# Insanity and blaming the mentally ill - a critique of the prior fault principle in the Law Commission's discussion paper

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*Crim. L.R. 21* *In 2013, the Law Commission published important provisional proposals for replacing the current insanity defence with a new special verdict of "not criminally responsible by reason of recognised medical condition". Despite the passage of time, the proposals are an important starting point for reforming the defence of insanity. One proposal was that the new verdict, unlike the current defence, should be subject to the prior fault principle. This article takes issue with that proposal. We argue that introducing fault and blame into mental illness is unwarranted. We conclude that instead the focus should be on strengthening the disposals available following the special verdict to ensure that suitable help and support is provided while at the same time enhancing public protection by providing that those who reject the support offered may face the prospect of adverse consequences.*

## Introduction

It is a lamentable fact that in England and Wales the legal test of insanity continues to be governed by the answers given by judges in 1843 to five abstract questions of law posed by the House of Lords.[1] Those answers constitute the M'Naghten Rules (the Rules).[2] The Rules are questionable both in relation to their provenance and, even by the standards of 1843, their understanding of mental illness.

Periodically, there have been proposals for reform of the law.[3] The most recent are those contained in a Discussion Paper (the DP) issued by the Law Commission *Crim. L.R. 22* (the Commission) in 2013.[4] Since then other commitments have prevented the Commission from returning to the project. As a result, reform of the insanity defence has fallen off the radar. However, despite the passage of time, it would be a mistake to view the DP as now being of merely historical interest. Whatever view one takes in relation to its specific proposals, there has since been no advance on the DP. Accordingly, despite its nascent status, it is the starting point for reform of the law.

Further, absent legislative reform, sooner or later the Supreme Court will be invited to revisit the case law that has interpreted the Rules. In our view, practitioners will find the DP a valuable resource for highlighting the manifest deficiencies of the Rules as hitherto interpreted as well as advancing arguments as to how the Rules should be properly interpreted.

In this article, we focus on one aspect of the Commission's proposals, namely the role that the principle of prior fault should play. In doing so, and despite being critical of the Commission's proposals in this regard, we hope this article will help to revive interest in both the DP and the need for reform.

The Commission provisionally proposed replacing the common law defence of insanity with a new statutory defence resulting in a verdict of "not criminally responsible by reason of recognised medical condition".[5] We refer to this as "the RMC defence".[6] Unlike the current insanity defence, it would not be available if D'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".[7]

The Commission also provisionally proposed that there should be a new statutory automatism defence.[8] The defence would be available if D

"wholly lacked the capacity to control his … conduct and the loss of capacity was *not* the result of a recognised medical condition (whether qualifying or non-qualifying)."[9]

As now a successful plea would result in an outright acquittal. Like the common law defence, it would be subject to the principle of prior fault.[10]

## The prior fault principle

The essence of the prior fault principle is that "culpable" behaviour on the part of D prior to the occurrence of the conduct element of the actus reus of an offence can result in D being held criminally responsible in some circumstances despite D not satisfying orthodox requirements for incurring criminal liability. The *Crim. L.R. 23* departure from orthodoxy is thought to be justified to prevent D from benefiting from his own culpable conduct.

 

Culpable behaviour can take diverse forms but the behaviour with which the prior fault principle is primarily associated is self-induced intoxication through the consumption of alcohol/dangerous drugs. [11] However, for the purpose of the current insanity defence and the proposed RMC defence, a state of self-induced intoxication is not a disease of the mind and would not be a recognised medical condition (RMC). [12] Accordingly, self-induced intoxication through the consumption of alcohol/dangerous drugs would be a relevant factor only in cases of co-morbidity where a state of intoxication co-exists with a RMC. [13]

### *The operation of the prior fault principle*

The prior fault principle operates to construct offences and to block defences which would otherwise be available. [14] With regard to the former, its operation is based on a judicially created distinction between "specific" and "basic" intent offences. [15] In relation to "basic" intent offences, the prior fault principle subverts orthodox principles by creating a fiction that D acted voluntarily and/or had the requisite mens rea even if in fact he did not.

The extent to which the prior fault principle forms part of English criminal law on defences is unclear. There is no legal presumption that a *statutory* subjective belief defence is subject to the principle. [16] Further, whether or to what extent the common law defences of duress and self-defence attest to the principle is debateable.

Regarding the former, the voluntary exposure to threats test formulated in *Hasan* [17] is of such width that it cannot be described accurately as an expression of the prior fault principle. [18] Regarding self-defence, even if D is the initial aggressor/provoker, the prior fault principle does not preclude the defence if the violence offered by V in response was so disproportionate that "the roles were reversed". ***Crim. L.R. 24*** [19]

### *"Culpable" conduct*

It might be thought that a pre-requisite for the effective operation of the principle would be clear and coherent rules for determining what constitutes "culpable" conduct. Instead, the case law reveals a lack of clarity and precision. The DP identifies no less than four possible tests. [20]

The lack of clarity and precision may reflect the complex nature of "culpability" for the purpose of prior fault. D, a diabetic charged with assault occasioning actual bodily harm, [21] pleads automatism on the basis that at the time of the alleged offence he was in a hypoglycaemic state through not eating sufficiently after taking insulin. [22] Several questions require consideration. Did D know that he should eat sufficiently? If "no", does it suffice that he ought to have known? Does his failure to eat have to be the result of culpability on his part? If "yes" does inadvertence amount to culpability? Does that depend on the basis of the inadvertence—mere forgetfulness or forgetfulness as the result of depression or fatigue?

Must D also foresee the consequences of not eating? [23] Or is it enough that he ought to have appreciated them? [24] What is denoted by consequences? Does it denote merely the onset of automatism? [25] If "no" must D foresee not only that he might become not just unpredictable or aggressive but that he might commit the actus reus of the offence charged and, in a non-automatism case like *Hardie*, [26] do so with the requisite mens rea? [27]

Since self-induced intoxication through the consumption of alcohol/dangerous drugs in itself is deemed to be culpable conduct sufficient to engage the prior fault principle, the problem of formulating a precise test for determining "culpability" in relation to other conduct can be overlooked. In our view, this is a relevant consideration when evaluating the merit of extending the principle to the RMC defence.

