose between right and wrong or, though knowing the difference, has no power to act on that knowledge, then it is not fair to hold that person criminally responsible. As Justice Somerville, a judge of the Supreme Court of Alabama, stated in 1886:

If therefore, it be true, as a matter of fact, that the disease of insanity can ...so affect the mind as to subvert the freedom of the will, and thereby destroy the power of the victim to choose between right and wrong, although he perceived it – by which we mean the power of volition to adhere in action to the right and abstain from wrong – is such a one criminally responsible for an act done under the influence of such a controlling disease? We clearly think not.⁹¹

⁸⁷ S J Morse and M B Hoffman, “The Uneasy Entente between Insanity and Mens Rea: Beyond *Clark v Arizona*” (2007) *Scholarship at Penn Law*, Paper 143, p 28. This argument has also been deployed by the American Psychiatric Association – see Mackay (1995) p 116 – and by C Slobogin, “The Integrationist Alternative to the Insanity Defense” (2003) 30 *American Journal of Criminal Law* 315, 320.

⁸⁸ S H Kadish, “Excusing Crime” (1987) 75(1) *California Law Review* 257, 283.

⁸⁹ See the example in Law Com 304, para 5.121.

⁹⁰ McAuley pp 48 to 49.

⁹¹ *Parsons v State* (1886) 81 Ala 577, 2 So 854. Somerville J’s opinion in *Parsons* is “widely recognized as a landmark decision”: R B Propst, “The *Parsons* Criminal Insanity Test in the light of the *Durham* Rule” (1957) 10(1) *Alabama Law Review* 118, 121.

- A.88 If, therefore, mental disorders which do impede self-control can be identified with confidence, then there is an argument that a reformed defence could and should cater for such situations. Whether such a defence would be workable in criminal trials is the issue we address in chapter 4.

THE EFFECT OF A PRIOR CULPABLE ACT OR OMISSION

- A.89 We have concluded that the fundamental justification for not holding a person culpable in criminal law is that it is unfair to punish someone if he or she lacked the capacity to conform to the law. This principle applies to a “defence” founded on “involuntary” behaviour – where the individual literally lacks the ability to control his or her actions. It also applies to a defence founded on mental or physical disorders which result in the person lacking the capacity for practical reasoning or ability to make his or her acts conform to what he or she has decided to do.
- A.90 There is an important caveat. If the lack of capacity results directly from a culpable choice by that individual made at a time when he or she did not lack capacity, then it is fair to hold him or her responsible for his or her acts or omissions even if the individual lacked the capacity to conform to the law at that later time.⁹² This principle was recognised by the authors of the draft Criminal Code who explained the governing principle expressly stating that a person is absolved from responsibility if he cannot choose to act otherwise than as he does “without relevant fault”.⁹³
- A.91 To take practical examples from case law: if D induces hallucinations by knowingly taking a hallucinogenic substance, then it is no injustice to hold him responsible for what he does while under the influence of the hallucinogen.⁹⁴
- A.92 Another example of a person at fault for the lack of capacity would be the person who suffers from diabetes and becomes aware that he or she is in imminent danger of going into a hypoglycaemic state. If he or she then decides to drive despite that risk, most people would have no difficulty in holding that person criminally responsible for any offence if a hypoglycaemic episode did then happen while he or she was driving.⁹⁵

WHAT IF A PERSON WILL ALWAYS LACK CRIMINAL CAPACITY?

- A.93 The view is proposed by a number of writers that there are some people who cannot live an autonomous life to a minimal degree and they should be simply

⁹² It has been argued that the true focus of responsibility is the earlier, culpable, act, and the offence charged should reflect that: P H Robinson, “Causing the Condition of One’s Own Defense” (1985) 71 *Virginia Law Review* 1.

⁹³ Law Com 177, para 11.3.

⁹⁴ *Lipman* [1970] 1 QB 152.

⁹⁵ *Marison* [1997] RTR 457.

exempt from criminal responsibility.⁹⁶ Such people, it is argued, should be recognised as lacking the capacity to be morally responsible.⁹⁷

- A.94 We do not accept these arguments, for a number of reasons. For one thing, it would be difficult to say which people should be in this category of people who could not be held responsible for their acts. Treating all mental illnesses, even all serious mental illness, as excusing responsibility at all times is questionable. Many people with mental illness are not “globally incompetent” in this way.⁹⁸ Mental illness varies in its impact not just from one person to another, but in its impact on a single person across different situations and across time. People may move in and out of a category of mental illness; it would be wrong to regard the group as fixed. Insanity as a status gives it permanency, which, some argue, is inappropriate because a person may suffer from mental illness, even severe mental illness, and yet behave rationally.⁹⁹
- A.95 Secondly, to treat one set of people as lying outside the scope of criminal responsibility, and labelled as such on a permanent basis would be counter to the “inclusive” principle. That is the principle that all individuals should be treated as full members of society with equal rights and responsibilities, and reasonable adjustments should be made to accommodate those with disabilities in society.
- A.96 In addition, a person who could not be held responsible at the time of the alleged offence may subsequently be fairly held to account. For example, those who treat people in secure hospitals may see the assumption of responsibility by patients for their actions as an important element of their treatment.¹⁰⁰ It might be assumed that all deterrent effect is lost on those who are compulsorily detained in a hospital, but this is not necessarily the case. Some of those detained may be deterred by knowledge that prosecution could lead to a conviction – making rehabilitation on release more difficult – and to punishment in the form of a fine.
- A.97 If there is a blanket immunity which applies once a person has received a particular diagnosis,¹⁰¹ the person would have carte blanche to offend. He or she could assault staff and patients in a secure hospital with impunity. The victim of

⁹⁶ V Tadros, *Criminal Responsibility* (2005) ch 5 and p 322. See Moore’s conclusion: that “responsibility can only be ascribed to an individual who has both the capacity and the opportunity to exercise the practical reasoning that is distinctive of his personhood”. M S Moore, “Causation and the Excuses” (1985) 73(4) *California Law Review* 1091, 1149.

⁹⁷ H Howard, “The Confinement of Personality Disordered Individuals: Questions of Justice and Safety” (2001) 65(2) *Journal of Criminal Law* 161. She has also written that “certain severely and permanently mentally ill individuals, who are not eligible to be considered moral agents, ought to be given a blanket exemption from prosecution” rather than a status defence: “Reform of the Insanity Defence: Theoretical Issues” (2003) 67(1) *Journal of Criminal Law* 51.

⁹⁸ “... mental distress is individual ... fluctuating ... [and] may be irrelevant.” MIND, *Achieving Justice for Victims and Witnesses with Mental Distress: A Mental Health Toolkit for Prosecutors and Advocates* (2010) p 15. On the meaning of “mental distress” see the glossary.

⁹⁹ Mackay (1995) p 77.

¹⁰⁰ This point was made to us by Dr Kevin Murray, Clinical Director of Broadmoor Hospital.

¹⁰¹ D Carson, “Prosecuting People with Mental Handicaps” [1989] *Criminal Law Review* 87, 94.

such an assault might justifiably claim that his or her ECHR rights had been violated.¹⁰²

- A.98 Further, it is difficult to establish exactly when a particular individual has gained this status: “it is difficult to understand therefore how such an approach towards insanity could operate in practice, and what procedural device might be used to establish the status.”¹⁰³
- A.99 Even if it can be said of a particular person or group of people that, due to their physical and/or mental condition, they can never be held criminally responsible for what they do, it does not follow that it is a good idea to create an exempt category.
- A.100 We accept that just because some, or even most, people would move in and out of a category might not mean it should not exist; there could be some who would always fall into this category, perhaps by reason of severe physical disability or learning disability. But even if there is an identifiable group of people who are so affected that it would never be fair to hold them criminally responsible for any criminal conduct, it does not follow that there *has* to be a legal category of people who are exempted, and we see no advantage in creating one.¹⁰⁴

The need for a causal link between the disorder and the behaviour

- A.101 The Butler Committee suggested that a verdict of not guilty on evidence of mental disorder ought to be available simply if the accused was suffering from severe mental illness or severe mental handicap at the time. The Committee did not recommend the need for the prosecution to show a causal link between the disorder and the commission of the act. This proposal was controversial: people thought that, even if a person was suffering from a severe mental illness, if it had not influenced the commission of the crime, then he or she should be treated like any other defendant in the trial process. The Law Commission agreed with this objection in its Code Report.¹⁰⁵ We still hold this view.

Conclusion

- A.102 We conclude that there should be no passport to exemption. In other words, no category of people who are as a matter of law always exempt from prosecution on the grounds of their condition, and that the defence should be framed with reference to some kind of link between the accused’s condition and the resultant lack of capacity.

¹⁰² See paras 5.61 and 5.62 in Part 5 of the supplementary material to the Scoping Paper in relation to art 2 of the ECHR.

¹⁰³ Mackay (1995) p 82.

¹⁰⁴ Our rejection of the status approach in the criminal field is consistent with our rejection of it in the civil sphere: “The status approach is quite out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have capacity to take.” *Mental Incapacity* (1995) Law Com No 231, para 3.3.

¹⁰⁵ Law Com 177, para 11.16. The Law Reform Commission of Western Australia also thought the Butler approach was wrong on this point: *The Criminal Process and Persons Suffering from Mental Disorder* (1991) para 2.9. To put it another way, the test should be a functional one which relates to the accused’s ability at the time, not a status test.

LEGAL CLASSIFICATION OF THE “DEFENCE” OF INSANITY

A.103 As we have discussed, a “defence” of insanity exempts a person from liability on the ground that he or she is not even responsible in a fundamental sense. Theoretical writers about the criminal law classify defences as exemptions, justifications, or excuses:

Exemptions operate where the defendant is not the kind of agent to be held responsible for his actions in general. Justifications operate where the defendant acts in a way that the law regards as morally permissible. Excuses operate where a capable defendant ought not to be held criminally responsible despite having acted in an impermissible way.¹⁰⁶

A.104 A justification “shows that an act that is morally wrongful in most instances is not wrongful in particular (justifying) circumstances. In contrast, an excuse does not create an entitlement to act in a certain way because it does not make the act any less wrongful. Instead, an excuse shows that the actor was not as culpable as others typically performing the same wrongful act.”¹⁰⁷ Or, more briefly, justifications negate wrongdoing, while excuses negate blame.¹⁰⁸

A.105 The various ways of ranking justifications and excuses are controversial and the merits of any one approach do not matter for our purposes. We are not concerned with justifications, nor with whether insanity is an excuse or a justification. What we are trying to explain here is that insanity and automatism constitute denials of responsibility and are neither excuses nor justifications.

A.106 Insanity and automatism are obviously not justifications, and we do not discuss justifications further. A defendant whose defence amounts to an “excuse” is one who puts forward reasons which exculpate a responsible person, as compared with the non-responsible person:

¹⁰⁶ V Tadros, *Criminal Responsibility* (2005) p 117.

¹⁰⁷ M S Moore, “Causation and the Excuses” (1985) 73(4) *California Law Review* 1091, 1096 relying on G Fletcher, *Rethinking Criminal Law* (1978) p 759. If the defence of insanity is not an excuse, then there is an important consequence in terms of what needs to be proved, as Mackay points out: “if [the defence of insanity] acts as an excuse, then [it] should only become relevant once it has been established that the accused’s act was wrongful ... On the other hand, if insanity is in the nature of a status, then the whole notion of defence becomes irrelevant, since instead the fundamental nature of the plea is that the prosecution process and criminal jurisdiction of the court are inappropriate to deal with this class of defendant.” Mackay (1995) p 81. See also G Fletcher, *Rethinking Criminal Law* (1978) p 836.

¹⁰⁸ W Wilson, *Central Issues in Criminal Theory* (2002) p 283. S H Kadish put it thus: a justification is a claim that “I did nothing wrong even though I violated the prohibition” whereas an excuse is a claim that “some disability in my freedom to choose the right makes it inappropriate to punish me”: S H Kadish, “Excusing Crime” (1987) 75(1) *California Law Review* 257, 258.

“Reasonable” and “unreasonable”, like “rational” and “irrational”, appraise the thoughts and actions of those who are operating within the realm of reason; but if a person is so disordered that he is not operating within that realm at all, he should be described as “a-rational” or “a-reasonable” rather than as irrational or unreasonable.¹⁰⁹

- A.107 Duff argues that a person must be responsible for the act as a pre-condition of being criminally liable. A defence of insanity is not a true “defence” because it denies responsibility in the first place. It is, therefore, an exemption rather than an excuse. This is Husak’s summary of Duff’s argument:

Because Duff contends that a plea of justification or excuse concedes responsibility – that the defendant has committed a presumptive wrong for which he must answer or face the imposition of liability – it is clear that some pleas universally recognized as excuses in textbooks in the United States do not qualify as genuine defenses. In particular, pleas of insanity or infancy contest rather than concede responsibility. Thus they should not be categorized as defenses at all. Instead, these pleas should be described as *exemptions*; they are unlike what are properly called defenses in that they allege the absence of responsibility because of the lack of capacity to respond to reasons. Surely Duff is correct to point out the structural differences between a paradigm case of excuse like (unjustified) duress and a plea of insanity. The question of whether this structural difference suffices to show that such pleas should not be regarded as excuses (or, indeed, as defenses of any kind) is one of the main terminological divides between theorists on each side of the Atlantic.¹¹⁰

- A.108 The defence of insanity has traditionally been classified as an excuse,¹¹¹ but it does not seem to us that this classification is satisfactory. What excuses and justifications have in common is, as Gardner points out, that “excuses and justifications are putative rational explanations of the wrong or mistake, and rational explanation is explanation in terms of the reasons that the agent had, and acted on ...”.¹¹² Insanity, however, is “an excuse that denies responsibility.”¹¹³ It makes more sense to describe someone who may rely on the insanity defence as exempt, following Duff:

¹⁰⁹ R A Duff, *Answering for Crime* (2007) p 289.

