Original article

The Law Commission's proposals for the reform of the defences of insanity and automatism

Medicine, Science and the Law
2015, Vol. 55(3) 156–161

DOI: 10.1177/0025802415582314
msl.sagepub.com
SAGE

David Ormerod

Abstract
The article offers an overview of the Law Commission's project on Insanity and Automatism and the provisional conclusions reached in its Discussion Paper in 2013.

Keywords
Automatism, Criminal Law, insanity, reform

Do the criminal justice and mental health systems deal fairly and equitably with mentally disordered offenders? The Law Commission – whose statutory function is to ensure that the law is as fair, modern and simple as possible – has concentrated on two separate but linked aspects of this question. The first relates to an accused who was mentally disordered at the time of the offence and is governed by the defences of insanity and automatism. The second relates to an accused who is mentally disordered at the time of criminal proceedings and asks whether he or she is fit to plead and stand trial. Both legal tests have their roots in 19th-century cases,[1] when the science of psychiatry was in its infancy. The criteria for both tests are widely regarded as outmoded and ripe for reform.

The reform process on insanity and automatism

With regard to the defences of insanity and automatism, the academic criticisms of the M'Naghten Rules are well-known, but there is less evidence that the defences create problems in practice. So the Commission published a Scoping Paper in July 2012 to elicit evidence of how practitioners and others work with the defences. We followed it up with a Discussion Paper on the defences of insanity and automatism, published on 23 July 2013.

From the responses to the Scoping Paper, we found that defence practitioners and psychiatrists tend to work round the legal technicalities of the M'Naghten Rules and focus on the outcome for the defendant.[2] The label of 'insanity' is still stigmatising for many.

The Discussion Paper

The question at the heart of the Discussion Paper is whether the law employs the right test to distinguish between those who should be held criminally responsible and those who, by reason of their medical condition, should not. The paper sets out provisional proposals for reform of the defences of insanity and automatism. In publishing these provisional proposals, we aim to contribute to the broader public debate on the reform of the criminal law as it relates to mentally disordered defendants.

The current law

It is for the defendant to prove, on the balance of probabilities, that he or she is insane within the test laid down in M'Naghten. 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'.[3]

Following a special verdict, the Crown Court has the power to make an absolute discharge (in other words, that there will be no further action) or a supervision order, 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.

Currently, the special verdict can only be returned on the written or oral evidence of two or more

Criminal Law Team, Law Commission, London, UK

Corresponding author:
David Omerod, Criminal Law Team, Law Commission, 52 Queen Anne's Gate, London, SW1H 9AG, UK.
Email: criminal@lawcommission.gsi.gov.uk

'registered medical practitioners', at least one of whom is duly approved.[4] 'Duly approved' means 'approved for the purposes of section 12 of the Mental Health Act 1983 by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder'. In practice, they are usually psychiatrists.

There is no procedure for a special verdict of 'not guilty by reason of insanity' in the magistrates' courts. The result is that where the defence succeeds, the defendant is acquitted.

If a person totally lacked control of his or her body at the time of the offence, and that lack of control was not his or her fault, then he or she may plead not guilty and may be acquitted. This is referred to as the 'defence' of automatism.[5] This exemption exists at common law and is available for all crimes. Although there is no statutory requirement for *expert* evidence to support a defence of automatism, case law states that there has to be evidence to support the defence,[6] and by the nature of the defence, it may have to be expert evidence. For example, if the accused claims to have suffered a blackout, then medical evidence will be expected.

Overview of the Law Commission proposals

The new defence: 'not criminally responsible by reason of recognised medical condition'

We think that people who totally lacked capacity not to commit the crime charged, because of a medical condition and through no fault of their own, should have a defence. We see no good reason to limit such a defence to mental disorders; rather, there are good reasons for it to cover physical and mental disorders.

We therefore provisionally propose abolishing the common law defence of insanity and replacing it with a statutory defence of 'not criminally responsible by reason of recognised medical condition'. This defence would be available where, because of a recognised medical condition, a person totally lacked one of the following capacities in relation to what they are charged with having done: to make a judgement rationally; to understand that they are doing something wrong; or to control their actions.