**The rationale for applying the prior fault principle to the RMC defence**

The DP states:

"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 ***Crim. L.R. 25*** 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." [28]

It is difficult to reconcile the claim that the aims are "not to introduce change" with what is being proposed, namely extending the prior fault principle to the RMC defence. We acknowledge that it was not part of the Commission's remit to consider the prior fault principle outside the spheres of insanity and automatism. [29] However, it was open to it to consider the merits of the principle before proposing that it should be extended to the RMC defence. [30] The Commission's overriding aim is to ensure consistency. However, consistency between the RMC and automatism defences could be achieved if *neither* were subject to the fault principle. Likewise, as regards the Commission's legitimate aim of ensuring that, where medication is prescribed for an RMC, there is no distinction between misusing it and not taking it. The price paid for the quest for consistency is that cases that currently qualify for the insanity defence would not qualify for the RMC defence. [31]

**An outline of the proposed RMC defence**
In the absence of prior fault, the RMC defence would be available if D:

"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. [32]

## *(i) A qualifying RMC*

For a medical condition to be "recognised" it must be recognised by professionals in the relevant field. [33] The requirement that it be a "qualifying" medical condition is dictated by policy considerations, namely that certain RMCs should not be allowed to ground the defence. The DP provides two examples—acute intoxication and anti-social personality disorder. ***Crim. L.R. 26*** [34]

A condition which is "external" to D is not a "disease of the mind". [35] Likewise a condition which, although "internal", does not impair D's "mental faculties of reason, memory and understanding". [36] These limitations would not apply to the proposed RMC defence. Accordingly, it is difficult to envisage any condition that currently constitutes a "disease of the mind" not being an RMC while conditions that currently do not constitute a "disease of the mind" would be RMCs. The result would be that cases that currently fall within the automatism defence, to which the prior fault doctrine applies, would fall within the RMC defence. [37] The automatism defence "would be restricted, broadly speaking, to cases of reflex and one-off causes of total loss of control". [38]

## *(ii) The three incapacities*

### (a) Rationally to form a judgment about the relevant conduct or circumstances

This would replace the "nature and quality" limb of the Rules. The focus would remain on D's cognitive ability but it is a more inclusive incapacity notwithstanding the non-inclusion of consequences. [39] The DP states that "the capacity in issue here is about *how* a person reaches a decision, not whether the decision itself may be judged to be rational." [40] A similarly, but not identically, worded incapacity—"to form a rational judgment"—operates in the context of the diminished responsibility defence. [41] Although that formulation might be thought to focus on the judgment itself, the Court of Appeal has stated that while a jury would need to

"assess a defendant's thinking processes in the context of assessing his ability to form a rational judgment … in some cases it may actually be extremely difficult to separate out the thought processes on the one hand from the 'outcome' on the other hand." [42]

### (b) To understand the wrongfulness of what D is charged with having done

This would replace the "wrongfulness" limb of the Rules. While it is clear that "wrongfulness" would not be restricted to illegality, [43] its intended meaning is not entirely clear. On one view, D would understand that the act was "wrong" if he ***Crim. L.R. 27*** appreciated that it was something he "ought not to do". [44] On another view, D would understand that the act was wrong if he appreciated that his act would be "generally regarded as wrong". [45] The two interpretations are not synonymous. [46] However, whichever is intended, it would represent a broader concept of "wrong" than the current test of "contrary to law". [47]

### (c) To control physical acts in relation to the relevant conduct or circumstances

The inclusion of this incapacity means that, unlike the current insanity defence, the RMC defence would not be restricted to D's cognitive abilities. Although the proposal setting out the incapacity [48] is framed in almost identical terms to that for automatism *not* arising from an RMC, [49] thereby suggesting that it is restricted to cases where D is in a state of automatism resulting from an RMC, it has a wider scope. [50]

In this respect, it is significant that in buttressing the argument, the DP states "The inability to control one's actions does play a part in the partial defence of diminished responsibility". [51] A plea of diminished responsibility can succeed if there is substantial impairment of D's ability "to exercise self-control." [52] For the purposes of the RMC defence, the incapacity is intended to accommodate cases where D is *totally* unable to exercise self-control but is cognisant of the conduct that he is perpetrating.

The three incapacities are more expansive than the limbs in the Rules which they would replace. In addition to accommodating cases which currently fall within the automatism plea, they would encompass cases currently outside the scope of both the insanity and automatism plea.

Further, the nature of the incapacities means that there would be an increase in the proportion of cases where D has the mens rea for the alleged offence. This is most obvious in relation to the "wrongfulness" and "control" incapacities, which are not inconsistent with D having the mens rea for the offence in question [53] but in addition a lack of capacity rationally to form a judgment is not necessarily incompatible with D having the requisite mens rea. We explore below the implications for cases involving offences of "specific" intent where D, having the requisite mens rea, would be precluded from successfully pleading the RMC defence because of his prior fault. ***Crim. L.R. 28***

#### Insanity and fault

The defence of insanity in English criminal law is "fault free" in the sense that "the law takes no notice of the cause of insanity." [54] This means that no matter how much to "blame" D was in relation to the onset or treatment of his "disease of the mind", a special verdict must be returned if D satisfies the other elements of the Rules. However, the Commission's view is that such a blanket exclusion of fault is no longer justified. One of us also originally supported this view questioning whether "the law should continue to adopt this approach." [55] The justification for this view was similar to that of the Commission, namely the need for consistency. However, before considering whether this "need" should take preference over the blanket exclusion of fault which currently underpins the insanity defence, it is worth exploring the reasons for this fault free position.

Prior to the development of the automatism defence, the insanity defence was used only in cases where the accused was suffering from what would now be regarded as a serious mental illness. There was no psychotropic medication at the time of Daniel M'Naghten and very limited treatment options. In such cases, it seems clear that it was regarded as inherently wrong to punish those who were adjudged legally insane. Even in the aftermath of the trial and acquittal on the grounds of insanity of Roderick Maclean for the attempted assassination of Queen Victoria [56] when the nomenclature of the special verdict was changed to that of "guilty but insane" [57] there was no suggestion that labelling the legally insane accused as "guilty" should result in

 

punishment rather than hospitalisation. [58] So do the development of medication to treat the mentally ill, coupled with the fact that the RMC defence would not be confined to those who are mentally ill, mean that the insanity defence should be updated to accommodate the prior fault principle? A principle which has developed out of an automatism defence and intoxication rule which themselves are open to criticism. Or should we, as proposed below, take advantage of a new RMC plea by advocating an alternative approach? ***Crim. L.R. 29***

**"Culpability" and the RMC defence**

Neither the RMC nor the automatism defence would be available if D's lack of capacity is "*due* to something D culpably did or failed to do". [59] On one interpretation, the sole issue would be whether D is culpable in *inducing* the lack of capacity. If so, whether D foresaw, or ought to have foreseen, the lack of capacity would not be in issue. This would represent a significant departure from the current law. [60] However, in our view, for the Commission "culpability" requires consideration not only of D's conduct resulting in the lack of capacity but also whether D foresaw the risk of lack of capacity as a consequence of that conduct. [61]

### *(i) D's conduct resulting in lack of capacity*

The DP states:

"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." [62]

In doing so it opines that if a failure to take a prescribed drug is due to a "lack of insight" or "forgetfulness" resulting from a medical condition then as there is no fault involved an RMC verdict should be returned. [63] However, there are two important points here which merit further discussion. The first is the problem of non-adherence to the medication regime, a major and common problem in mental illness. The second is that in some cases it will be difficult to make a clear distinction between the types of behaviour resulting from lack of insight or forgetfulness and behaviour to which fault might be attached.