¹¹⁰ D Husak, “Answering Duff: R A Duff’s Answering for Crime” (2010) 29(1) *Law and Philosophy* 101, 111 to 112 (emphasis in original).

¹¹¹ Tadros writes, “it is relatively common to argue that, because there are cases of mental disorder which ought to ground a defence, but which do not undermine the status of the accused in total, mental disorder defences ought to be categorised as excuses rather than exemptions”: V Tadros, *Criminal Responsibility* (2005) p 127 citing Mackay (1995) pp 81 to 90 and Scot Law Com 195.

¹¹² J Gardner, “The Mark of Responsibility” (2003) 23(2) *Oxford Journal of Legal Studies* 157,161.

¹¹³ R A Duff, *Answering for Crime* (2007) p 285. See also “only those who are responsible in the basic sense can offer excuses”: J Gardner, “The Mark of Responsibility” (2003) 23(2) *Oxford Journal of Legal Studies* 157,161.

Someone who offers an excuse admits responsibility, but seeks to block the transition from responsibility to liability by explaining her action and her reasons for action in a way that, without showing it to have been right or permissible (for that would amount to a justification), shows that it did not display a kind of fault that merits blame or a criminal conviction By contrast, an exemption exempts the person from having to answer for her conduct altogether.¹¹⁴

A.109 Duff says we should “classify some of what have traditionally been called ‘excuses’ as ‘exemptions’”,¹¹⁵ and if he is including insanity in that group, we agree. A person who is so mentally disordered as not to be responsible for his or her conduct is, as a matter of analysis, exempt from responsibility (and therefore from liability also).¹¹⁶ We would extend this to anyone who lacks the relevant capacity whether as a result of mental disorder or physical disorder, so long as the person had not culpably caused his or her loss of capacity.

A.110 It does not, however, follow that such a person might never be held responsible for his or her actions – there is no entitlement to a *general* exemption as a result of his or her status as a mentally-disordered or physically ill person. Rather, the exemption operates as regards the individual’s state at the time of the act.

Conclusion

A.111 If, at the time of the offence, a person lacked the relevant capacities, without culpable fault, then he or she is denying responsibility in a fundamental sense. The defendant may defend himself or herself against the charge by pleading his lack of capacity due to some physical or mental illness, but it is not a defence in the sense of an excuse (still less in the sense of a justification).

A.112 The defence is not merely a denial of mens rea but a denial of having been accountable at the time. It is not, however, a continuing or permanent status: it relates to the accused’s mental state at the time of the alleged offence. It is neither a general exemption nor a statement about the accused’s capacities generally.

A.113 Strictly speaking, it follows that we should not call the insanity defence a “defence” at all. While such an approach would be theoretically correct, in our view it would seem odd to practitioners, who are very used to thinking in terms of “the insanity defence”, and so we continue to use the phrase in this paper.¹¹⁷

¹¹⁴ R A Duff, “Psychopathy and Answerability” in L Malatesti and J McMillan (eds), *Responsibility and Psychopathy* (2010) p 201.

¹¹⁵ R A Duff, *Answering for Crime* (2007) p 266. See also J Horder, “Criminal Law: Between Determinism, Liberalism and Criminal Justice” (1996) 49(1) *Current Legal Problems* 159, 166 to 168.

¹¹⁶ As we go on to say, we do not see any reason for distinguishing between physical and mental disorder in the basis for a lack of capacity defence.

¹¹⁷ When it comes to proposing a reformed insanity defence, however, our conceptualisation of it as a prior denial of responsibility means that we see it as a plea to be made at the early stage of proceedings, not a defence to be raised after the prosecution case has been made out.

Legal classification of the “defence” of automatism

- A.114 The defence of automatism may be analysed in terms of a denial of the actus reus, as has traditionally been done in this jurisdiction, or in terms of denial of mens rea, as happens in other jurisdictions.¹¹⁸ We think that, as with the insanity defence, it is more accurately understood as a denial of *responsibility* for the conduct.
- A.115 Where a person is claiming automatism because the action was beyond his or her control, he or she is denying responsibility on a fundamental level, saying in some sense that the act was “not his”. The defendant is not denying a particular mental state, and the defence is not a denial of mens rea, (though it entails a denial of mens rea where mens rea is an element of the offence) because you cannot be said to intend actions if your mind is so disconnected from your body that they are hardly “your” actions at all.
- A.116 Like the “defence” of insanity, in our view, the defence of automatism/involuntariness is not strictly speaking a defence at all. We shall nevertheless refer to it as such in this paper, for convenience.

CRIMINAL RESPONSIBILITY: CONCLUSION

- A.117 In order to be criminally responsible, a person must be, at the time of the act, accountable. That means that he or she must be an agent, and have some basic concept of him or herself as an agent. It also means he or she must have had the capacity to conform to the law. A person might lack that capacity by being incapable of practical reasoning, and/or by being incapable of controlling his or her actions. Where there is such a complete breakdown of the normal human capacities of rationality and self-control, for reasons which are not the accused’s fault, then the accused should not be held criminally responsible for what he or she is alleged to have done.

¹¹⁸ See paras 5.5 to 5.8 above.

APPENDIX B

ANALYSIS OF RESPONSES TO INSANITY AND AUTOMATISM SCOPING PAPER

NUMBER OF RESPONSES

- B.1 Twenty written responses were received and one telephone response. Most of these were sent on behalf of an organisation or represented the views of many people. Such responses were sent by:

the Criminal Cases Review Commission (CCRC),

the Justices' Clerks' Society (JCS),

the Crown Prosecution Service (CPS),

Mr Justice Holroyde on behalf of the judiciary,

the Magistrates' Association,

the London Criminal Courts Solicitors' Association (LCCSA),

the Criminal Bar Association (CBA),

NHS Protect,

the Yorkshire Centre for Forensic Psychiatry,

the Royal College of Psychiatrists (RCP), and

the CECJS Northumbria group (School of Law, Centre for Evidence and Criminal Justice Studies, Northumbria University). This last response was drafted following a two hour seminar run by the Centre for the purpose of discussing the Scoping Paper, which was attended by over 40 practitioners. Those present at the seminar included: members of the judiciary (Circuit Judges, Recorders and a District Judge); practising barristers and solicitors (including members of the Crown Prosecution Service); consultant psychiatrists; and academics in law and other disciplines.

- B.2 Individual responses were received from TV Edwards (solicitors), Joy Merriam (solicitor), three mental health practitioners (Dr James Reed, Dr Neil Boast (consultant forensic psychiatrist and clinical director) and one unnamed), Nicky Padfield (academic and Recorder), Professor Ronnie Mackay, HHJ Paul Thomas QC (who prosecuted in the sleepwalking case of *Thomas*¹ and Lord Justice Davis (who presided over the case of *Thomas*).
- B.3 In addition, there was feedback from a meeting with the Criminal Law Committee of the Law Society, and from a seminar with North London Forensic Psychiatrists.

¹ Nov 2009 (unreported).

B.4 There were two confidential responses.

NATURE OF RESPONSES

B.5 Many of the questions asked for examples and experience, and these were provided by consultees. They have not usually been summarised in this document, as the detail is often necessary.

B.6 As regards data, little further data was forthcoming. We were referred to a table as to diagnoses of those found not guilty by reason of insanity (in research of which we were aware), the CECJS Northumbria group provided some data (see below) and we were provided with data on assaults against NHS staff (see below).

CONSULTEES' MAIN POINTS

- (1) Fitness to plead is the bigger issue.
- (2) The insanity and automatism defences are so outmoded, inappropriate and complicated that they are seen as irrelevant. Practitioners work round them. The law can be an impediment to justice, and this is frustrating.
- (3) While a defence should not depend on a distinction between physical and mental disorders, the internal/external demarcation between insane and non-insane automatism is a real problem, particularly in cases of sleep disorders² and post-traumatic stress disorder ("PTSD"). The distinction is, in the words of Lord Justice Davis, "illogical, little short of a disgrace and should be abolished".
- (4) The lack of a definition of automatism that fits with medical/psychiatric concepts is problematic. Psychiatrists also find the need for a *total* loss of conscious awareness of actions causes difficulty, whereas in law the total loss of control is a significant borderline. As the RCP put it, "the law requires definite, unequivocal answers that psychiatry is often unable to provide".
- (5) The defences are only a part of the picture, and not necessarily the most important part. They should be appropriate (with an appropriate label; simple enough to understand; fit with modern medical understanding) but they need to sit well with the whole criminal justice system. The fit between the criminal justice system and the services available to mentally disordered and substance-abusing offenders needs to be suitable. Proper treatment reduces the risk of harm, both to the individual and to the public. Resources are key. There also needs to be coherence with other initiatives in the criminal justice system (so that, for example, the initiative to speed up cases does not work against the need to procure expert medical reports, which takes time).

² The BBC reported on 28 Nov 2012 that sleep disorder clinics are getting up to 50 new referrals a week: <http://www.bbc.co.uk/news/magazine-20340562> (last visited 24 May 2013).

- (6) Diversion, at least pre-court, is not generally related to whether a defence of insanity or automatism is likely to be available. Cautions require an admission of guilt, which may not be suitable for a person with a mental disorder.
- (7) The Court Liaison and Diversion scheme can be beneficial.
- (8) Legal and medical practitioners, and the accused, have the eventual outcome very much in mind. Thus, if a hospital order is thought to be appropriate and is going to be secured, then they may not worry about whether that is via a guilty plea or a not guilty by reason of insanity (“NGRI”) plea, especially if the accused has a criminal record. Similarly, if the accused is being treated for his or her condition, the CPS may drop the case if a prosecution is not perceived as being in the public interest.
- (9) The label “insanity” is seen as stigmatising by some. The label is also clearly inaccurate in that disorders which are not mental disorders within the meaning of the 1983 Act (such as epilepsy, diabetes and sleep-walking) fall within the defence of insanity. The label is also problematic in that it sometimes deters legal practitioners from discussing the possibility of a NGRI plea with their clients.
- (10) The law in this area is particularly defective as regards offenders under 18, with potentially damaging results for the public as well as the young person. The issue of effective participation is being raised in the youth courts more frequently and the available disposals are not necessarily suitable.
- (11) How assaults on hospital staff are dealt with is a concern.
- (12) Some respondents were concerned that there is inadequate public protection in cases where the disorder is not of a kind which requires psychiatric treatment. The CPS made suggestions for use of other existing powers.
- (13) There was perceived to be a gap between absolute discharge and hospital order which the supervision order is unsuitable to fill. Supervision orders are not favoured because there is no possible sanction for breach; there is support for something more akin to Community Treatment Orders (where steps can be taken if the order is not complied with).
- (14) Disposals are not suitable for youth offenders.
- (15) Scaleable disposals (disposals which bear relation to the potential harm) would help.

B.7 Some respondents (Nicky Padfield, NHS Protect and the CECJS Northumbria group) put in pleas for more research, and the CBA recommended that no proposed changes should be undertaken until a significant amount of data is obtained.

INSANITY

1. Can consultees provide information about:

(a) the numbers of people with mental disorder who are arrested on suspicion of criminal charges?

(b) the numbers of people with mental disorder whose mental disorder led to them being diverted from the criminal justice system rather than charged and prosecuted?

(c) the number of those with mental disorder who are charged with criminal offences?

(d) how the current definitions of insanity and automatism defences influence these figures?

B.8 Most of the responses to this question were to the effect that no data could be provided. Only those responses which give some kind of positive information are included here.

B.9 Dr James Reed:

(a) I cannot give any specific numbers. However as mental disorder in a broad sense is very common in the population (eg schizophrenia has a population prevalence of around 1%) then it is likely that the numbers are large. However, just because a mental disorder is present does not necessarily have any bearing on their offending.

(b) Again I cannot give numbers, but there are likely to be a large number of these. However, often it is not necessarily a formal process of diversion but that the CPS see it as not in the public interest to bring charges. A common example would be someone charged with a minor offence who is identified as mentally ill in the police station and admitted to hospital. Commonly no charges are then brought because it is not seen to be in the public interest. In the case of more serious offences (eg assaults on hospital staff) this is very unhelpful.

(d) I do not believe that they have any real influence. These defences are little understood, and decisions to admit to hospital from a police station are likely to be based entirely on a clinical assessment and the Mental Health Act criteria rather than with reference to a possible defence. The vast majority of those with mental disorder who are prosecuted will not end up relying on either of these defences in my experience.

B.10 The CECJS Northumbria group wrote:

The consensus amongst our members was that empirical research would be required and should indeed be encouraged in order to properly answer the above questions. A limited amount of empirical data is available from the Northumbria and Teesside area as a result of on-going projects aimed at diverting those with mental health problems from the criminal justice system (including the Big Diversion

Project North East, which was set up by the North East Offender Health Commissioning Unit (NEOHCU) and which began on the 9th December 2010). Contractors for the Department of Health are currently carrying out an audit of diversion schemes across the country. Our members suggested that the Law Commission should contact the Department of Health for further information.