The rationale for the new defence does not depend on the kind of offence that the defendant is charged with, and therefore the new defence would be available in relation to any kind of offence. This would represent a change from the position under the current law whereby, in the magistrates' courts, a defence of insanity is not, on one view, available for offences of strict liability.[7]

The new defence would not depend on the seriousness of the offence that the defendant is charged with, and so the new defence and special verdict would be available in the magistrates' courts as well as in the Crown Court.

The proposed new defence would lead to a new special verdict – 'not criminally responsible by reason of a recognised medical condition'. Following this verdict, both the Crown Court and the magistrates' courts would be able to make a hospital order, a supervision order or an absolute discharge, and the Crown Court would be able to make a restriction order. As regards children and young people, we think that the courts should also have the option of making a non-penal Youth Supervision Order. A court could attach non-punitive requirements, such as a mental health treatment requirement, or a medical requirement, where the court thought it would be beneficial.

A reformed defence of automatism

The reformed defence of automatism would cover the situation where the accused had been unable to control his or her actions for reasons *other* than a recognised medical condition. So, for example, where conduct that would otherwise be criminal was no more than a reflex action, the person would be able to plead automatism. If successful, that plea would lead to an acquittal, as now. We anticipate that very few such cases would come before the courts.

The recognised medical condition defence and the automatism defence would be mutually exclusive. In other words, if a person's loss of capacity is due to a recognised medical condition, then the defence of automatism is not available.

The relationship to the law on intoxication

The new defences would need to be coherent with the rules on voluntary and involuntary intoxication.[8] We therefore provisionally propose one minor change to the rules on involuntary intoxication, but we do not go into that here.

Procedural aspects

The reverse burden of proof. Under the current law, the burden is on the accused to prove the defence of insanity. Our view is that this is wrong in principle and is unnecessary.[9] We propose instead that the accused should have to call evidence from two experts, but that once he or she has done that, it should fall to the Crown to disprove that defence.

Lack of need for a trial. Empirical research has shown that in some cases, the need to put a case before a jury for the jury to return a verdict of 'not guilty by reason of insanity' is a waste of court time and resources, as all parties are agreed on the outcome and the verdict is a formality.[10] We therefore propose that the jury verdict can be dispensed with if the accused is legally represented, no jury could reasonably reach any other verdict and the judge records the reasons for the verdict.[11]

The Law Commission proposals in detail

In the rest of this article, we examine specific aspects of the proposals, in particular we look at what constitutes a recognised medical condition, what the role is of the expert in this new defence, how many expert reports will be required as a minimum, the specific cases involving sleep disorders, and how redrawing the boundary between the new defence and automatism brings advantages.

'Recognised medical condition'

Whether a condition is a recognised medical condition is to be a question of law for the court to determine. This requires the judge, District Judge or lay bench to decide whether there is evidence from which a jury could conclude that the condition caused the accused's lack of capacity as alleged. If this initial hurdle is not passed, then there will be no legal basis on which the defence could proceed.

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 that 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, but even if it is, that does not mean that it will invariably constitute a 'recognised medical condition' for the purposes of the new defence. Equally, in some very rare cases, a condition which is not listed might be accepted by the courts as a 'recognised medical condition' if there is adequate evidence of its general acceptance by professionals.

The significance of the condition is the impact it has on the relevant capacities: it must have given rise to the total lack of a relevant capacity.

As a matter of policy, not all medical conditions will qualify as 'recognised medical conditions'. Medical conditions are defined and diagnosed primarily for medical purposes, and it does not always follow that a medical condition should form the basis for a defence in criminal law. The reason is, as Lord Justice Hughes has stated, that 'there will inevitably be considerations of legal policy which are irrelevant to the business of medical description, classification, and statistical analysis'.[12]

An obvious example is acute intoxication, which appears as a condition in standard reference manuals. It would be odd, and contrary to well-established principles in the common law, to allow the state of being voluntarily very drunk to act as a non-responsibility defence. Acute intoxication, therefore, would not be a qualifying recognised medical condition.

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.

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.[13]

The role of the expert

Expert evidence will be necessary, though not conclusive. 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 person's motives and behaviour'.[14] The question of 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, public condemnation and the attribution of blame.