### *(ii) The non-adherence problem*

Medication is essential for the effective treatment of many mental illnesses. However, non-adherence to a prescribed medical regime is a common and serious problem. The reasons for non-adherence are numerous and complex. [64] The psychiatric research on this topic reveals some common themes for patient non-adherence to the medication regime prescribed to treat mental illness. In a systematic review of studies dealing with psychotropic medication non-adherence, it was found that: ***Crim. L.R. 30***

"Almost half of patients with major psychiatric disorder did not adhere to their psychotropic medication. Patients' individual behaviour, lack or poor social/family support, treatment and illness-related clinical conditions, and the health system barriers are influencing factors of psychotropic medication non-adherence among patients with major psychiatric disorders." [65]

It is clear from the psychiatric literature that non-adherence is a major problem which is difficult to overcome. [66] Further studies also indicate that non-adherence may be associated with an increased risk of violence. [67] This, in turn, has led to the development of the idea of "meta-responsibility" described by Mitchell as

"the notion that the mentally disordered may in some way be culpable for the causation/exacerbation of the aetiology/symptomatology of their own mental disorder, and that this element of prior fault may have an effect on their criminal responsibility (denoted by the neologism 'meta-responsibility')". [68]

In his detailed discussion of "meta-responsibility" Mitchell argues that this notion of fault liability in respect of the mentally disordered should be applied both to those whose criminal behaviour results from a knowing failure to comply with medication and to those who purposely fail to take medication (or overdose) [69] with a view to inducing aggressive behaviour. [70] However, although the author concludes that the goals of meta-responsibility theory are not punishment but rather treatment and

 

deterrence, it is clear that to achieve what is described as "greater concordance with common-sense notions of justice" [71] a conviction must be returned. This mirrors the view of the DP where it is made clear that there is equal culpability attached to those who abuse their medication regimen whether through a failure to ingest or ingesting too much [72] and that the ensuing liability should not depend on whether or not there was "an underlying medical condition". [73]

### *(iii) Distinguishing behaviour on the basis of fault*

However, as mentioned above, although the Commission does make it clear that in some cases the "the medical condition itself" [74] can play a role in this connection, there is little discussion of the difficulties of making a distinction between behaviour ***Crim. L.R. 31*** resulting from lack of insight or forgetfulness and behaviour to which fault might be attached.

In addressing this issue, the Commission simply states that if in cases where there is an RMC and "The explanation for their behaviour lies in their medical condition … the new special verdict would reflect that" since they "are not culpable in inducing the loss of capacity". [75] But this seems to underestimate the problem of applying the notion of "fault" in cases of non-adherence to the medication regime. Commentators have questioned

"whether there is a clear moral distinction to be drawn between defendants on the basis of the reasons for their non-compliance with medication. In reality, there may be numerous reasons for non-compliance including *inter alia* the stigma attached to certain medications, religious beliefs, paranoia, side effects, and depression." [76]

If the DP is suggesting that there is a clear fault line divide dependent on whether or not the explanation for non-adherence lies in the RMC itself, this circumvents the problem of identifying a contextualised and nuanced test for determining whether D's non-adherence is culpable. However, if so, it seems to follow that D's particular circumstances and beliefs would be immaterial as would systemic obstacles to adherence.

At the same time, a jury would still have to determine whether or not the reason for non-adherence was the "medical condition itself". Consider the case of non-adherence to the medication regime because of adverse side effects. On one view, the side effects are the result of taking the medication and the taking of the medication is a response to the medical condition. Accordingly, the explanation can be traced to the medical condition itself. On another view, the medical condition is not the reason for failing to take the medication in the way that forgetfulness arising from Alzheimer's is. There is the additional difficulty that there are degrees of adverse side effects. [77] Should a jury's determination of culpability depend, at least in part, on their assessment of the extent of the side effects?

The proposal that the prior fault principle should apply to the RMC defence pre-supposes that clear moral distinctions can be drawn between defendants who fail to comply with their medication regime. Given the myriad of reasons for non-compliance, some personal and some systemic, [78] we question the Commission's assumption. In particular, even if one accepts that the prior fault principle has a place in determining criminal liability, we question whether it should be applied to those who are on a prescribed medication regime precisely because they have ***Crim. L.R. 32*** a precarious mental state frequently exacerbated by struggles with alcohol and drug abuse. [79]

### *(iv) Foresight of the risk of total loss of capacity*

Even if, contrary to our view, the application of prior fault to the RMC defence is justified in principle, the practicality of proving that D foresaw the risk of the total loss of capacity is a concern. In this regard, the Commission's proposal regarding the burden of proof is relevant. The Commission proposes that if sufficient evidence is adduced on which a properly directed jury could reasonably conclude that the defence might apply, the prosecution should bear the burden of disproving the defence beyond reasonable doubt. [80] This would entail proving either that at the time of committing the alleged offence, D had not totally lost the capacities or, if unable to discharge that burden, that D had foreseen the risk of total loss of those capacities. [81]

The practical issues are two-fold. First, as Loughnan and Wake point out, a jury would be required to undertake an

"onerous task that would potentially require an assessment of the defendant's antecedent record, medical history, and the documentation provided to the individual regarding the medication regimen." [82]

 

Second, the Commission emphasises correctly that capacity is "issue and time specific" [83] and that the incapacities do not "exist in the abstract: it must be incapacity in relation to a particular act or omission". [84] It follows that to establish culpability, it would not suffice to prove that D, when ceasing to adhere to or overdosing on his medication, appreciated that this might impact on his general capacity for rational thought, understanding wrongfulness or controlling his actions. [85] It would have to be proved that D foresaw something far more specific, namely that he might totally lack the capacity "rationally to form a judgment about the *relevant* conduct or circumstances", [86] "to understand the wrongfulness of what he … is *charged with having done*" [87] or "to control his … physical acts in relation to the *relevant* conduct or circumstances". ***Crim. L.R. 33*** [88]

In this regard, it is interesting to note the Commission's critique of *Bailey* [89] namely that the Court of Appeal adopted a very narrow approach because

"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." [90]

In our view, it would be no less difficult to show that D, when ceasing to adhere to his medication regime, appreciated that he might totally lack the capacity to rationally form a judgment about or to understand the wrongfulness of conduct which "he had no intention to commit". In this regard, the example in the DP illustrating how incapacity to rationally form a judgment could ground the RMC defence is pertinent.