The available data at present suggests that those with mental disorders make up 14/15% of the total caseload of Newcastle Crown Court. Current statistics from the last quarter show that, of that number, 23% have serious mental disorders and are dealt with by acute mental illness specialists; the other 77% are dealt with by the Court following thorough assessment by the mental health team and then follow up by nursing staff and/or secondary services. Despite the number of those with serious mental disorders being dealt with by the court, anecdotal evidence suggests that those who could meet the criteria necessary for a successful plea of insanity are rare. Thus far under the scheme only two people would potentially have satisfied the M’Naghten criteria but both individuals were “sectioned” from court under the Mental Health Act 1983. A far greater proportion of those with mental disorders are identified as potentially being unfit to plead (there are currently 35 cases before Newcastle Crown Court that have been identified as raising fitness to plead issues).

2. In practice, how does the possibility that the accused will plead insanity or automatism play a part in decisions about which cases should proceed to trial?

- B.11 In theory, the Code for Crown Prosecutors answers this question, but in practice, information at charge is often inadequate and incomplete. It was also pointed out that while there is guidance of various kinds, the Code is the only statutorily applicable guidance.
- B.12 Charging decisions are focused more on the likely eventual outcome, and how that reflects on the public interest criterion in the Code.

3. In practice, is the defence of insanity commonly pleaded in the magistrates’ courts?

- B.13 No. Cases where it might be raised either go out (are diverted out of the criminal justice system) or up (are sent to the Crown Court).
- B.14 An observation by a medical practitioner that “[cases] where an insanity plea etc may be used are beyond the experience of most magistrates and they are likely to seek if possible for them to be dealt with by an experienced judge in a Crown Court” is supported by the comment from the Magistrates’ Association that “[they] think the case is likely to be serious if the CPS is pursuing a prosecution at all once they have been made aware of the issues, therefore with the complication of a plea of insanity, magistrates are highly likely to decline jurisdiction”. Judges

also, of course, may not have experience of the insanity defence because it arises infrequently in the Crown Court also.³

- B.15 There may also be the underlying reason of practitioner ignorance: “In our experience when lecturing solicitors on representing mentally disordered offenders in the Magistrates Court and Crown Court, the majority of them do not know that insanity can be pleaded in the Magistrates Court.” (TV Edwards).

4. Can consultees provide examples of the use of the defence of insanity in the magistrates’ court?

- B.16 Examples provided include charges of assault, including one where the individual was believed to be about to harm himself with a knife and then turned it towards the officers, of a defendant charged with motor vehicle interference, criminal damage and burglary of a dwelling who entered not guilty pleas in the magistrates’ court.

5. Does the inability of the magistrates’ court to return a special verdict with relevant disposal powers (supervision orders and hospital orders) create difficulties in practice?

- B.17 No, but “supervision orders are not really understood in practice and are of little benefit in treating a mentally disordered offender, as compared to a hospital order (which might lead to a community treatment order)” (Dr James Reed).⁴

6. How frequently is automatism pleaded in the magistrates’ court? How often is it successful?

- B.18 It is rarely pleaded. It may be successful. Members of the Criminal Law Committee of the Law Society thought the automatism defence is little understood in the magistrates’ courts, especially the internal/external factor distinction. It is still seen as a “quagmire” (a reference to the description of this area of the criminal law by Lord Justice Lawton in *Quick*).⁵

7. Can consultees confirm that in practice the more difficult cases involving pleas of insanity or automatism in either way cases are dealt with in the Crown Court?

- B.19 See the answers to Q 3 above.

8. How frequently is automatism pleaded in the Crown Court? How often is it successful?

- B.20 Rarely or very rarely. One solicitor had run the defence successfully twice, once in a murder case. Mr Justice Holroyde noted that he had been in criminal practice for 34 years and could only recall two or three cases in which insanity or automatism had arisen.

³ See below at para B.20.

⁴ On supervision orders, see also Q 50 below.

⁵ [1973] QB 910, 922.

- B.21 The lack of data may partly be explained by the fact that if a plea of automatism is successful, it results in an acquittal and will be recorded as an acquittal, but the reason for the acquittal will not be recorded.

9. Can consultees provide examples of pleas of insanity that have been made unsuccessfully and provide some evidence of how frequently such pleas are made?

- B.22 It is rarely pleaded unsuccessfully. One reason may be that “the defence is so difficult to make out that psychiatrists are unlikely to support it unless the criteria are very clearly made out and there is little room for debate” (Dr James Reed). This comment is supported by Professor Mackay’s research.
- B.23 “On average we raise the defence of insanity in approximately 6 cases per annum in the Crown Court and 3 in the magistrates’ court.” (TV Edwards)

10. Are consultees aware of any reasons why cases of successful insanity pleas might not have been recorded in the official data?

- B.24 Not only are successful automatism defences (which lead to a straightforward acquittal) recorded as “acquitted after trial” but so, it appears, are successful insanity pleas, at least by CPS data (CPS response).
- B.25 The CBA suggest that over time, “fewer clerks [have been] allocated to courts making it less likely figures would be entered”.

11. Can consultees confirm that, in their experience, these diagnoses [schizophrenia, mood disorders and epilepsy or post-ictal state]⁶ are the ones that most commonly lead to pleas of insanity being made? If not, what other mental disorders are commonly relied on as the basis of an insanity plea?

- B.26 There was general agreement that these are the diagnoses which most commonly support a plea of NGRI. More specifically, schizophrenia and bipolar affective disorder are common diagnoses supporting the plea, though TV Edwards have had a few cases of PTSD.
- B.27 The CPS referred to a table compiled in the course of research into the prosecution of offenders with mental health problems or learning disabilities in 2010:
http://www.cps.gov.uk/publications/research/offenders_with_mental_health_problems.html

12. Can consultees offer explanations as to why the number of special verdicts is so low?

- B.28 The following reasons were suggested:
- (1) ignorance on the part of the legal practitioner, either the defence who do not raise it, or the prosecution who drop it (“poor understanding of mental illness by some in the criminal justice system means that prosecutions

⁶ See para 1.46 of the Law Commission Scoping Paper on Insanity and Automatism (2012).

are not pursued as soon as the issue of mental ill health arises”: NHS Protect);

- (2) it is difficult for the defence practitioner to raise the issue with the client;
- (3) difficulty in obtaining funding for an expert report;
- (4) difficulties of proof;
- (5) “it is very difficult for most cases of mentally disordered offending to qualify within the terms of the M’Naghten rules” (Dr James Reed), and “the M’Naghten Rules represent a very high threshold of cognitive impairment that is rarely present, even in the most severely mentally ill person” (RCP);
- (6) “there is no incentive to try to argue strongly for NGRI especially if it is a difficult argument to support” (Dr James Reed);
- (7) “in the long term management of high risk patients it is often advantageous to be able to refer to a historical conviction for an offence when doing risk reduction work” (Dr James Reed);
- (8) that people who might otherwise have “qualified” for the special verdict will have been diverted from the system, or found unfit to plead. The CPS commented that dropping the case due to the defendant being unfit to plead “is likely to be the case where a defendant has a severe and enduring disorder, including a learning disability, that was present when the offence was committed and continues to impair”;
- (9) if the charge is murder there is no incentive to plead insanity as opposed to diminished responsibility;
- (10) the verdict is stigmatising;
- (11) cases where the alleged offence was committed in hospital may be filtered out by medical staff without reaching the police or the CPS;
- (12) if the medical evidence shows no mens rea or that the insanity defence is likely to succeed, then the evidential stage of the Full Code test will not be passed and the prosecution will be dropped;
- (13) even if the evidential test is passed, there may be public interest reasons for not proceeding with a prosecution eg the defendant is now receiving hospital treatment and there is a low risk of reoffending;
- (14) disagreements between the police, CPS and clinicians on what level of information is required to make a decision on prosecution;
- (15) the “correct” outcome may be reachable without having to plead insanity, in the view of the practitioner and/or the accused;
- (16) the practitioner is uncertain about the consequences of a special verdict;

- (17) the accused, though fit to plead and to stand trial, lacks insight into his or her condition and therefore does not accept that a NGRI plea may be suitable;
- (18) the individual themselves cannot see an advantage to pleading it, and can see disadvantages related to the potential outcomes, in particular as to when he or she might be released from hospital; or
- (19) the defence is raised but unsuccessfully and the accused is convicted.

13. Are consultees aware of difficulties in practice arising from the requirement to prove an “act”, and the problems in identifying the “act” element in an offence?

B.29 This has been encountered. It posed difficulties in a case of assault where the accused believed he was defending himself.

B.30 The CPS make this comment, which bears on the fitness to plead project:⁷

In cases where a mental element has been blended into the actus reus, the “trial of facts” is indistinguishable from the full trial so where the “actus reus” has not been proved beyond reasonable doubt the defendant is acquitted. The original purpose of the trial of facts was to protect the defendant from being subject to the power of the criminal court to commit him to hospital for an indefinite period, where there was no evidence that he had committed an offence. The purpose of the special verdict is also frustrated as in its absence the court has no power to make a hospital order for the therapeutic benefit of the defendant or a restriction order to protect the public.

14. Does the definition of “defect of reason” give rise to problems in practice by excluding from the scope of the defence those who ought not to be held criminally responsible? If so, please explain why.

B.31 This question was understood partly in terms of kind of defect, and partly in terms of threshold.

B.32 Mr Justice Holroyde disagreed with what he thought was an unstated premise:

If a man knows the nature and quality of his act, and knows that it is wrong, an impairment of his ability to control his emotions or resist his impulses may provide mitigation, but it seems to me that as a matter of policy it should not exempt him from criminal liability.

B.33 The CPS also thought this premise underpinned the question, and similarly, had misgivings:

There is a risk that by extending the defence to those with a disorder that impairs their practical reasoning and their power of control over actions such as those with clinically diagnosed personality disorders,

⁷ See <http://lawcommission.justice.gov.uk/areas/unfitness-to-plead.htm>.

including sadomasochism and paedophilia, to be absolved of any criminal responsibility for their actions. If the insanity defence was successful, the court could not make a hospital order, still less a restriction order, unless appropriate medical treatment in hospital was available. The extension of the defence could undermine confidence in the ability of the criminal justice system to punish, rehabilitate and deter and to protect the public from violence and sexual abuse.

- B.34 The RCP commented that “[the] fundamental problem with the M’Naghten Rules, which has been recognised since the nineteenth century, is the fact that they are essentially a cognitive test and even though someone may be severely psychotic, their cognitive abilities may well still be intact”.
- B.35 A mental health professional thought that the scope of the defence should vary according to the seriousness of the offence charged.
- B.36 The Yorkshire Centre for Forensic Psychiatry suggested bringing diminished responsibility into line with the M’Naghten test: “diminished responsibility could be redefined: the defendant must be suffering from an abnormality of mental functioning arising from a recognised medical condition of such severity as to not know the nature and quality of the act he was doing or if he did know it that he did not know that what he was doing was wrong”.

15. Can consultees provide examples of cases in which the inability to plead insanity in cases where the accused lacked self control presented problems in practice?

- B.37 No respondents produced any examples. The CPS did not think that this feature of the insanity defence is a defect, and distinguished between lack of self control and an act over which a person has no control:

We do not consider that the inability to plead insanity in cases in which the defendant lacks self control causes injustice. The purpose of both the automatism and insanity defences is to prevent a person from being convicted for an act that he has no control over. The defences are based on the premise that “but for” the condition, the offence would not have been committed. There can be no such assumption for those who have difficulties controlling their impulses, although this would be taken into account by the CPS when determining whether the public interest requires a prosecution and might amount to mitigation which can be reflected in sentencing if a prosecution proceeded.

16. Does the wide interpretation of “disease of mind” create problems in practice?

- B.38 Respondents addressed this question in terms of the reach of the insanity defence, in terms of the interpretation of “disease of the mind” as including a physical condition, and in terms of the gap between medical and legal terms and lay understanding.
- B.39 The JCS noted that a narrower definition (presumably one which confined “disease of the mind” to mental conditions) could create greater problems, and

that “the root of the loss of control is ... less significant than the proof of actual loss of control”.

- B.40 The problem was identified as one of confusion arising from a “mental illness label” being given to a situation caused by a non-mental condition, as in the example given by the CPS: “in one case a vasovagal syncope was held not to amount to a disease of the mind, because it is a physical condition, and therefore a verdict of not guilty by reason of insanity was not available”.
- B.41 Professor Mackay and Dr James Reed referred to the difficulties where “there is a finding of insanity “for conditions that have no relation to mental illness – such as sleepwalking, epilepsy etc”. Professor Mackay referred to the case of a person found NGRI when he had suffered a “cardiac event” – where his heartbeat increased rapidly moments before the collision – and was in a state of impaired consciousness. (See http://www.edp24.co.uk/news/norfolk_solicitor_found_not_guilty_in_death_crash_trial_1_885495)
- B.42 The response from the CECJS Northumbria group noted the “absurd” results that have followed from the external/internal factor distinction.
- B.43 The CBA and the CECJS Northumbria group could see that the legal meaning might cause problems for medical practitioners and for lay people. Dr James Reed referred to the confusion this can cause for defendants, and for victims and witnesses.

17. Do medical practitioners have difficulty in preparing reports for trials of insanity because of the legal definition of disease of the mind?