We conclude that the ultimate question – whether a person is not responsible due to his or her lack of capacity – is not ultimately an expert judgment. It is a judgment by the jury or magistrates, informed by expert opinion.

The current law requires evidence from two medical practitioners, one of whom must be a psychiatrist, to support a defence of insanity, but this requirement would not be appropriate for a defence which extends beyond mental health conditions to any recognised medical condition. The kind of expert evidence will depend on the kind of recognised medical condition which is in issue. So the relevant expert might be a psychiatrist, a medical practitioner, a psychologist or a person with another expertise. We therefore propose retaining the requirement for two experts, but only one of them need be a medical practitioner.[15]

The expert evidence would address questions of whether the condition is a medical condition recognised by the relevant profession; whether the condition the accused is said to have could cause a lack of capacity as is claimed in the particular case; 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.

Redefining the boundary between 'insanity' and sane automatism

One consequence of the courts' broad interpretation of M'Naghten is that people with conditions that would not generally be described as mental disorders have been held to come within the M'Naghten test. These include, for example, sleepwalkers, and people with epilepsy[16] or diabetes.[17]

This has come about because the law, in the interpretation of M'Naghten,[18] has adopted a distinction between whether the cause of the accused's lack of control was due to an 'internal factor' (i.e. some malfunctioning of the person's body) or an 'external factor' (such as a blow to the head). 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. The 'external factor' category includes cases 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'.[19] This leads to illogical and strange results, some of which are illustrated by the sleep disorder cases below.

If the defence of insanity were reformed as we suggest, those defendants who suffer a total loss of control due to a recognised medical condition would fall within the new recognised medical condition defence unless they were at fault in bringing about their loss of capacity. This would include cases of automatic conduct resulting from medical conditions such as a sleep disorder.

Our proposals abolish the distinction based on internal or external causes, with the following advantages.

First, the incoherent results 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.

Second, 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 conditions.

Lastly, this approach allows for greater public protection than 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. The court has no powers to take steps for the protection of the public if a person is acquitted, but if, say, the diabetic or the person with a sleep disorder 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 less likely.

Specific case: sleep disorders

The courts' approach to crimes committed while sleepwalking has changed over time. In the 19th-century case of *Tolson*,[20] 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*.[21] However, in *Burgess*,[22] 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.

There are signs, in very recent years, that in applying *Burgess* the lower courts have not applied *Burgess* strictly treating sleepwalking as a plea of sane automatism. Recent examples include *Bilton*,[23] 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 disorder'[24] but rather appears to be a clear somnambulistic episode, traditionally within the ambit of *Burgess* and the insane automatism defence.[25]

The strict approach in *Burgess* may also be contrasted with the Canadian case of *Parks*,[26] 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'.

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.[27] 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?'.[28]

There is even less clarity in the correct legal approach where internal and external factors coexist, for instance, where an individual sleepwalks and suffers from alcohol-induced confusional arousal.[29] This confusion can be seen in the contrasting cases of *Lowe*[30] and *Pooley*.[31]

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.[32]

However, in *Pooley*, 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, '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'.[33]

Finally, an important consideration is that the court has discretion as to disposal, including absolute

discharge and supervision, but these powers depend on a verdict of insanity, whereas if 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'.[34]

If, for example, an HGV driver crashes into another vehicle and there is expert evidence that it was a case of undiagnosed sleep apnoea, 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 proposals would lead to sleep disorders being treated as 'recognised medical conditions', and allow courts to exercise the disposal powers that would go with the new special verdict.

Read the paper

The full discussion paper, and a summary paper, can be downloaded from http://lawcommission.justice.gov.uk/areas/insanity.htm