D, a parent who is clinically depressed to the point of being suicidal, jumps off a bridge holding her child. The child dies but D survives and is prosecuted for murder. It is suggested that 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." [91]

Suppose that two weeks before, when depressed but not to the point of being suicidal, D ceased to take her medication so that money spent on medication could instead be spent on clothes. In doing so, she is aware that her depression might worsen. [92] Coming off the medication results in a rapid escalation of her depression leading to the decision to jump off the bridge.

Even if the decision to jump off the bridge is attributable to an acute state of depression resulting from the decision to come off the medication, it would not be possible to prove that in making that decision D foresaw that she might be incapable of rationally forming a judgment regarding the act that resulted in the child's death. The possibility of such an act was simply not in her mind at the point of coming off the medication.

The capacity which seems most receptive to application of the fault principle is the control capacity. "Control" is a tangible concept in a way which rationality and wrongfulness are not. People are more likely to contemplate and appreciate how their conduct might impact on their ability to control their actions as opposed to their capacity for rational thought or understanding wrongfulness. In addition, the difficulties arising from capacity being issue and time specific are to some extent ameliorated where the time span between the conduct inducing the incapacity and the alleged offence is short. A short time frame is often a feature of cases involving diabetics who are unable to control their actions when driving. ***Crim. L.R. 34***

### *(v) The problem of driving offences*

The paradigm case is the diabetic driver experiencing an episode of hypoglycaemia after having taken insulin. [93] Under the current law, such cases give rise to the automatism plea as the consumption of the insulin is an "external" factor. [94] Under the DP's proposals, D's condition would be an RMC.

According to Wasik and Rumbold, "Usually, it is the case that the diabetic driver has been at fault in some way for the onset of the hypoglycaemia." [95] An example is failing to eat sufficiently. Even in cases where the *onset* of hypoglycaemia is not attributable to any fault, the driver may nevertheless be at fault by deciding or continuing to drive despite warning signs of its onset. [96] We acknowledge that at first blush cases of driving with warning signs of a hypoglycaemic episode, involving as

they do the risk of a collision resulting in death or serious injury, constitute a strong case for the application of the prior fault principle to the RMC defence. However, in our view, the RMC defence would have no application in such cases.

It is settled law that a driver who falls asleep can be convicted of dangerous driving on the basis that the offence is committed when he continues to drive despite feeling drowsy. [97] Since the offence is complete prior to the point at which D becomes incapable of controlling his actions, the issue of automatism does not arise. By analogy, our diabetic driver commits the offence when he starts to or continues to drive aware of the pending onset of a hypoglycaemic episode. If so, the RMC defence is inapplicable because the offence has been committed before D loses the capacity to control his actions. [98]

It might be thought that the same analysis cannot be applied if the alleged offence is causing death by dangerous or careless driving and the collision resulting in death occurs after D has lost consciousness. Although the conduct element of the actus reus occurs while D is in control, the consequence element does not. In *Marison* [99] the charge was causing death by dangerous driving following a collision at which point D was unconscious as a result of a hypoglycaemic episode. Upholding D's conviction, McCowan LJ stated:

"In our judgment, automatism does not come into this case at all … Even if the appellant was in an automatic state for the last few seconds, he had already ***Crim. L.R. 35*** committed the offence by driving to that point, in circumstances which he knew were such that he might have a hypoglycaemic attack at any moment." [100]

Strictly, D had not "already committed the offence" prior to the collision. However, for the purpose of the current automatism defence and the proposed RMC defence, McCowan LJ's analysis merits consideration. Normally, to say that D's driving was careless or dangerous is a description of the way that D drove the vehicle and the extent to which it fell below the standard of a competent and careful driver. Accordingly, if the charge is causing death by careless or dangerous driving, the focus must be on the way that D was driving at the point of collision and whether he was "driving" at that point in the sense of having total control of his actions.

However, where D is driving with warning signs of a hypoglycaemic episode, he is driving carelessly or dangerously not because of the way that he is driving but because driving with those warning signs is in itself careless/dangerous. The careless/dangerous character of the driving is present from the outset and it is not dependent on a complete loss of control materialising. Accordingly, if a collision does materialise resulting in death, the fact that it occurs after the stage where the hypoglycaemic episode has resulted in a complete loss of control should be immaterial. If immaterial, so too are the automatism and the RMC defences. As a result, applying the fault principle to the RMC defence is not required in order to ensure that those driving in an unconscious state following warning signs of hypoglycaemia can incur criminal liability for deaths caused by their driving.

However, there will be cases where the RMC defence will apply in respect of driving offences. These will be cases where a sudden and unforeseen condition is experienced by D while he is driving. Ian MacBrayne was found not guilty by reason of insanity of causing death by careless driving. Five medical professionals testified that the most likely cause of the crash was that D had suffered a "cardiac event"—where his heartbeat increased rapidly moments before the collision—and was in a state of impaired consciousness. [101] D was given an absolute discharge. It seems clear that a case like this would properly qualify for the RMC defence. The problem is disposal as the lack of any driving restrictions placed upon D has been the subject of criticism on the basis that driving sanctions are penalties which can only be imposed on conviction. The answer, in our view, is to be more creative as to the nature and content of supervision orders which can be imposed after an insanity verdict. We return to this topic in our conclusion.

**The effect of a finding of culpability**

The DP provides an example of D suffering from an RMC who culpably fails to take his medication aware that as a result he is likely to become aggressive or unpredictable. He commits an offence while suffering a total loss of a relevant capacity. [102] As the Commission makes clear although "at present he would be treated as insane" [103] he would under the new scheme be "acquitted of a specific ***Crim. L.R. 36*** intent offence but convicted of... a basic intent offence on the basis of prior fault." [104] But what is of note here is that the Commission does not stipulate which total loss of capacity is "relevant" in this example.

 

What is clear is that the fault principles which underpin the intoxication rules, upon which this extension of the fault principle is based, require a level of self-induced incapacity resulting in a state of automatism and/or a lack of mens rea. Only then will the plea operate so as to reduce a specific intent to a basic intent offence. So, in the example given by the Commission, if P's complete loss of capacity relates to understanding "the wrongfulness of what he or she is charged with having done" then the fault principle cannot operate for as Irwin LJ stated in *Loake v CPS*:

"It is possible for someone to have the full mens rea for a criminal offence whilst at the same time, because of a defect of reason arising from a disease of the mind, not know what he is doing is wrong." [105]

There is, therefore, no means here of reducing a specific intent to a basic intent offence as the issue of mens rea is not engaged where the wrongfulness limb is relied upon. The Commission seems to have overlooked the point in its support for expanding the fault doctrine. Indeed, if self-induced intoxication is the model upon which the fault doctrine is based then it is difficult to understand how this can operate not only when applied to the "wrongfulness" capacity but also in respect of the "control" capacity and even in some cases the "rationally to form a judgment" capacity as this capacity is more expansive than the current nature and quality limb of the Rules. As a result, it would seem that once "fault" is proved in cases of this nature D should be convicted of the offence charged irrespective of whether it is one of "specific" or "basic" intent as that distinction becomes irrelevant if mens rea is not in issue.