- B.44 The medical practitioners present at the CECJS Northumbria seminar had limited experience in preparing cases for trials of insanity, but it was suggested that the fact that the term “disease of the mind” is a legal rather than a medical term has the potential to cause problems in practice. This was also Professor Mackay’s view.
- B.45 A mental health practitioner thought that medical practitioners would usually revert to their own training and understanding of conditions, whereas Dr James Reed thought it was not usually a problem, but only because insanity is only raised in cases where it is clear-cut.

18. Would an insanity defence based on distinctions between physical and mental “diseases” or “conditions” create arbitrary distinctions in application?

- B.46 Three respondents answered yes, or that this was likely (JCS, Professor Mackay and CECJS Northumbria group). Dr James Reed commented that it would be extremely difficult to differentiate between such disorders. The CECJS Northumbria group gave the following explanation:

It would be difficult to distinguish between physical and mental conditions. The ICD-10 provides some guidance but this is predicated on “practical considerations – mainly which kind of medical specialist usually treats patients presenting with the syndrome in question –

rather than by fundamental aetiological considerations” (RE Kendall, “The Distinction Between Mental and Physical Illness” *The British Journal of Psychiatry* (2001) 178, 490-493). Similarly, the DSM-IV simply provides a list of the types of disorders that are witnessed and treated by American psychiatrists and clinical psychologists. In this context, it has been suggested “that the [American Psychiatric] Association regards the distinction between mental and physical disorders as a meaningless anachronism” [RE Kendall, as above]. In light of these considerations, a defence based upon distinctions between mental and physical “diseases” or “conditions” would undoubtedly create interpretational difficulties in practice.

Furthermore, such a distinction is likely to present significant problems in practice where it is believed that a combination of factors caused the defendant’s conduct. Descriptions of specific mental disorders are “usually catchall categories that include many different underlying malfunctions” (K Weir, “The Roots of Mental Illness” *Monitor on Psychology* June 2012, Vol 43, No 6). This is clearly a problem with the current internal/external factor test.

B.47 Responses to this question distinguished between the condition which should be relevant to a defence, and orders that might be made after verdict. Thus the CPS stated that “a defence should be available where a medical condition, whether physical or mental in origin, has resulted in a total loss of control” but noted that this distinction is significant when it comes to disposal as a person who does not have a mental disorder “cannot and should not be detained and treated in a psychiatric hospital”. The distinction between mental disorders and other disorders must therefore persist. The CPS commented that “this distinction may be perceived as discriminating against a defendant with a mental disorder rather than a physical condition that caused impairment but continued to pose a risk of harm to the public”.

B.48 The CPS questioned the purpose of a revised insanity defence. They wrote:

The original purpose of the current insanity defence was to provide psychiatric treatment for those who were not criminally responsible for their actions, while protecting the public from future harm. It is unclear what function a revised insanity defence is intended to serve. A person who had a disease or condition that does not amount to a mental disorder cannot and should not be detained and treated in a psychiatric hospital, so there would continue to be a distinction in orders that could be made following a successful insanity defence. This distinction may be perceived as discriminating against a defendant with a mental disorder rather than a physical condition that caused impairment but continued to pose a risk of harm to the public. However, we agree that a defence should be available where a medical condition, whether physical or mental in origin, has resulted in a total loss of control.

B.49 Dr James Reed commented that a distinction is drawn in law between a mental disorder and any other disorder (in the 1983 Act) and “there is a working understanding of a mental disorder within the Mental Health Act 1983”.

19. Are consultees aware of cases in which the insanity and automatism defences have been pleaded (a) successfully or (b) unsuccessfully in relation to physical or mental states arising from diabetes or its treatment? If so, please give details.

- B.50 The CCRC gave some details of three cases. The first was a case where automatism was pleaded as a defence to a charge of causing death by dangerous driving, but the judge had ruled that the defence was not available as the defendant knew such a state was likely (having previously suffered hypoglycaemic episodes).
- B.51 The second was a case where D pleaded guilty and made an application to the CCRC (and subsequently sought to have the verdict referred to the Court of Appeal) on the basis that he was in a state of automatism at the time of the sexual offences due to his diabetes medication. “The Court noted that the offences took place over a considerable length of time and the applicant had not sought help to change his medication. These factors, and existence of a motive for the offending behaviour, led the Court of Appeal to dismiss the appeal.”
- B.52 Third, the CCRC referred to a charge of attempted murder where “in his application to the Commission [the applicant] argued that he was not in control of his behaviour at the relevant time due to the combination of illegal drugs (anabolic steroids and human growth hormone) and undiagnosed diabetes caused by his drug use. The applicant submitted that he could not reasonably have been aware of the effects of the medication when combined with his undiagnosed medical condition”. The CCRC declined to refer the case because there was no compelling new evidence or argument capable of forming the basis of a reference by the Commission.
- B.53 The CPS referred to the case of C.⁸ In summary, the defendant pleaded automatism to a charge of causing death by dangerous driving due to a hypoglycaemic episode. The court reiterated the issues:

If the defendant wished to run the defence of automatism he had to provide evidence that he was totally unable to control the car due to an unforeseen hypoglycaemic attack. But that would not be enough. He would also have to provide an evidential basis for asserting that he could not reasonably have avoided the attack, by advance testing and that there were no advance warnings during the course of his drive.⁹

The court ordered a fresh trial at which, according to the news report, the defendant pleaded guilty, and he was sentenced to prison for four and a half years. The judge said, “monitoring of his condition and his blood sugar levels in particular were to put it mildly grossly mismanaged and grossly inadequate”.¹⁰

- B.54 With regard to diabetes, the CECJS Northumbria group noted that:

⁸ [2007] EWCA Crim 1862, [2007] All ER (D) 91 (Sept).

⁹ [2007] EWCA Crim 1862, [2007] All ER (D) 91 (Sept) at [35].

¹⁰ http://news.bbc.co.uk/1/hi/wales/south_east/7133285.stm (last visited 24 May 2013).

In terms of the conditions that are recognised, specific consideration has not been afforded to the various sub-divisions of diabetes, for example, brittle, ketosis prone, nonketotic, neonatal, etc., or diabetes complicated by other conditions (World Health Organisation ICD-10, 'Endocrine, nutritional and metabolic diseases' Chapter IV (E00-E90) available at: <<http://apps.who.int/classifications/icd10/browse/2010/en#/E10-E14>> accessed on 17/10/2012). Similarly, insulin is now so fast-acting that it should be taken with food, so references to failing to eat after having taken insulin are inaccurate.

20. Are consultees aware of cases in which the strict internal/external distinction has been impossible or difficult to apply because of there being multiple causes of the accused's defect of reason?

- B.55 The CCRC wrote that it had "considered a number of applications made on the basis of a claim of automatism ... where the argument is based on a combination of internal and external factors, for example mental illness, such as stress or depression, and the effect of prescription medication or alcohol" and noted that "in [these] cases ... there has generally been compelling evidence to suggest that the defendant was not suffering from a loss of control at the material time. Such considerations have rendered nugatory the automatism argument, irrespective of whether the relevant factors were internal or external".
- B.56 The CBA focused on diabetes cases, and while it would welcome clarification, did not "easily see how the blurring in this area can be resolved".
- B.57 The CPS referred to the case of *Thomas* (sleepwalking, murder charge) in which there was "evidence to suggest that the condition was precipitated by external factors namely withdrawal from medication and/or stress" and commented that it was not pursued because the outcome of a hospital order was not going to be appropriate.
- B.58 The RCP made comments, not specifically in response to this question, but in relation to automatism more generally, which merit reproducing in full:

The two main areas that forensic psychiatrists generally find difficult is the lack of a definition of automatism that fits with medical/psychiatric concepts and the need for a total loss of conscious awareness of actions. The definition of "insane and non-insane" automatism makes little sense to psychiatrists, especially as they are determined by the concept of "internal or external factors". The issues relating to diabetes and insulin are well rehearsed and highlight this issue. Psychiatrists, while accepting the concept of automatism, would use a completely different way to classify it. For example:

Organic causes – where the automatic acts arise as a result of a disturbance of brain function, or

Psychogenic causes – where the automatic acts result from dissociative states, which are either, normal (due to alterations in attention, such as absent-mindedness), or due to psychopathology.

It has been argued (Buchanan (2000) *Psychiatric Aspects of Justification, Excuse and Mitigation in Anglo-American Criminal Law*) that the legal distinction between insane and non-insane automatism does not exist to free those who did not know what they were doing, but rather to ensure the detention in hospital of those whose behaviour during an automatism is violent. This is why more and more types of automatic behaviour have moved from “insane” automatism to “non-insane” automatism. It is therefore argued by Buchanan (and others) that the insanity defence alone is adequate to deal with automatism.

The defence of automatism also brings into sharp focus the area where the law and psychiatry do not mix well. The law requires definite, unequivocal answers that psychiatry is often unable to provide. This is so in particular in relation to the requirement that acts are either voluntary or involuntary, with either conscious or a complete absence of conscious awareness. Psychiatrists understand that there are degrees of both of these and it is rare to find a complete absence of either.

- B.59 The CECJS Northumbria group thought that practitioners did not give much consideration to the nuances of the defences of insanity and automatism because they arise so rarely, but that the “delineation is capricious since many factors, both internal and external, can affect the blood sugar level of a person suffering from diabetes”, and the labelling of a person with diabetes as “insane” is “unpalatable”.
- B.60 On PTSD cases, the CECJS Northumbria group commented, “When does an extremely shocking event cease to operate as an external cause and result in more long-term psychological damage for the purposes of the defence?”

21. Are consultees aware of cases in which a defendant’s claim to have committed the offence while sleepwalking has been treated as a plea of automatism rather than insanity? Please give details.

- B.61 This question asked for examples. Dr James Reed dealt with a case of sleepwalking in the context of a sexual assault:

This was clearly an insanity case, but the judge eventually decided not to put the case before the jury and ordered the prosecution to offer no evidence. The rationale for doing this was not clear and it did not seem to conform to the established means of dealing with the case. My inference was that the judge was unhappy with the prospect of describing an otherwise healthy man (also a serving soldier at the time) as “insane”.

- B.62 The CPS expressed the view that “each case will turn on its own facts and merits. The issue as to whether sleep-walking amounts to non-insane or insane automatism is always one for the trial judge”. They continued:

The CPS does not have details of any case in which the defence have argued that “sexsomnia” amounts to insane automatism, or where the court has come to such a finding. In our experience the

condition has been treated as non-insane automatism and the medical evidence does not assert that “sexsomnia” is a disease of the mind.

In one case, the complainant woke up to find a friend performing oral sex on him. The defence case was that he did not consciously engage in sexual activity with the complainant and that if he did then it must have been when he was asleep or otherwise unconscious. A medical report concluded that the defendant had a predisposition to sexsomnia and that it was possible that the sexual act was committed during a sexsomnia episode. The prosecution expert concluded that there was very little evidence to support the possibility that the defendant had sexsomnia. The jury acquitted the defendant, apparently on the basis that they could not be certain that the defendant was not suffering from sexsomnia at the time.

We are aware of an acquittal in an old case of indecent assault by one man on another in shared sleeping accommodation. The complainant was asleep naked under a sheet and became aware that his genitals were being touched by the defendant. He changed position to avoid any further accidental contact but was touched again. The defence put forward “somnambulism.” The defendant had a documented history of sleep walking from an early age, and expert evidence was called by the prosecution and defence. Much evidence was heard to show how young people can drive when never having been behind the wheel of a car and in one case a child drove for 15 miles in the USA without mishap. There was no undermining evidence against the victim, who gave evidence that the defendant showed no sign of sexual arousal. The defendant was acquitted because of the absence of a male bodily reaction. Had this been a male fully awake who was groping another in the full circumstances that occurred there would be some evidence of excitement. There was not, hence the acquittal.

- B.63 Lord Justice Davis referred to the case of *Thomas*, over which he presided, in which the accused’s actions were either internally caused (“night terror violence” akin to sleepwalking) or, on the defence view, caused by “what was said by the defence to be the ‘external factor’ of the prior incident involving the yobs (a further and alternative external factor was said by the defence to be a recent change in Mr Thomas’ medication regime)”. He noted that “the jury were somewhat bemused” to be presented with the choices only of “not guilty by reason of insanity” or an acquittal. Davis LJ’s response continues:

Matters got no better for them [the jury] in the light of the distinguished expert evidence received (all experts being agreed that the act was committed whilst Mr Thomas was asleep and suffering a “night terror”). There was much learned discussion about (a) genetic predisposition; (b) “priming” factors and (c) “trigger” factors.

All the psychiatric and medical experts complained, politely, that the legal concept of “insanity” in this context bears no relation to the medical (or lay) concept of insanity. The legal and medical concepts,

they all said, did not fit together. From no psychiatric point of view was Mr Thomas insane or suffering a disorder of the mind. There was also no possibility of benefit in sending him to a mental hospital: there was nothing psychiatric relating to him for such a hospital to treat. All also agreed that the possibility of recurrence of such an act arising from “night terror violence” on the part of Mr Thomas was remote in the extreme. What happened had depended on a unique concatenation of circumstances.

All the experts further struggled in their evidence to the jury to try to explain the difference between “external” and “internal” factors – unsurprisingly. One bluntly said that the legal differentiation was “incredibly artificial from the point of view of medicine”.

If Mr Thomas were found “not guilty” he would of course have been absolutely discharged. If found “not guilty by reason of insanity” my sentencing options extended from making a hospital order (which all relevant experts agreed could serve no purpose) to, again, an absolute discharge – the preferred disposal of at least one of the experts. None, I repeat, thought that Mr Thomas presented any risk (save, perhaps, to himself).