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Notes

1. *M'Naghten's Case* [1843] 10 Clark and Finnelly 200, [1843] 8 ER 718, [1843–60] All ER Rep 229 and *Pritchard* [1836] 7 C & P 303 respectively.
2. An analysis of the responses to the Scoping Paper was published as Appendix B to the Discussion Paper.
3. Section 2(1) of the Trial of Lunatics Act 1883.
4. Section 1(1) of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.
5. A well-known definition of automatism takes it to involve 'an involuntary movement of the body or limbs of a person [following] a complete destruction of voluntary control': *Watmore* v *Jenkins* [1962] 2 QB 572, 587, by Winn J.
6. *Stripp* [1979] 69 Cr App R 318; *Bratty* [1963] AC 386, 413; and see *Moses* v *Winder* [1981] Road Traffic Reports 37 and *Cook* v *Atchinson* [1968] Crim LR 266.
7. According to one interpretation of the law in *Director of Public Prosecutions* v *Harper* [1997] 1 WLR 1406, it is only available if there is a mental element in the offence.
8. For consideration by the Court of Appeal of the interaction of insanity, automatism and intoxication, see *C* [2013] EWCA Crim 223, [2013] All ER (D) 06 (Apr).
9. We discuss this issue in detail in chapter 8 of the Discussion Paper.
10. The results from empirical studies suggested that, during the period studied, in more than half of cases in which the insanity defence succeeded, the jury was directed by the judge to give a verdict of not guilty by reason of insanity. See RD Mackay, BJ Mitchell and L Howe, Yet more facts about the insanity defence [2006] Crim LR 399.
11. We discuss this issue fully in chapter 7 of the Discussion Paper.
12. *Dowds* [2012] EWCA Crim 281, [2012] 1 WLR 2576 at [30].
13. 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 and *C* [2013] EWCA Crim 223. We note also the approach of the Canadian Supreme Court in the case of *Bouchard-Lebrun* [2011] SCC 58.
14. See EP Trager, The insanity defence revisited *Medico-Legal J Ireland* 1998; 4 (1): 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, *Am Bar Assoc J* 1983; 69 (2), 194, 195. 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.
15. If a psychiatrist is the relevant expert, then he or she would still be subject to the requirement of section 12 of the Mental Health Act 1983.
16. *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, *South African Law J* 1996; 9: 191; GM Paul and KW Lange, Epilepsy and criminal law, *Med Sci Law* 1992; 32: 162.
17. *Hennessy* [1989] 89 Cr App R 10; *Bingham* [1991] Crim LR 433; compare *Bailey* [1983] 2 All ER 503; *Quick* [1973] QB 910.
18. See e.g. *Sullivan* [1984] AC 156.
19. *Quick* [1973] QB 910, 922.
20. [1889] QBD 168, 187.
21. See *Bratty* [1936] AC 386 at 409, by Lord Denning and at 415, by Lord Morris of Borth-y-Gest.
22. [1991] 2 QB 92.
23. *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 RD Mackay and M Reuber, Epilepsy and the defence of insanity: time for change? [2007] Crim LR 782, 791.
24. 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, *Med Sci Law* 2008; 48 (2): 124.
25. RD Mackay and BJ Mitchell, Sleepwalking, automatism and insanity [2006] Crim LR 901.
26. *Parks* [1992] 2 SCR 871.
27. I Ebrahim and P Fenwick, Sleep-related automatism and the law, *Med Sci Law* 2008; 48: 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.

28. Mackay (1995) p.46.
29. I Ebrahim and P Fenwick, Sleep-related automatism and the law, *Med Sci Law* 2008; 48 (2): 124.
30. *Lowe* (19 Mar 2005) *The Times* (unreported).
31. *Pooley* (12 Jan 2007) *The Daily Mail* (unreported) and RD Mackay and M Reuber, Epilepsy and the defence of insanity: time for change? [2007] Crim LR 782, 791.
32. RD Mackay and BJ Mitchell, Sleepwalking, automatism and insanity [2006] Crim LR 901.
33. RD Mackay and M Reuber, Epilepsy and the defence of insanity: time for change?' [2007] Crim LR 782, 791. See also CPS guidance on self-induced intoxication: *Defences – Sleepwalking as a defence in sexual offences cases*. www.cps.gov.uk/legal/d_to_g/defences_-_sleepwalking_as_a_defence_in_sexual_offence_cases/ (accessed 3 Sept 2013).
34. W Wilson, I Ebrahim, P Fenwick, et al. Violence, sleepwalking and the criminal law: Part 2: The legal aspects [2005] Crim LR 614, 622. See also D Ormerod and K Laird, *Smith and Hogan's Criminal Law* (14th ed 2015), Ch 11.