The Commission states:

"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." [106]

However, in our view, in those cases where D has the requisite mens rea there is no "coherence" because the intoxication rules do *not* operate to reduce a "specific" intent to a "basic" intent offence.

**Diminished responsibility and prior fault**

As a partial defence to murder resulting in a manslaughter conviction, diminished responsibility is not subject to the prior fault principle. Even self-induced intoxication may not prevent a successful plea if the intoxication co-exists with an RMC. [107] Rather, it is only where the intoxication alone is used to ground the ***Crim. L.R. 37*** plea that the "fault" involved precludes the intoxication being classed as an RMC. [108] Examples of successful diminished responsibility pleas, despite clear evidence that D knowingly failed to comply with his medication, are not hard to find. To give but two examples. In the first case, where D fatally stabbed a stranger, one of the experts told the court that D was "highly dangerous" and had been "duplicitous" by picking up prescriptions for his schizophrenia but not using the medication for many months. D also told jurors that he could not remember the last time he took his medication. The jury returned a verdict of diminished responsibility and D was given a restriction order. [109]

In dismissing an appeal by the Attorney-General that the sentence was too lenient, Bean LJ stated:

"We consider that the defendant's complete lack of insight into his condition is a very important feature of this case. As Dr Lock opined, it is highly unlikely that he would have committed the offence if he had been taking his medication. He was not taking his medication, and was deceiving the doctors by continuing to receive a supply of it, *because* he believed that there was nothing wrong with him, and that therefore there was no reason for doctors to be prescribing him medication. It is not suggested that his belief was a pretence. In the case of a patient with insight into his condition such deceit would indeed be an aggravating factor, but not in the present case." [110]

In a second case where D again fatally stabbed a stranger, the judge remarked:

"On the day you committed this offence you were in a state of relapse and had either stopped taking your oral medication or had unilaterally reduced the amount you were taking to a level at which its effectiveness was materially reduced." [111]

A plea of diminished responsibility was accepted by the prosecution and D was given a hospital direction and a limitation direction under s.45A of the Mental Health Act 1983 with a sentence of life imprisonment and a minimum term to serve of eight years. In doing so, Wall J remarked:

"In my judgment you retain a significant amount of responsibility. I do not assess it as full responsibility, but I do not regard it as minimal either." [112]

It is clear, therefore, that some degree of "fault" relating to medical regimes was present in both of these cases and, while this might have an impact on sentence, [113] it does not prevent a successful diminished responsibility plea. ***Crim. L.R. 38***

There would be differences between the RMC and diminished responsibility defences. The latter requires "substantial" but not total impairment of D's capacity to do certain things. [114] In relation to the RMC defence, the burden of proof would be on the prosecution to negative the defence beyond reasonable doubt whereas for diminished responsibility the burden of proof lies on the defendant on the balance of probabilities. However, there would be shared features. Both would require that D suffers from an RMC. Two capacities—forming a rational judgment and exercising control—would be common to both. Given these shared features, in our view, as a matter of principle the prior fault principle should apply either to both or to neither.

Seemingly, the Commission has not considered the practical implications of subjecting the RMC defence to the prior fault principle while the diminished responsibility defence remains fault free. We noted above that if D is charged with a "specific" intent offence and the RMC defence fails because of D's prior fault, provided he has the mens rea for the offence, D ought to be convicted of that offence to ensure consistency with the intoxication rules.

The possibility of a finding of guilt resulting in a conviction for murder could operate as a disincentive to pleading the RMC defence. Despite the burden of proof, D might consider it prudent to plead diminished responsibility and secure a manslaughter verdict, albeit that would not be D's preferred verdict. In our view, the disincentive to pleading the RMC defence is unsatisfactory.

One way of addressing the problem would be to provide for D to enter alternative pleas—not criminally responsible by reason of RMC and guilty of manslaughter by reason of diminished responsibility. Assuming the prosecution refused to accept both pleas, the jury would be directed to consider first the RMC plea. Only if they rejected that plea would they consider the diminished responsibility plea. This would remove the disincentive to plead the RMC defence. However, the different burdens and standards of proof would necessitate complex jury directions.

An alternative route would be to apply the prior fault principle to diminished responsibility. This would remove the disincentive to pleading the RMC defence and would result in congruity between the defences. It would, however, mean that whichever defence D pleaded, a finding of prior fault would result in a murder conviction.

In our view, the preferred route is not to apply the prior fault principle to either defence. There would be congruity between the defences, no disincentive to pleading the RMC defence and no need for complex jury directions.

**A way forward?**

Fault is a complex factor in automatism the parameters of which are unclear. As the Commission emphasises, it is a doctrine which has led to incoherence and inconsistency. [115] But one thing is clear. Fault liability would effectively disappear in automatism as the Commission's new automatism defence will be reduced in scope to such an extent that it will no longer be of any practical importance. Rather, virtually all types of automatism, whether sane or insane, will in future fall within ***Crim. L.R. 39*** the new RMC defence. In which case why not take the opportunity with the introduction of a new RMC defence of ridding the criminal law of the doctrine of fault in respect of sane automatism and so restricting its operation to cases of self-induced intoxication? In our view, this could be achieved by adopting a different approach to that of the Commission, which we now outline.

At the outset, we consider that the status quo of a fault-free insanity defence should remain and apply equally to the new RMC defence. There are fundamental reasons for this approach which we believe remain intact. To introduce fault and "blame" into mental illness is troubling and seems unwarranted. The focus should be on providing help and support rather than a criminal conviction and penal sanction. With this in mind, a better approach would be to allow for a return of the new special verdict in

 

cases of non-adherence to medication. This, in turn, would permit the judge to decide which form of disposal is most appropriate in the light of D's medication problems. If D needs in-patient treatment, then a hospital order would be given allowing proper care and treatment. There would be no discharge until the medication problems had been resolved and, if conditionally discharged, medication compliance would remain a vital factor. [116]

In other cases where hospitalisation is not required but there are medication problems, we consider that the way forward is to be found in the Commission's approach to supervision orders contained in its Report on Unfitness to Plead. [117] There the Commission recommends a strengthening of supervision orders by extending the maximum period for such an order to three years [118] together with an optional review function where the court considers it appropriate [119] and, finally, the introduction of a procedure for those that fail to comply with such an order which in turn may lead to a custodial sentence. [120] Acting on the assumption that the Commission's recommendations relating to disposal will apply also to the new RMC plea, this means that this new style supervision order could be used to give help and support to those subject to the new special verdict where the onset of the RMC is the result of medication problems of the type the Commission considers are based on "fault".