Given the way the evidence was going, I thought it right to raise with the prosecution in the absence of the jury whether the public interest was being served by continued pursuit of the proceedings. (In any case, whatever the verdict, an absolute discharge was on the cards.) The prosecution then decided, really quite readily, not to proceed further. I then directed the jury to acquit.

In my view, based on my experience in this case:

The distinction between “sane” and “insane” automatism, and “internal” and “external” causes, is not simply unsatisfactory, as stated in paragraph 1.22 of the scoping paper: it is illogical, little short of a disgrace and should be abolished.

The distinction between sane and insane automatism depends entirely on legal concepts which do not fit with medical concepts or any sensible notion of “insanity”.

To seek to explain the current distinction to a jury is potentially fraught with difficulty and is likely – and for good reason – to be difficult for a jury, however alert, to follow.

The decision in *Burgess* should be abrogated.

The concept of automatism is a valid and valuable one. But “insanity” should play absolutely no part in it, at all events in the context of sleepwalking or night terror cases (and probably in all cases). In such cases, in my view, if the jury accept there was, or may have been, sleepwalking the (only) verdict should be “not guilty”. If they reject it, the verdict should be “guilty [of the substantive offence]”.

References to “insanity” in this particular context should be precluded.

- B.64 As regards the internal/external distinction, Mr Justice Holroyde wrote, “It does seem to me that this is an area in which consideration should be given to legislation, though my feeling is that it could be dealt with as a discrete statutory change rather than necessarily as part of a wider change in the law relating to insanity and automatism”.

22. Can consultees provide examples of problems in practice where defendants have based pleas of insanity or automatism on their having been intoxicated and asleep at the time of the offence? Please give details.

- B.65 This question also asked for examples.

- B.66 Dr James Reed added to the example given at Q21:

The case described above [answer to Q 21] also had these aspects. The defendant had been drinking extremely heavily the night before the offence and so it was difficult to deal with the competing arguments of intoxication, sleepwalking or sleepwalking provoked by intoxication. I offered an opinion that the evidence was less indicative of intoxication for various reasons. However it was difficult to arrive at a conclusion concerning sleepwalking alone (insanity) or sleepwalking provoked by alcohol – possible sane automatism due to external factors, or possibly no defence at all because of voluntary intoxication. There was some evidence that the defendant might have been able to expect to sleepwalk after drinking heavily, but no indication that he might have expected to offend in this way. Would therefore the consumption of alcohol be culpable and rule out any form of defence?

- B.67 The CPS answered that they “have examples of cases in which the defendant has advanced a defence of automatism despite being intoxicated at the time of the offences” but did not mention any in which the defence succeeded.

23. Does the wide interpretation of “disease of mind” and the distinction between internal and external factors create problems in practice? Please provide details.

- B.68 There was a conflict in the responses to this question. Some respondents thought that the distinction does indeed cause problems in practice, but the CPS thought not. However, it is evident from earlier answers that this interpretation and distinction concern legal and medical practitioners.

24. Does the narrow interpretation of the nature and quality limb of the M’Naghten Rules present difficulties in practice? Please provide details.

25. Does the inability to plead insanity in cases where D lacked self control rather than lacked cognitive ability, present problems in practice?

26. Does the inability to plead insanity in cases where D’s mental disorder appears to be emotional in nature, rather than cognitive, present problems in practice?

B.69 Respondents’ views were mixed, and followed the same pattern in relation to all three of these questions. Mr Justice Holroyde, the CPS, and the Yorkshire Centre for Forensic Psychiatry thought there is no difficulty; Professor Mackay and Dr James Reed thought otherwise. Dr Reed gave this example:

A recent case of mine involves a man who killed his mother. I believe that he did not believe that it truly was his mother whom he was attacking (perhaps believing her replaced by an imposter - a well recognised symptom). Whilst he knew he was attacking a person, he may not have realised he was truly attacking his mother. I think that this being the case he did not realise what he was doing, but it is very unclear whether this would qualify as “not knowing the nature or quality of the act”.

Therefore there is a very odd situation in which “the man on the Clapham omnibus” would clearly understand that the defendant was acting in a completely irrational manner driven by a severe illness - but yet they are held to effectively know what they are doing and to therefore be not insane.

B.70 Dr James Reed considered that the defence as it appears in the current law misses the point:

[the insanity defence] largely prevents those with mental disorder who have committed a crime because of their mental disorder from having access to an insanity defence. The key aspect to offending by the mentally disordered is not so much that they are so disorganised that they have no understanding of the act and its wrongness, but rather that they are driven to commit such an act by “more real than real” beliefs or other normal reactions such as the desire to defend oneself from being harmed or killed. It is the motivation for actions rather than the actions themselves which is affected most by mental disorder.

B.71 He wrote also that, “It is difficult to isolate ‘emotions’ as such from a more general clinical judgment. Any reform of the law must have direct reference to established clinical concepts rather than a more general lay understanding of ‘emotions’. An individual suffering from a severe depression is completely different to someone merely unhappy - and yet both may be said to have ‘emotional’ components to their presentation.”

B.72 The CECJS Northumbria group thought that “this narrow focus on cognitive disorders is outdated in terms of contemporary medical development and is difficult to reconcile with the revised concessionary defence of diminished

responsibility, which recognises a range of emotional, behavioural and cognitive disorders”.

27. What principal practical problems arise from the interpretation of the nature and quality limb of the defence?

- B.73 In response to this question, Dr James Reed reiterates that “very few individuals can ever qualify. It is rare indeed for anyone however ill to truly not know this - the classic example of a man cutting off another man’s head under the impression that he is cutting a block of wood would be an extremely rare presentation of mental illness. I have never seen such a case”. The RCP’s answer was along similar lines: “Psychiatrists find it difficult to fit conditions into this narrow legal requirement”. The CPS, on the other hand, was not aware of any problems of interpretation.
- B.74 This was another aspect on which the CECJS Northumbria group commented that practitioners did not engage with the technical points of the defence because it arises so rarely.

28. Does the fact that the defence of insanity does not apply to those who do understand the legal wrongness of their acts create any problems in practice?

- B.75 Mr Justice Holroyde and the CPS did not see any difficulty with the law being as it is. The JCS, by contrast, thought it a side issue: “The key issue for determination is whether the accused is able to prevent themselves from committing the act and the knowledge that act is wrong is less significant in terms of criminal responsibility and the ultimate aim of protecting the public from further acts from the perpetrator”.
- B.76 Three practising psychiatrists thought there is a problem. One (a consultant forensic psychiatrist and clinical director) wrote that “simply knowing that it is against the law to kill should not negate a defence of insanity”.

29. Is it consultees’ experience that in those cases in which insanity is pleaded, the wrongness limb of the defence is relied on more commonly?

- B.77 As to which limb experts rely upon, only four respondents addressed the question. Two of them wrote that in their experience the wrongness limb is more commonly relied upon (Professor Mackay and Dr James Reed), and the CECJS Northumbria group thought that it was in practice almost impossible for an accused to rely on this limb. The CPS said it had not analysed such cases but they were “aware of one case in which the psychiatric report concluded with the opinion that the defendant did not know the nature and quality of the act, or if he did know, that it was wrong. The defendant did not raise either limb but entered a plea of guilty”.

30. Do consultees have experience of a variation between the legal interpretation of the wrongness test and what is applied in practice?

- B.78 The CPS and Dr James Reed said they had no experience of this. Dr Reed commented that if psychiatrists do apply a different test from that which the law requires it will be either because they are ignorant of the law or because they are bending it.

- B.79 The CECJS Northumbria group referred to “evidence” that this is what happens in practice. The evidence may be that obtained and published by Professor Mackay.

31. Do medical practitioners find that the M’Naghten test causes difficulties when preparing a report for a criminal case? What are these?

- B.80 Opinions here were divided (and only three responded). The Yorkshire Centre for Forensic Psychiatry thought there was no difficulty, whereas Dr James Reed thought there was. (The third had no direct personal experience.)

32. Do medical practitioners have experience of cases in which in their opinion the accused’s mental condition did not meet the M’Naghten test, but his or her mental state at the time of the offence was such that he or she ought not to have been held criminally responsible? How are such cases dealt with?

- B.81 Professor Mackay referred to a case where he conducted an inquiry into a person who was charged with attempted murder. He had pleaded guilty, but Professor Mackay queried whether he was criminally responsible.
- B.82 Dr James Reed, a critic of the M’Naghten test, thought that even those who are very mentally disordered frequently retain some responsibility for their actions.

33. Does the enhanced role of the psychiatric evidence create difficulties in practice?

- B.83 The CPS was not aware of any difficulties; Dr James Reed referred to practical difficulties: “usually delays, greater expense (due to multiple reports), confusion and disagreement between experts, and perhaps most importantly delays, confusion and distress for the defendant. Trying to explain to them the implications of insanity (not to mention the somewhat stigmatising nature of the term) is very difficult”.

34. Are consultees aware of a practice of the prosecution accepting insanity pleas and/or judges directing juries to return the special verdict?

- B.84 Although Professor Mackay’s research shows that this happens, the only case respondents referred to in which it did happen is that of *Thomas*.

35. Do experts feel that the present test inhibits psychiatrists from expressing their views with clarity and confidence about matters of psychiatry?

- B.85 Dr James Reed wrote that “The present test does not really relate in any meaningful way to the practice of psychiatry. Therefore diversions into discussions about the M’Naghten rules are not very helpful in conveying an understanding of the clinical situation to the court”. On this question, see also the comment of the RCP that the law requires definitive statements, to which psychiatric assessment does not always lend itself (page 221 above).

36. Does the requirement to have a jury verdict create difficulties in practice?

- B.86 One respondent who thought it created difficulty was the mental health professional who wrote, “subjecting some alleged perpetrators to trial when their

mental health might be unstable (or even when stable stress will have a negative impact in their mental state) would not be useful”, but this is mixing fitness to stand trial into the question.

- B.87 Neil Boast thought juries were not always adequately guided by judges: “I have had to subtly drop in to testimony that the accused is in hospital and I think should stay in secure hospital care when judges have deliberately not explained the nature of a special verdict. It has been clear to me that juries think the patient is simply to be released!”
- B.88 The CECJS Northumbria group thought it could be problematic in that the jury has to adjudicate between competing expert views, or may even reject agreed expert views (even to the extent that some of the group would recommend letting the judge decide as a matter of fact whether the insanity defence applied). Mr Justice Holroyde, on the other hand, would see the jury’s role as important in principle.
- B.89 None of the three other respondents who answered this question thought there was a practical problem. The North East London Forensic Psychiatrists present at the seminar on 23rd November 2012 did not think there was any difficulty in practice on this point and agreed that it was important in principle.

37. If prosecuted would the insanity defence be likely to be pleaded? [in the context of a strict liability offence]

- B.90 The CPS thought that the law is not entirely clear as to whether an insanity defence may be run for a strict liability offence. Two respondents (Professor Mackay and the mental health practitioner) thought it ought to be. TV Edwards wrote that in such cases they would make representations to the CPS to get the case dropped.

38. In practice, is the defence of insanity applied to offences of strict liability in the magistrates’ court? Please give examples.

- B.91 No respondents could give any examples of this occurring. The JCS responded, “Extensive enquiries would suggest that it is not seen that this is a legitimate course of action to take in defending prosecutions in such cases”.

39. Does the present test based on M’Naghten create difficulties for experts in diagnosing those who may be deserving of a defence on the basis of a lack of criminal responsibility? Please provide examples.

- B.92 Three respondents (Professor Mackay, Dr James Reed and a mental health professional) thought that the law is “out of step” with psychiatric diagnoses. Dr Reed thought the greater difficulty is in dealing with epilepsy and sleepwalking.

40. Does the M’Naghten test impede experts in writing reports?

- B.93 Dr James Reed commented that it requires some “verbal gymnastics”, but also that “this is true with most other legislation as well - even the Mental Health Act relies on a concept (mental disorder) which has no direct clinical correlation so in this respect insanity is little different”. The CPS was not aware of any difficulties in this regard.

B.94 A solicitor (Joy Merriam) said that it can be difficult for the expert to say whether the M’Naghten test is satisfied for the time when the offence is alleged to have been committed if the dates in the charge span a period of time: the accused may have been ill for part of that period only. She gave an instance of a case where the psychiatrist would not support a NGRI plea, even though it was clear that the accused was very unwell soon after the relevant time period, because the date of the alleged assault on a child could not be pinned down.

B.95 See also the response of a mental health professional to Q41.

41. Does the M’Naghten test create difficulties for experts in testifying in trials where insanity is pleaded? Please provide examples.

B.96 Dr James Reed commented that “however the law is phrased there will always be a need for some form of interpretation [between legal and clinical terms] but it would be useful to dispense with the term insanity, especially when dealing with cases which do not involve mental illness eg sleepwalking, epilepsy etc”.

B.97 A mental health professional referred to the difficulty in extrapolating backwards for the purposes of an expert report: “One of the main difficulties would be trying to establish what the state of mind of the accused might have been at the time of the offence unless the expert was conversant with the case and knew the person well. One can speculate but not have [a] degree of certainty unless [the] offence takes place within a clinical environment and there are contemporary records to provide evidence”.

42. How significant should changing the label of the verdict be in the reform of the law of insanity?

B.98 Nine respondents had views on this question, most of them apparently strongly-held, and eight of them were critical of the label.

B.99 The CBA thought it an “offensive and cruel” term and the LCCSA thought it undoubtedly carried a stigma. The Northumbria group thought that a “degree of stigma continues to be attached to mental disorder generally” but that “the label ‘insanity’ is particularly problematic”.

B.100 Defence solicitors thought “insanity” had not lost its stigma, and that this created significant difficulties in discussing the possibility of the defence with their clients. TV Edwards made this point, writing that “we find it very difficult to explain to clients that the term insanity is not to be seen as a derogatory one which is what they perceive but that it is an old fashioned way of confirming that they were mentally disordered at the time of the offence”. They thought it “very important that the label “insanity” is changed during the reform of the law”. Members of the Law Society’s Criminal Law Committee and of the CECJS Northumbria group also found the label itself creates a barrier between the solicitor and his or her client.

B.101 Dr James Reed thought the label had lost some of its stigma but that part of the problem was that the label “can be misleading and suggest mental disorder when none is present”.

B.102 A mental health professional thought that any alternative would be equally stigmatising, though less archaic.

B.103 As to what a new label might be, Neil Boast advised:

It would be better to term the verdict “found to have (done whatever the person did) but lacking in criminal responsibility due to mental disorder”. ... It must be for the CPS to have to prove criminal responsibility and intent. If they cannot do so ordinarily the person is acquitted. If the defence raise lack of criminal responsibility due to mental disorder and it is not possible for the CPS to establish otherwise, then the ‘special verdict’ would follow. If the CPS prove responsibility then the special verdict cannot follow.

B.104 Despite several of the respondents emphasising the difficulty of a defence labelled as if it is limited to mental disorder when it in fact, due to the interpretation of “disease of the mind”, extends to physical disorders, the replacement labels suggested by some of the same respondents centre on “mental disorder”.

B.105 The CPS, however, wrote,

It may be helpful to first define the scope of any new defence and then to agree a label that succinctly describes the defence in language that is causes least offence. Any new label should reflect that the defendant has been absolved of criminal responsibility because the act was committed only because of a physical or mental impairment over which he has no control.

B.106 The CECJS Northumbria group also moved away from a label limited to mental disorders, and suggested “impaired responsibility” instead, although they recognised that “this might be regarded as being too similar to “diminished responsibility”, creating the potential for confusion with the partial defence”.

B.107 As to the word “automatism”, Dr James Reed wrote that “automatism is used so rarely that it is not stigmatising as such, because no-one understands it!”

43. Can practitioners provide examples from their experience where the label of “insanity” has deterred an accused from pleading the defence when his or her condition would have satisfied the M’Naghten Rules?

B.108 Practitioners did not offer examples, though Dr James Reed thought reporting of the Thomas case disclosed that his family were very keen to avoid that label. TV Edwards stated that they have had to persuade clients to pursue this defence when the client was unhappy due to the label.

B.109 The CECJS Northumbria group stated that “our practitioner members felt that it would be difficult to discuss ‘insanity’ in an appropriate case without causing offence and potentially a breakdown in the relationship between counsel and client”.

44. Can consultees provide examples of cases in which the requirement for the defendant to bear the burden of proof causes unfairness?

- B.110 The JCS acknowledged the concern, but had no examples because the defence is so rarely pleaded in the magistrates' courts.
- B.111 Mr Justice Holroyde and the CPS were of the view that it is appropriate and practical for the burden of proof to be on the defendant, and the CECJS Northumbria group that it was "arguably unavoidable". The CPS explained, "The prosecution may be unable to obtain any evidence to counter the defence assertion of insanity, as the prosecution cannot compel the defendant to submit to a medical examination or to cooperate with the examination, and defendants may be advised not to do so. It is unlikely that other evidence would be sufficient to disprove insanity beyond reasonable doubt."
- B.112 The CECJS Northumbria group made a similar point: "If the burden was on the prosecution to disprove insanity, the prosecution would need to be able to have the accused examined by a psychiatrist. There is, at present, no means by which the prosecution can compel an accused person to submit to a psychiatric examination and to introduce such powers would potentially breach Article 8 ECHR." They referred also to the position taken by the Scottish Law Commission on the burden of proof (to leave the burden on the accused).
- B.113 The CPS also wrote:

It seems that both the presumption of doli incapax and the defence of insanity were intended to protect those who lacked criminal responsibility from the death penalty. The protection for children was removed when doli incapax was abolished by the Crime and Disorder Act 1998, partly because the sentencing regime for young people was no longer punitive but was based on principles of welfare, rehabilitation and restorative justice. Similar principles now apply to the sentencing of offenders with mental disorders as hospital orders, guardianship and community treatment are available for all offences and reduced culpability is reflected when sentencing those with mental disorders.

45. Do practitioners have examples of challenges based on the compatibility of the law of insanity or automatism with the ECHR?

- B.114 No respondents had experience of any such challenges.

46. Does the fact of the burden of proof falling on the accused inhibit the use of the defence in cases in which it ought to be relied on?

- B.115 Three respondents answered this question (the CPS, the Northumbria group and Dr James Reed), all in the negative. The CECJS Northumbria group thought the narrowness of the defence is the greater difficulty.
- B.116 The CPS explained, in effect, that where the defence obtain an expert report showing that the accused satisfied the M'Naghten criteria, then they would be asked to review the decision to prosecute. In such cases they might conclude that there was no longer sufficient evidence for the prosecution to proceed, or that, if the accused is receiving appropriate treatment, it is not in the public

interest to proceed. In other words, the legal burden being on the defendant does not undermine the defence.

48. Are consultees aware of cases in which the defence was raised by the prosecution? Please give details.

49. Are consultees aware of this [ie the judge raising the defence] happening in practice? Please give details.

B.117 No respondents could give any such examples apart from *Thomas*.

B.118 The CECJS Northumbria group thought it unclear whether the prosecution may in fact do this, despite the dicta in *Bratty*.¹¹ They commented:

In any event, our members could not envisage any circumstances in which the prosecution would want to raise insanity, save possibly on a charge of murder where the defendant seeks to rely on diminished responsibility. It was further pointed out that it would be difficult for the prosecution to raise insanity as prosecutors are frequently not in possession of sufficient information about the defendant to know whether the M’Naghten tests might apply.

B.119 Mr Justice Holroyde found it difficult to see when the evidential basis might be there but neither prosecution nor defence had raised the defence.

B.120 TV Edwards recalled cases where they acted for someone who refused to give his consent for them to instruct a psychiatrist (due to his lack of insight into his illness). “The judge (generally at the PCMH), has been helpful by adjourning the proceedings specifically for a psychiatric report to be prepared to start the process”.

50. Does the limited range of disposals available for a person found not guilty by reason of insanity create problems in practice? Please give details.

B.121 The Yorkshire Centre for Forensic Psychiatry found no difficulty. Others found three kinds of difficulty in the kinds of disposals available – referred to in answers to other questions.

(1) There was what was perceived as a gap between absolute discharge and hospital order which the supervision order is unsuitable to fill.

(2) There is the difficulty of a disorder which does not require psychiatric treatment leading to a special verdict, but no appropriate disposal powers are available.

(3) There is the position of mentally disordered offenders under 18 (on which see Q60).

B.122 (1) This was an issue mentioned by the North East London Forensic Psychiatrists: supervision orders are unpopular because they have no teeth. The

¹¹ [1963] AC 386.

psychiatrists would make more use of community treatment orders. Dr James Reed wrote of “a need for more robust clinical supervision over a longer period that can be provided by a supervision order”. TV Edwards made a comment to similar effect: “As far as a Supervision Order is concerned, it is a rather odd order in comparison with a Community Rehabilitation Order as it cannot be breached so there is no power to revoke and re-sentence”. They go on:

Also, the provisions under paragraph 4 of Schedule 1A of CP(I)(a) 1964 mean the Court cannot impose a medical treatment requirement without the written or oral evidence of at least two registered medical practitioners.¹² This is in direct contrast with a Community Rehabilitation Order which can have a mental health treatment requirement where all that is required is confirmation from the treating psychiatrist that she/he or the community mental health team are willing to offer the treatment under the Order. Consideration could therefore be given to changing the Supervision Order to Community Rehabilitation Order with all the attendant requirements that can be combined with that Order. Further, there would be no reason why a conditional discharge might not be appropriate in these cases.

- B.123 (2) The CPS, a mental health professional, and the North East London Forensic Psychiatrists, all referred to the difficulties of disposal where the disorder did not fall within the 1983 Act. Treatment might be required, but not psychiatric treatment. This problem has been emphasised in discussions with consultees.
- B.124 Other difficulties also result from the disposals. Some respondents (LCCSA and North East London Forensic Psychiatrists) referred to difficulties in understanding, particularly by the public in a local area, why someone who had committed what appeared to be a very serious crime was released without penalty (as it appeared) a relatively short time afterwards. In such cases, what had happened was that the accused had received a special verdict, received medication and made a significant improvement and therefore been released from hospital.¹³ (cases of murder by multiple stabbing (Malik), and of arson)
- B.125 Mr Justice Holroyde noted a lack of certainty about the outcome following a special verdict, both on the part of the accused and of his or her legal adviser (“the disposals available upon a special verdict will often appear, to the lay client, to represent the extreme ends of an overall range which includes the sentences available to the court upon conviction”) and therefore, as a matter of risk assessment, a guilty plea may be entered.
- B.126 Mr Justice Holroyde and members of the Law Society Criminal Law Committee also referred to the difficulties of acting for someone, representing their best interests, who has limited insight into his or her disorder.

¹² Since this response was written, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 has removed the requirement for expert opinion when making a mental health requirement as part of a supervision order in para 4 of sch 1A to the Criminal Procedure (Insanity) Act 1964.

¹³ Professor Mackay referred to the case of Malik, <http://www.dailymail.co.uk/news/article-2129635/Insane-husband-stabbed-wife-120-TIMES-frenzied-killing-walks-free-court-hears-recovered.html> (last visited 17 June 2013).

51. Does the requirement for two practitioners, one of whom must be duly approved, give rise to problems in practice? Please provide details.

- B.127 This question was understood in different ways.
- B.128 The issue of different experts reaching different conclusions was thought by the JCS to be a problem but others thought that a difference of opinion amongst experts was neither unusual nor necessarily a problem.
- B.129 The Yorkshire Centre for Forensic Psychiatry and the CPS thought that the seriousness of the potential outcomes meant that “there should be two section 12 approved psychiatrists with relevant training and experience providing evidence”.
- B.130 The LCCSA and TV Edwards referred to the burden repeated examinations placed on a disordered defendant: “The multiple examinations of vulnerable defendants can be distressing”. The LCCSA made the point that often three examinations are required, not two.
- B.131 The LCCSA, TV Edwards and the CBA referred to funding difficulties for obtaining expert reports. TV Edwards explained the position as follows:

All defendants are eligible for legal aid and prior authority must be obtained from Legal Services Commission before instructing a psychiatrist. In our experience the prosecution will not even consider accepting psychiatric evidence or telling the defence if they are going to contest the evidence unless two reports are obtained. The necessity for two reports in our submission is unnecessary both in costs and is inconsistent when one looks at civil trials. Nowadays it is common for there to be a joint instruction of an expert in civil trials and there is no reason why instead of a second report being obtained by the defence and a subsequent further report by the prosecution, that the second report could not be commissioned jointly by both prosecution and defence.

- B.132 TV Edwards referred also to the delay that results from the difficulty of finding a psychiatrist who is available to make the examination and report: “This can have the effect of clients telling us they just want to plead guilty to get it over and done with rather than go down the insanity route.”

52. Are consultees aware of difficulties or delays in transfers occurring between prison and hospital? Please provide details.

- B.133 The first point to note is that the provisions governing transfer of a prisoner to hospital do not apply to defendants under 18, as the CPS pointed out.
- B.134 Four other respondents who answered this question referred to significant delays. For example, Dr James Reed wrote, “In general any prisoner who needs hospital will be admitted but it may take much longer than would be desirable” and TV Edwards of “enormous difficulties and delays in transfers occurring between prison and hospital”. Further, for the prisoner who has not yet been transferred, “prison healthcare facilities are still wholly inadequate and sometimes very disturbed prisoners are detained far too long in prison”.

53. Do the possible outcomes of a special verdict deter people from pleading the defence, and if so, why?

- B.135 Mr Justice Holroyde's answer to Q50 above is relevant here, as is TV Edwards' response to Q51. They both thought that delay and uncertainty can deter people from pleading NGRI.
- B.136 Dr James Reed and the LCCSA thought it may be a particular problem in relation to less serious offences. As regards more serious offences, a mental health professional thought a hospital order is indeed a deterrent because of the possible longer time that the person might spend in hospital as compared with a fixed-term prison sentence ("Many of the patients on [hospital orders with restriction orders] (not only special verdicts) query the fact that they have 'served their time' and if they had gone to prison they would have been out by now"). The experience of the CECJS Northumbria group echoed this view:

Conversely, some of our members felt that defendants might be deterred from pleading insanity by the prospect of a hospital order. Our practising members had experience of occasionally being instructed not to raise mental disorder at any stage, even in mitigation, by defendants who feared receiving hospital orders, preferring the prospect of the more palatable fixed prison term. It seems to us that there is no way round this difficulty as, whatever label is attached to the defence and however it is defined, a hospital order would inevitably have to be an available disposal option or sentence.