The review function could be tailored to address the medication issue [121] so that if the supervisee continues to breach the review conditions then as a final resort this failure could result in a custodial sentence up to a maximum of two years' ***Crim. L.R. 40*** imprisonment. [122] However, what is of prime importance is that the conviction in question is for the breach of the order rather than for the original offence. In our view, rather than blaming the mentally ill for non-adherence to the medication regime (or overdosing) by using a fault doctrine which is both clumsy and complex, a better approach is to try to help and support those individuals whose conditions are leading to such problems. To repeat, we advocate the abandonment of the fault doctrine not only in the RMC defence but also in relation to automatism.

Much more important is to retain the blanket exclusion of fault in the new RMC defence which could be achieved in the manner outlined above, leading to a more holistic and supportive approach to those who have medication problems not only concerning mental illness but also connected to other medical conditions such as diabetes. Returning a special verdict in all such cases irrespective of fault is in our view a better approach while at the same time ensuring help and support is given by using an appropriate form of disposal whether it be a hospital or supervision order.

Finally, in respect of the latter, we also consider that there will be a need either to further strengthen supervision orders and/or to introduce relevant ancillary orders so as to deal with those who use the RMC defence for driving offences. As indicated above, the *MacBrayne* case shows that there is a need to give the courts powers in respect of driving restrictions which are currently unavailable if an insanity verdict is returned. We make two points here. The first is that the current law already permits a number of ancillary orders to be made after an insanity verdict is returned. [123] So, there is no reason why imposing driving restrictions after a successful RMC plea to a driving offence should not be permitted. Secondly, in answer to the argument that driving restrictions are dependent on a conviction, we point to the change in nomenclature of the new RMC special verdict which rather than one of "not guilty by reason of insanity" will be "not criminally responsible by reason of recognised medical condition". This is an important alteration in the nature of the verdict in that it signifies that D is "would not be to blame" [124] rather than "not guilty". This in our view will more easily permit the introduction of driving restrictions as part of a supervision order and/or as an ancillary order.

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## Footnotes

1 It is significant that, in his dissenting opinion, Maule J bemoaned both "the very short time I have had to consider the questions" and the fact that there had been "no argument at your Lordships' bar or elsewhere, on the subject of the questions". *M'Naughten (1843) 10 Cl & Fin 200, 204; 8 E.R. 718*.

2 *M'Naughten (1843) 10 Cl & Fin 200; 8 E.R. 718*.

3 *Report of the Committee as to the Existing Law, Practice and Procedure relating to Criminal Trials in which the Plea of Insanity as a Defence is Raised (London: HMSO, 1923), Cmnd 2005*; *Report of the Committee on Mentally Abnormal Offenders (London, HMSO, 1975), Cmnd 6244*.

4 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (London: TSO, 2013)*. Responses were not invited.

5 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 4.159 and 10.7*.

6 We outline below the terms of the defence, including what is meant by "recognised medical condition".

7 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.58*. Curiously, this proposal does not feature in the formal list of proposals set out in Ch.10.

8 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.17*. On whether automatism operates as a defence, see J.J. Child and A. Reed, "Automatism is never a defence" (2014) 65(2) N.I.L.Q. 167.

9 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.18* (emphasis added). The RMC defence and the automatism defence would be mutually exclusive—*Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.5.119*.

10 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.3.18*.

11 "Dangerous" drugs are those generally perceived as leading to unpredictable or aggressive behaviour. There is no judicial definition of "intoxication" and consequently no minimum threshold for legal purposes. In the light of *Taj [2018] EWCA Crim 1743; [2019] 2 W.L.R. 380; [2019] Crim. L.R. 167* a state of intoxication can exist even if the alcohol or drug is no longer chemically active in D's body.

12 By contrast, "alcohol dependency syndrome" is a disease of the mind and "might be a qualifying condition", *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.88*.

13 *Burns (1974) 58 Cr. App. R. 364; [1975] Crim. L.R. 155*; *Roach [2001] EWCA Crim 2698; [2001] All E.R. (D) 98*. See *A. Loughnan and N. Wake, "Of Blurred Boundaries and Prior Fault: Insanity, Automatism and Intoxication" in A. Reed and M. Bohlander, General Defences in Criminal Law: Domestic and Comparative Perspectives (Farnham: Ashgate, 2014), Ch.8, p.114*.

14 *J.J. Child, "Prior fault: blocking defences or constructing crimes" in Reed and Bohlander, General Defences in Criminal Law: Domestic and Comparative Perspectives (2014), Ch.3, p.37*.

15 *DPP v Beard [1920] A.C. 479; (1920) 14 Cr. App. R. 159*; *DPP v Majewski [1977] A.C. 443; [1976] 2 All E.R. 142; [1976] Crim. L.R. 374*. The DP defines "specific" intent offences as those where the predominant mens rea is knowledge, intention or dishonesty—*Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), Ch.6*, fn. 5. All other offences are ones of "basic" intent.

16 *Jaggard v Dickinson [1981] Q.B. 527; [1980] 3 All E.R. 716; [1980] Crim. L.R. 717*. A statutory (partial) defence which is not subject to the principle is diminished responsibility. We discuss this below. By contrast, the principle is reflected in the statutory (partial) defence of loss of control—Coroners and Justice Act 2009 s.55(6)(a) and (b).

17 *Hasan [2005] UKHL 22 at [39]; [2005] 2 A.C. 467; [2006] Crim. L.R. 142*.

18 See the opinion of Baroness Hale in *Hasan [2005] UKHL 22 at [78] to [79]; [2005] 2 A.C. 467; [2006] Crim. L.R. 142*.

19 *Keane [2010] EWCA Crim 2514 at [17]; [2011] Crim. L.R. 393* citing *Burns v HM Advocate 1995 J.C. 154; [1995] S.L.T. 1090* at 1093H. Commentators have pointed out that the position is unclear if D intended or anticipated the disproportionate response—see Q. Jahangir, J.J. Child and H.S. Crombag,

 

"Prior fault and contrived defences: Coming to the law with clean hands" (2017) 1 Institute of Law Journal 28, 30.

20 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 6.12–6.28*.

21 A "basic" intent offence contrary to Offences Against the Person Act 1861 s.47.

22 The example is similar but not identical to the facts of *Quick [1973] Q.B. 910; [1973] 3 All E.R. 347; [1973] Crim. L.R. 434* and *Bailey [1983] 1 W.L.R. 760; [1983] 2 All E.R. 503; [1983] Crim. L.R. 533*. Under the Commission's proposals, such facts would give rise to the RMC defence and not automatism.