- B.137 The CPS said it was aware of cases in which the prosecution had been served with medical reports to support a defence of insanity, yet the defendant had pleaded guilty to one or more counts on the indictment, but the CPS had not been informed as to the reason for the plea.
- B.138 Professor Mackay noted that his research did not reveal this effect. The CECJS Northumbria group noted that the same disposals apply in fitness cases, and there had been an increase in the number of claims of unfitness to plead. They thought this indicated "that defendants are not being deterred from claiming unfitness by the range of disposals that are available".

54. Do consultees consider that those who might plead insanity understand the range of disposals available and their implications?

- B.139 Responses were mixed on this point in that some thought they do and some that they do not. One respondent thought it was too broad a question to answer. Mr Justice Holroyde referred to his answer to Q50.
- B.140 The CECJS Northumbria group commented that a hospital order can be made following a conviction in any event, and that sentences of Imprisonment for Public Protection are more feared than other disposals.

55. Do consultees have experience of cases in which a defendant was convicted and received a criminal penalty, but in view of his or her mental condition it would have been more appropriate for him or her to have pleaded insanity?

- B.141 Dr James Reed answered this question affirmatively: “On the current rules this is relatively unlikely given the difficulty of satisfying the test. However, I have many patients under my care who have committed serious offences as a direct result of a mental disorder who might have been better dealt with by a more appropriate defence directed at their mental disorder”. A mental health professional also could think of one possible case. The CPS thought *Mehmet*¹⁴ might be another such case, though it is not known whether there was sufficient medical evidence in that case.
- B.142 The CECJS Northumbria group took a pragmatic view, shared by those on the Criminal Law Committee of the Law Society, that so long as the “right” outcome (ie a hospital order) is reached, it does not matter too much what the route is. One comment by the North East London Forensic Psychiatrists, however, was to the effect that a conviction is significant to those responsible for risk management in hospital.
- B.143 The CECJS Northumbria group commented:

In the Paper, the Law Commission takes the view that it is important as a matter of principle that criminal responsibility should be correctly ascribed for the reasons set out at para 2.121. It is unclear to what extent the Law Commission envisages widening the scope of the defence, if at all, which would appear to be a prerequisite to greater use. A preliminary issue that therefore needs to be determined is how severe a person’s mental disorder must be before he will be afforded a complete defence. Our members identified that, if an increase in the use of the defence is envisaged, the plea would have to be drafted in such a way as to make it more widely applicable. Any revised formulation would also need to be clearer than the current defence so that it is easier to apply in practice. If the defence was defined more widely, the distinction between a special verdict and a conviction might begin to matter to practitioners.

56. Are consultees aware of cases in which these other consequences [such as effect on employment prospects] have influenced a defendant’s decision on entering an insanity plea? Please provide details.

- B.144 The CECJS Northumbria group, Dr James Reed and a mental health professional did not think other consequences would bear on an accused’s decision as to plea.
- B.145 Mr Justice Holroyde added “that a previous special verdict would be relevant in the event of a subsequent criminal conviction in circumstances which required the judge to consider dangerousness under CJA 2003 ss 225 – 228. By s 229(2),

¹⁴ [2005] EWCA Crim 2074, [2005] Crim LR 877.

the judge in determining dangerousness ‘may take into account any information about the offender’”.

57. Are consultees aware of research into the likelihood of reoffending following imprisonment as compared with the likelihood of reoffending if the offender had instead received treatment either in hospital or as part of a supervision order?

B.146 Dr James Reed referred to anecdotal evidence, and made an important point:

No research as such, but anecdotal evidence suggests that the risk of reoffending from discharged hospital inpatients is much lower. This is not only due to the treatment, but due to the fact that discharge from section is not usually an accident of timing (as with determinate prison sentences) but rather following a clear determination that the individual’s risks are safely manageable in the community. In this sense it is much more akin to [an] indeterminate prison sentence with parole board review.

B.147 The CPS referred to research: “We understand that Professor Swaran P Singh at Warwick University is formulating a research proposal Reducing Violence and Aggression in early Psychosis: the Reprieve Project that seeks to reduce risk and prevent a cycle of violence in mentally ill young people.”

58. How do magistrates’ courts approach these issues [disposal in the magistrates’ courts]? Do they create problems in practice?

B.148 TV Edwards was clearly of the view that the insanity defence applies in the magistrates’ courts.

B.149 The JCS gave the following “rough guide to the approach which is adopted in the Magistrates’ Courts to issues regarding a mental illness where possible disposal of cases under s 37 of the Mental Health Act might arise”:

Courts frequently have to make decisions about defendants who demonstrate mental illness prior to plea. These decisions may relate to bail and custody or trial management. Many courts have referral mechanisms to ensure that such defendants can see a community psychiatric nurse so that decisions regarding the conduct of the case can be made on best available information. CPS may consider their position on the basis of such information. Defence solicitors may request an adjournment of criminal proceedings in order to commission a psychiatric report either privately or under public funding. This would be for the purpose of satisfying the defence solicitor that the client defendant is fit to plead. Such information could also be useful to a solicitor in preparing a plea in mitigation if it is clear that the client is capable of understanding the issues and wishes to explain criminal behaviour rather than deny the charge.

If the defendant is put to plea but there is evidence to suggest he is not fit to stand trial, the court can hear evidence to determine whether or not he did the act or omission complained of. At first hearings there is frequently insufficient information to enable the court to decide that

it is necessary to set up a fact finding hearing rather than proceed to trial. This often leads to an initial adjournment for assessment of the defendant's mental health. Depending on local resources available, these preliminary inquiries can take time to complete with unwelcome consequences for the accused. Fact finding is not only relevant for the making of orders under section 37 but also for the purpose of requesting a medical report under section 11 of the Powers of the Criminal Court (Sentencing) Act 2000. This power enables the Magistrates to adjourn or remand for medical report a defendant who has not been convicted but who the Magistrates are satisfied did the act or made the admission charged and the Magistrates are of the opinion that enquiry ought to be made into his or her physical or mental condition. A condition of bail will be imposed requiring the accused to undergo medical examination and for that purpose to attend a relevant institution. In rare cases Magistrates' Courts are able to remand a defendant to a mental institution under section 35 of the Mental Health Act 1983. Remand to hospital under this provision may only take place if the offence in issue is punishable on a summary conviction with imprisonment and the court is satisfied on the written or oral evidence of a registered medical practitioner that there is reason to suspect that the defendant is suffering from a mental disorder. The court is of the opinion that it would be impractical for a report on the defendant's mental condition to be made if he were remanded on bail and one of the following conditions is met, namely:

- (a) the defendant has pleaded guilty, or
- (b) the defendant has been convicted or found guilty after trial, or
- (c) the defendant has consented to such a remand.

If the court proceeds and makes a finding that the defendant has done the act or admission charged, the court can proceed to obtain two psychiatric reports before considering making a Hospital Order or Guardianship Order, see the provisions of section 37 of the Mental Health Act. It is also possible at this stage for a court to make an Interim Hospital Order for a period of up to twelve weeks, such period being renewable. However, it should be noted that there is no power to make an Interim Hospital Order on finding that the defendant did the act or made the admission charged in accordance with section 37(3) of the Act. In serious matters where there is risk of a defendant posing a risk to the public at large, the Magistrates have the power to commit the defendant to the Crown Court with a view to a Restriction Order being made under section 41 of the Act. Note that the defendant must have been convicted of an offence which is punishable on summary conviction of imprisonment. Such committal must be in custody.

Where the defendant is fit to plead and stands trial, on conviction the court can consider not only orders under the Mental Health Act 1983, but is also able to include a mental health treatment requirement in a

community order. It should be noted that trials in Magistrates' Courts involving defendants who appear to be suffering with mental illness or mental disorders are uncommon in that low level offending that is a product of mental illness tends to be diverted away from the criminal justice system.

- B.150 TV Edwards commented that guidance on the evidence necessary to support an insanity defence in the magistrates' courts would be helpful.
- B.151 Both TV Edwards and the CPS doubted that a section 37(3) order could be made following an acquittal.

59. Does section 11 of the 2000 Act work well in practice?

- B.152 The issue here was one of resource. The JCS noted that "the main constraint on the effectiveness of section 11 is the shortage of available forensic psychiatrists to provide reports that are essential to ensure that cases are dealt with quickly and effectively." The CPS and a mental health professional referred to the potential contribution of a court Liaison and Diversion scheme: "screening reports can be provided quickly and without additional cost that may enable the magistrates to reach a decision without requesting reports which may be inconclusive" (CPS).

60. Do the limited powers of the magistrates' court create problems in practice? Please provide details.

- B.153 Not necessarily. TV Edwards thought "a defendant could be said to be better off in the Magistrates Court raising insanity than in the Crown Court because in the former he gets an outright acquittal whereas in the latter, although he is found not guilty by reason of insanity, there is still a disposal procedure and he can be made subject, for example, to a Supervision Order".
- B.154 The JCS referred to the absence of a power to commit cases to the Crown Court for a restriction order: "The one problem which has been referred to JCS is the inability of the court to commit cases to the Crown Court for a Restriction Order under s 41 of the Mental Health Act when the court is dealing with an offender who is not capable of standing trial and the court has made a finding in accordance with s 11 of the 2000 Act or s 37(3) of the 1983 Act, namely that the defendant did the act or made the admission. The power to commit is only available on conviction" whereas the CPS thought "the absence of a power to commit to Crown Court for consideration of a restriction order ... consistent with the level of risk of harm posed by a defendant who has been found to have committed the actus reus but not convicted of a summary offence".
- B.155 The CPS did, however, think that the limited disposal powers meant that "where the defendant does not meet the criteria for a hospital order the court has no power to deal with him, so there is neither an order to deter reoffending and put right the harm caused to victims, nor treatment to reduce the risk of future reoffending".

61. Are consultees aware of examples from similar cases in which ECHR challenges have been made? Please provide details.

- B.156 No consultees were aware of any such examples.

62. Are consultees aware of similar cases? [to Keenan]¹⁵

- B.157 Dr James Reed wrote that “access to suitable care is always available but by different mechanisms. A person in prison requiring treatment can be transferred but under the terms of s 47 of the Mental Health Act”, which contrasts with the concern expressed about the speed of transfers (see above).
- B.158 The CPS commented that hospital orders may be made for those who are convicted, and a custodial sentence is not always wrong: “It is not wrong in principle to pass a custodial sentence on offenders with a mental disorder who are criminally responsible for their behaviour and are fit to be tried (*Drew*).¹⁶ It may be more appropriate if there is an element of culpability in the offence that justifies punishment or where responsibility was reduced but not diminished (*JA*).¹⁷”

63. We are interested to hear of examples of the insanity defence operating unfairly against people with learning disability.

- B.159 The CPS was the only respondent to answer this question. They were not aware of any such cases. They noted that if the disability is intransient, as is likely, then the defendant is unlikely to be fit to plead. They noted also that a hospital order is only possible if the learning disability is associated with abnormally aggressive or seriously irresponsible conduct (section 1(2A) of the 1983 Act) and the court could only make a supervision order or an absolute discharge, and that these outcomes are “less onerous disposals than a hospital order, in that the supervision order is finite and there is no restriction of liberty”.

64. Is there a particular problem as regards youth defendants in that the orders a court could make, if an insanity defence succeeded, would not produce the outcomes which are seen as being in the defendant’s interests, or in the public interest?

- B.160 The CPS gave a very full answer to this response, culminating in:

It is rarely the case that a youth with low cognitive ability will meet the criteria for detention in hospital for compulsory treatment ... that makes it clearer why young people are seen as being “immune”. The result [of the current law] is that young people who are charged with criminal offences are seen as being immune from criminal justice intervention which undermines the confidence of victims and communities in the youth justice system, particularly where the offending behaviour is violent, sexual or persistent. There is also a risk that unless there is appropriate intervention to tackle such behaviour, both the offending and the mental disability will deteriorate and the youth will add to the growing number of prisoners with mental health problems when he reaches adulthood. An amendment to the legislation to allow the youth court to make a supervision order following a finding that the youth had committed the actus reus, would

¹⁵ *Keenan v United Kingdom* (2001) 33 EHRR 38 (App No 27229/95).

¹⁶ [2003] UKHL 25, [2003] 1 WLR 1213.

¹⁷ [2005] EWCA Crim 2077, [2006] 1 Cr App R (S) 91.

place a youth under the supervision of a member of the youth offender team and could include conditions to engage in programmes to address the causes of the offending behaviour with the aim of preventing further offending.

- B.161 A member of the Criminal Law Committee of the Law Society stated that it is regularly the case that an accused in the youth court understands very little of the proceedings, but does not fall within MHA criteria.

65. Are there practical problems caused by the mismatch between the criminal law's approach and the broader criminal justice initiatives for dealing with the mentally ill?

- B.162 The CPS did not think there was a mismatch, rather that the two could be complementary:

The purpose of the insanity defence is to prevent a person from being criminalised for their behaviour when they are suffering from significant mental illness and to provide treatment and protection for the public where necessary. This seems consistent with the cross government Health and Criminal Justice Programme which recognises that many offenders have mental health and/or substance misuse problems and social care needs. The overarching aim is to improve health and social outcome for adults and children in the criminal justice system. It focuses on early intervention, liaison and diversion from custody where diversion from the criminal justice system is not possible.

It seems to us that while the purpose of the insanity defence should be as described, there are strong arguments for saying that that is not how it is working at present.

- B.163 The CECJS Northumbria group were critical of piecemeal reform in this area, in other words, of reform of one part of a relevant area of law without reform of the related areas. The example they gave was of reform of diminished responsibility "in isolation from homicide". They commended a holistic approach:

Insanity does not cause practical problems because it is so rarely applicable. Of more interest to practitioners of all disciplines are criminal justice initiatives (such as diversion projects, fitness to plead and treatment following sentence). A more holistic approach seems to be being adopted in relation to such initiatives and we think it essential that any reforms to the insanity defence are informed by the work that is ongoing in these areas.

- B.164 A solicitor (Joy Merriam) felt that there was a serious practical difficulty arising from the fluctuating nature of mental illness: her client may be unfit to plead at one stage, but then fit later, which makes it difficult then to prepare for trial in time.

AUTOMATISM

66. Are consultees able to provide examples of how the automatism defence applies in such cases in practice?

- B.165 Examples provided by consultees were the Thomas sleepwalking case (on which see the response of Lord Justice Davis); the MacBrayne cardiac event while driving case; one mentioned by a mental health professional in which the accused said that a killing and serious injury were committed in the throes of a post-epileptic fit (but the defence did not succeed at trial); and one mentioned by the CCRC of indecent exposure in which the accused argued that it was committed in a state of automatism due to hypnotism (the defence did not succeed).

67. Are consultees able to provide examples of whether the automatism defence has been applied in such cases in practice? [such cases here meaning cases of internal malfunctioning which is not a disease of the mind]

- B.166 The CPS did not have any examples of cases in which a defence of automatism is based on an internal malfunction of the body that is not a disease of the mind, such as cramp or a heart attack. The CPS surmised that any such cases, where adequate evidence was supplied to the CPS of a total loss of control due to a physical cause would result in the CPS dropping the case as it would fail the evidential test.
- B.167 Professor Mackay wrote that:

I'm not so sure that an attack of cramp is not an internal factor as it is stated that "Recent developments indicate that the cause of cramps most likely involves hyperactivity of the nerve-muscle reflex arc. In this scheme, some of the normal inhibitory activity of the central nervous system (CNS) reflexes is lost as a result of CNS fatigue or overuse of feedback communication with muscles. These spinal reflexes use two receptors, known as Golgi tendon organs and muscles spindles, found in skeletal muscles. Golgi tendon organs may become inhibited and muscles spindles can become hyperactive, leading to sustained activation of the muscle".

68. Are consultees able to provide other examples of the automatism defence being applied in such cases? [such cases here meaning cases where a person is in a dissociative state due to trauma]

- B.168 No examples were provided. Dr James Reed commented that "in truth any 'disease of the mind' might be traced back to some form of external factor but this could not therefore render all insane automatisms sane by virtue of this".

69. Does the lack of clear definition give rise to problems in practice?

- B.169 Counsel and the judge involved in the Thomas sleepwalking case thought the lack of clear definition and difference in outcome (according to whether an action is sane or insane automatism) caused "substantial practical difficulties". HHJ Thomas QC described the distinction between sane and insane automatism as "paper thin". Dr James Reed thought it caused "very significant" problems, namely delay and possible injustice.

- B.170 The CBA thought that there could usefully be a clear statutory definition, and commended Lord Denning's definition in *Bratty*¹⁸ but without the words "or whilst sleepwalking".

70. Does the application of the automatism defence in cases of strict liability give rise to problems in practice?

- B.171 Two respondents answered this question affirmatively. Dr James Reed thought the most likely problem was that the defence is not considered in strict liability cases.

71. Are consultees aware of this requirement for a complete loss of control giving rise to difficulties in practice? Please provide examples.

- B.172 Professor Mackay wrote, "Isn't there also the argument that *A-G's Reference (No 2 of 1992)*¹⁹ only applies to driving offences? In which case here we have another complication." He also queried the requirement for a complete loss of control and how that sits with sleepwalking cases.
- B.173 Lord Justice Davis wrote of "real problems in practice of the lack of any clear definition or sensible framework in which to apply it in sleepwalking cases". See also the earlier RCP comment as to the difficulty which arises when the law requires a definitive answer when the medical view is that there are degrees of loss of consciousness and loss of control.
- B.174 The CCRC referred to a case of wounding with intent to cause grievous bodily harm where the question of whether the accused had suffered a complete loss of control was in contention.
- B.175 The CPS expressed the view that partial loss of control may be relevant to mitigation, but not lead to a conclusion that a person wholly lacked criminal responsibility.

72. We would welcome examples of recent cases in which the automatism defence has been successfully applied in cases other than those involving road traffic offences.

- B.176 CECJS Northumbria stated that a senior forensic psychiatrist had experience of at least one case in the last twenty years where sleepwalking had been treated as a plea of automatism rather than insanity; this plea was based upon a combination of intoxication and somnambulism and was successful.
- B.177 The CPS was able to refer to one case (see Q21).
- B.178 Lord Justice Davis referred to *Thomas*.

¹⁸ [1963] AC 386, 409.

¹⁹ [1994] QB 91.

B.179 The CCRC mentioned one case it had referred to the Court of Appeal in which the issue of automatism might have been raised on appeal in respect of a co-defendant but noted that the defence was not in fact raised (*Shale*).²⁰

73. Can consultees provide examples of cases in which automatism pleas have been made based on defendants having taken intoxicants or medication?²¹

B.180 The CCRC “has considered several cases where automatism due to intoxicants or medication was raised in the application. These cases tend to fit into two broad categories. The first is where medical opinion suggests that the drug in question could not be a factor in a claim of automatism. Examples of such medication are anti-depressants and over-the-counter painkillers. The second category concerns those cases where the taking of intoxicants or medication (such as alcohol or illegal drugs) carried a risk of harmful behaviour and that the applicant fully knew this before taking the substance in question.” The case mentioned by the CCRC concerning wounding with intent to cause grievous bodily harm was one in which the automatism was said to have been brought about by medication.²²

B.181 A member of the Criminal Law Committee of the Law Society gave the following example where he represented a woman in breach of a restraining order forbidding her going into particular charity shops. She had been traumatised and he suspected had PTSD and self-medicated with alcohol. She had no understanding that what she did in the charity shops is wrong. She would breach the restraining order, be prosecuted, the case would go off for trial, and she would commit further breaches in the interim.

B.182 The CPS wrote:

As indicated in our response to Questions 5 and 22 above, in our experience, pleas of automatism are usually made despite evidence that the defendant has taken intoxicants.

A defendant was tried summarily for theft and common assault arising from an attempt by a store detective to apprehend the defendant when he left the shop without paying for a book. The defendant said that he had no recollection of the theft; he left the shop in a haze and was confused and distressed when he lashed out at a young black man who he thought was trying to rob him. The defendant and his GP gave evidence that at the time of the offences, the defendant was taking newly prescribed medication that had side effects that led to the defendant forgetting to pay for the book and being confused. The defendant stated that he had taken more than the prescribed dose because he had lost his glasses and could not read the instructions, but in cross examination admitted that he was in so much pain that he would have taken more than the prescribed dose anyway.

²⁰ [2009] EWCA Crim 1362, [2009] All ER (D) 106 (Jul).

²¹ Since the publication of the Scoping Paper, the Court of Appeal has considered the effect of voluntary intoxication on a plea of automatism: see C [2013] EWCA Crim 223.

²² See above at para B.174.

In cross examination, the GP agreed that he had based his opinion on the defendant's version of the events, but continued to say that the incidents were out of character. The defendant was convicted and sentenced to a conditional discharge (he was in his 60s and had no previous convictions) and a compensation order. The magistrates accepted the evidence of the store detective that the defendant was watchful and looked around him before taking the book which he concealed inside his jacket. They also found that the store detective approached the defendant and asked him to return to the store with the book, but that the defendant struck the store detective several times in an attempt to get away. They were not satisfied that any prescribed medication that the defendant may have taken had caused him to behave in the way he claimed.

In another case, a defendant was acquitted of two common assaults and criminal damage during an episode of "air rage." He gave evidence that he had taken two sleeping tablets and alcohol at the beginning of the flight and had no recollection of his behaviour. Additional evidence was adduced to state that the defendant was not aware that the tablets should not be combined with alcohol. The defence of automatism was successful; apparently the jury accepted that the defendant was not reckless enough to voluntarily consume the tablets and alcohol."

B.183 Dr James Reed referred to

a case of sleepwalking where the defendant had been drinking heavily beforehand. The offence was a sexual assault. One of the issues was whether the consumption of alcohol would have negated any later automatism because it was voluntary and the defendant had previously sleepwalked after taking alcohol.

My argument was that there was no reasonable expectation that he could have known that he would commit such an offence as it had never occurred before whilst sleepwalking. Unfortunately this point was not ever decided upon but it does highlight the difficulties with the defence.

74. Does the fact that the burden of proof rests on the prosecution in automatism create difficulties in practice? If so, please provide examples.

B.184 Two respondents said that it did not create difficulties. Lord Justice Davis said that it did not create difficulties in the *Thomas* case, but had the prosecution gone ahead it could have done.

B.185 The CPS response read:

The usual practice in "sexsomnia" cases is for the defence to assert that the act happened while the defendant was asleep and then to adduce evidence of previous occasions in which the defendant initiated sexual activity in his sleep. A history of similar incidents, especially when supported by previous partners, lends credibility to the defence and makes it unlikely that the prosecution can prove

beyond reasonable doubt that the defendant was not asleep and therefore did not lack mens rea at the time of the offence. Please see our answer to Q 21 for further details about our legal guidance in “sexsomnia” cases.

75. Does this difference in burdens between insane and sane automatism create difficulties in practice? Please provide examples.

- B.186 Respondents accepted that the differing burdens of proof can or do create difficulties, but the CPS were not aware of cases other than *Roach*²³ in which this had been a problem. Mr Justice Holroyde thought that a careful “route to verdict” could deal with it.

76. We are interested in whether the present law provides adequate public protection. Do consultees have experience of cases in which a defendant successfully pleaded insanity or sane automatism where there was an obvious risk of recurrence of his or her criminal behaviour? What was the outcome?

- B.187 The CPS referred to the lack of powers to protect the public when there is an acquittal. They noted that restraining orders are not available following a finding of unfitness. They also made the following points:

There is a range of civil orders that can be sought by the police and/or local authority that may reduce the risk of recurrence of criminal behaviour such as Anti-social Behaviour Orders, Drinking Banning Orders and Risk of Sexual Harm Orders. These orders may be more effective for those who were acquitted on the basis of sane automatism as they are [more] likely than those who are “insane” to understand the terms of the order and the consequences of breach.

It would be useful to explore greater use of section 3 Mental Health Act 1983 where a defendant is acquitted and a hospital order is not made, although the statutory grounds for compulsory treatment in hospital are satisfied. Consideration could also be given to introducing legislation that would allow a civil court to make a restriction order where a patient is detained under section 3 Mental Health Act 1983 and the patient poses such a risk to the public that he should not be discharged without the leave of the Secretary of State or the Mental Health Review Tribunal.

- B.188 HHJ Paul Thomas QC referred to the case of *Thomas* and said that “more flexibility is essential”.
- B.189 Dr James Reed was also concerned about sleepwalking cases, and gave the example of where a sleepwalker had committed a sexual assault and the case was discontinued by the prosecution at the direction of the judge. There were, however, in Dr Reed’s view, “significant risk issues associated with this individual’s behaviour as a result of a combination of sleepwalking and heavy alcohol consumption. He had previously behaved in a high-risk manner (although

²³ [2001] EWCA Crim 2698, [2001] All ER (D) 98 (Dec).

not in a sexually aggressive manner) when either sleepwalking or intoxicated, and there was no reason to suppose that he would not commit similar acts when sleepwalking in future". Adequate protection for the public was not provided by existing disposals, leading Dr Reed to conclude that "it should be possible to impose some form of supervision on those acquitted because of automatism as in many cases (depending on the nature of the automatism) the behaviour might well be prone to recur".

OTHER MATTERS

- B.190 There was concern amongst solicitors, CPS and NHS Protect about assaults on hospital staff: both that they are not prosecuted because they go through a clinical filter, and that they are automatically prosecuted, depending on the practice of the particular institution.
- B.191 A solicitor pointed out that if an individual is prosecuted and a conviction or guilty plea results, then a hospital order may be appropriate. However, the individual may not be accepted by the hospital due to the nature of the offence, and so be imprisoned, and then possibly transferred back to hospital.
- B.192 There is a problem with policy in relation to diversion because full admission is a precondition for a caution or conditional caution. This is not necessarily practicable for someone who is unwell.

LIST OF CONSULTEES

Organisations
Criminal Bar Association
Criminal Cases Review Commission
Criminal Law Committee of the Law Society
Crown Prosecution Service
Justices' Clerks Society
London Criminal Courts Solicitors' Association
Magistrates' Association
Mr Justice Holroyde on behalf of the Judiciary
NHS Protect
North London Forensic Psychiatrists
Royal College of Psychiatrists
School of Law, Centre for Evidence and Criminal Justice Studies, Northumbria University
Yorkshire Centre for Forensic Psychiatry
Individuals
Dr James Reed (Consultant Forensic Psychiatrist)
Dr Neil Boast (Consultant Forensic Psychiatrist and Clinical Director)
HHJ Paul Thomas QC (Welsh Circuit)
Joy Merriam (Solicitor)
Lord Justice Davis (Court of Appeal)
Nicola Padfield (Fitzwilliam College, University of Cambridge, Senior Lecturer)
Professor Ronnie Mackay (De Montfort University, Professor of Criminal Policy and Mental Health)
TV Edwards LLP (Solicitors)