23 *Bailey [1980] 1 W.L.R. 760; [1983] 2 All E.R. 503; [1983] Crim. L.R. 533* suggests "yes".

24 *Quick [1973] Q.B. 910; [1973] 3 All E.R. 347; [1973] Crim. L.R. 434* suggests "yes".

25 *Quick [1973] Q.B. 910; [1973] 3 All E.R. 347; [1973] Crim. L.R. 434* suggests "yes"; *Bailey [1980] 1 W.L.R. 760; [1983] 2 All E.R. 503; [1983] Crim. L.R. 533* suggests "no". In both cases the relevant observations were obiter.

26 *Hardie [1985] 1 W.L.R. 64; [1984] 3 All E.R. 848*.

27 *A.P. Simester et al, Simester and Sullivan's Criminal Law-Theory and Doctrine, 7th edn (Oxford: Hart Publishing, 2019), p.133* interprets *Hardie* as an automatism case. We respectfully differ.

28 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.58*.

29 As a result, the DP does not discuss fault in relation to diminished responsibility, see below. Previously the Commission had considered the prior fault principle—*Law Commission, Intoxication and Criminal Liability, (London: TSO, 2009), Law Com. No.314, Cm.7256*. The recommendations did not involve a fundamental challenge to the prior fault principle. It has to be acknowledged that the way that the prior fault principle operates in the sphere of self-induced intoxication through the consumption of alcohol/dangerous drugs is viewed favourably by judges, politicians and the public. In this respect, the principle is impervious to criticism and is here to stay.

30 Bearing in mind that in the passage cited, the Commission states that the rules are "complex".

31 Further, as we explain below, in an important respect the Commission's proposals would not be consistent with the voluntary intoxication rules.

32 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 4.160 and 10.8*. Just as "disease of the mind" is a question of law, so too is "qualifying RMC"—*Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.10*.

33 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.67*.

34 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 4.89–4.109*.

35 *Quick [1973] Q.B. 910; [1973] 3 All E.R. 347; [1973] Crim. L.R. 434*.

36 *Sullivan [1984] A.C. 156 at 172 by Lord Diplock; [1983] 1 All E.R. 577; [1983] Crim. L.R. 740*. An example of such a condition is cramp, a condition that can result in loss of control.

37 Examples are *Quick [1973] Q.B. 910; [1973] 3 All E.R. 347; [1973] Crim. L.R. 434* and *T [1990] Crim. L.R. 256 (Crown Court)*.

38 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.2.61*.

39 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras.4.160(i) and 10.8(i)* make no reference to "consequences" and this does not appear to be an oversight. Paragraph 4.11 states that "it would in practice be hard to pin down what kind of consequences a person might be expected to be able to appreciate". But why not those consequences that are within the actus reus of the offence?

40 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.13* (emphasis in original). This confuses "judgment" with "decision". For discussion in relation to diminished responsibility, see R. Mackay, "The Impairment Factors in the New Diminished Responsibility Plea" [2018] Crim. L.R. 462, 468.

41 Homicide Act 1957 s.2(1A)(b) as amended by Coroners and Justice Act 2009 s.52.

42 *Conroy [2017] EWCA Crim 81 at [37]; [2017] 2 Cr. App. R. 26*.

43 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.33*.

44 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 4.22 and 4.33*.

45 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.31*.

46 See the judgment of the Canadian Supreme Court in *Oommen [1994] 2 SCR 507 at 513; (1994) 168 N.R. 200*.

 

47 *Windle [1952] 2 Q.B. 826 at 834; [1952] 2 All E.R. 1*.

48 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.8(iii)*.

49 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.18*. The only difference is that one refers to "physical acts" and the other to "conduct".

50 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 4.48–4.49*.

51 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.46*.

52 Homicide Act 1957 s.2(1A)(c) as amended by the Coroners and Justice Act 2009 s.52.

53 See *Loake v CPS [2017] EWHC 2855 (Admin) at [41]; [2018] Q.B. 998; [2018] Crim. L.R. 336*. See below for discussion.

54 *DPP v Beard [1920] A.C. 479 at 500; (1920) 14 Cr. App. R. 159* by Lord Birkenhead LC.

55 *R.D. Mackay, Mental Condition Defences in the Criminal Law (Oxford: Clarendon Press, 1995), Ch.3, p.161*. A similar, if rather ambivalent, view is put forward by Z.D. Torry and K.J. Weiss in "Medication noncompliance and criminal responsibility: Is the insanity defence legitimate?" (2012) 40 Journal of Psychiatry & Law 219. For a contrary view, see G. Maliha, "Noncompliant Insanity: Does It Fit Within Insanity?" (2018) 41 Harvard Journal of Law & Public Policy 647. This article, which explores the question of insanity caused by an omission, namely failure to take medication, concludes at 649–650 that "the courts should maintain the status quo for now - and confine the insanity inquiry to the events directly surrounding the crime."

56 See *S. White, What Queen Victoria Saw—Roderick Maclean and the Trial of Lunatics Act 1883 (Chichester: Barry Rose Law Publishers Ltd, 2000)*.

57 Trial of Lunatics Act 1883 s.2(1).

58 In the Parliamentary debate leading up to this changed verdict, the Attorney-General explained it as follows: "As the law stood at present, lunatics charged with crime were found not guilty on the ground of insanity; and it had been wisely thought that people who were only partially mad at the time they found the resolution to commit a crime would be more deterred from so doing if the verdict was one of guilty of committing the act charged. *The result would be entirely the same after the verdict had been taken; because insane prisoners would be detained at the pleasure of the Crown, as now.* It had been thought better that this alteration of the law should be made, and there was no reason against it" (emphasis added). See *Hansard, HC Deb Vol.283 cols 921–922 (16 August 1883)*, https://bit.ly/32SCCf2 [Accessed 24 October 2021].

59 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras.3.19 and 5.111* (emphasis added).

60 *Quick [1973] Q.B. 910; [1973] 3 All E.R. 347; [1973] Crim. L.R. 434*; *Bailey [1980] 1 W.L.R. 760; [1983] 2 All E.R. 503; [1983] Crim. L.R. 533*; *Hardie [1985] 1 W.L.R. 64; [1984] 3 All E.R. 848*.

61 See *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 6.74 and 6.76(2)(3)*. Further, para.5.111 states that the issue of culpability should be determined "as provided for by the common law".

62 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.80*.

63 Above.

64 See D.I. Velligan et al, "Why do psychiatric patients stop antipsychotic medication? A systematic review of reasons for nonadherence to medication in patients with serious mental illness" (2017) 11 Patient Preference and Adherence 449. https://doi.org/10.2147/PPA.S124658 [Accessed 21 October 2021].

65 A. Semahegn et al, "Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: a systematic review and meta-analysis" (2020) 9(17) Systematic Reviews 16. https://doi.org/10.1186/s13643-020-1274-3 [Accessed 21 October 2021].

66 P. Kardas, P. Lewek and M. Matyjaszczyk, "Determinants of patient adherence: a review of systematic reviews" (2013) 4 Frontiers in Pharmacology 91. https://doi.org/10.3389/fphar.2013.00091 [Accessed 21 October 2021].

67 K. Witt, R. van Dorn and S. Fazel, "Risk Factors for Violence in Psychosis: Systematic Review and Meta-Regression Analysis of 110 Studies" (2013) 8(2) Public Library of Science (PLoS) 10: "…we found evidence that non-adherence with medication increased violence risk. Given the link between medication non-adherence and a range of adverse outcomes, this observation highlights the important role of treatment, and in particular therapies aimed at increasing treatment adherence". https://doi.org/10.1371/journal.pone.0055942 [Accessed 21 October 2021].

 

68 E.W. Mitchell, "Madness and meta-responsibility: The culpable causation of mental disorder and the insanity defence" (1999) 10 Journal of Forensic Psychiatry 597, 617–618.

69 This distinction is recognised medically. The former is known as non-adherence a term which includes unintentional refusal by the patient. The latter is referred to as non-compliance which includes deliberate or intentional refusal by the patient.

70 *E.W. Mitchell, Self-Made Madness-Rethinking Illness and Criminal Responsibility (Farnham: Ashgate, 2003), Ch.3* where a distinction is drawn between what is termed "consensual and purposive meta-responsibility".

71 *Mitchell, Self-Made Madness-Rethinking Illness and Criminal Responsibility (2003), p.216*.

72 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.79*.

73 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.78*.

74 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.80*.

75 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.80.*

76 *Loughnan and Wake, "Of Blurred Boundaries and Prior Fault: Insanity, Automatism and Intoxication" in Reed and Bohlander, General Defences in Criminal Law: Domestic and Comparative Perspectives (2014), Ch.8, p.131*.

77 See T. Scott Stroup and N. Gray, "Management of common adverse effects of antipsychotic medications" (2018) 17(3) World Psychiatry 341 which states at 341: "The adverse effects of antipsychotic medications range from relatively minor tolerability issues (e.g., mild sedation or dry mouth) to very unpleasant (e.g., constipation, akathisia, sexual dysfunction) to painful (e.g., acute dystonias) to disfiguring (e.g., weight gain, tardive dyskinesia) to life threatening (e.g., myocarditis, agranulocytosis). Some adverse effects have little short-term clinical implications (e.g., increased prolactin or serum lipid levels), but may involve long-term risk of medical complications."

78 See Velligan et al, "Why do psychiatric patients stop antipsychotic medication? A systematic review of reasons for nonadherence to medication in patients with serious mental illness" (2017) 11 Patient Preference and Adherence 449. https://doi.org/10.2147/PPA.S124658 [Accessed 21 October 2021].

79 Above, where it is confirmed at "…that a negative attitude toward medication and substance abuse are consistent reasons for nonadherence to antipsychotic medication."

80 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 4.163 and 10.11*.

81 Accordingly, while the requirement that the lack of capacity must be total restricts the scope of the defence, it could work to D's advantage in cases where, prior to D's conduct in inducing the total lack of capacity, D's capacity is already reduced thereby impairing his ability to foresee a risk of total loss of capacity.

82 *Loughnan and Wake, "Of Blurred Boundaries and Prior Fault: Insanity, Automatism and Intoxication" in Reed and Bohlander, General Defences in Criminal Law: Domestic and Comparative Perspectives (2014), Ch.8, p.131*.

83 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.3.5*.

84 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.6*. In other words, the conduct that constitutes the alleged offence.

85 In our view, it is questionable whether, when adjusting their behaviour, most people pause to consider whether a possible consequence would be a total loss of capacity for rational thought or understanding wrongfulness.

86 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.8(i)* (emphasis added).

87 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.8(ii)* (emphasis added).

88 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.10.8(iii)* emphasis added).

89 *Bailey [1983] 1 W.L.R. 760; [1983] 2 All E.R. 503; [1983] Crim. L.R. 533*.

90 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.23*.

91 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.4.16*. Given the proposed burden of proof, D would be entitled to the verdict if the jury found that the depression might have deprived her of the capacity.

92 Suggesting that her capacity to form a rational judgment about coming off the medication is impaired.

 

93 See M. Wasik and J. Rumbold, "Diabetic Drivers, Hypoglycaemic Unawareness, and Automatism" [2011] Crim. L.R. 863.

94 By contrast, cases where a diabetic drives in a state of hyperglycaemia because of *not* taking insulin give rise to the insanity plea since the hyperglycaemia results from the diabetes, an "internal" factor—*Hennessy [1989] 1 W.L.R. 287; [1989] 2 All E.R. 9; [1989] Crim. L.R. 356*. The plea can succeed even if D is "culpable" in not taking the insulin.

95 Wasik and Rumbold, "Diabetic Drivers, Hypoglycaemic Unawareness, and Automatism" [2011] Crim. L.R. 863, 865.

96 Wasik and Rumbold point out at p.865 that there is a condition known as hypoglycaemic unawareness where the warning signs occur *after* the blood sugar level has dropped low enough to cause mental impairment. There will be no awareness of the impending onset of a hypoglycaemic episode and so no culpability unless possibly the driver has been made aware in the past by friends that he may be prone to lapse into hypoglycaemia that others are aware of, but he is not.

97 See *Hill v Baxter [1958] 1 All E.R. 193; [1958] 1 Q.B. 277* where Pearson J states at 286–287: "Then suppose the man in the driving seat falls asleep. After he is asleep he is no longer driving, but there is an earlier time at which he was falling asleep and therefore failing to perform the driver's elementary and essential duty of keeping himself awake and therefore he was driving dangerously."

98 We acknowledge that in *Moses v Winder [1981] R.T.R. 37; [1980] Crim. L.R. 232* the Divisional Court proceeded on the basis that the offence of careless driving, if committed, was committed after D had lost consciousness.

99 *Marison [1997] R.T.R. 457; [1996] Crim. L.R. 909*.

100 *Marison [1997] R.T.R. 457 at 461; [1996] Crim. L.R. 909*.

101 See https://www.edp24.co.uk/news/norfolk-solicitor-found-not-guilty-in-death-crash-trial-474892.

102 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), paras 6.76(3) and 6.77(3)*.

103 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.76(3)*.

104 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.77(2)*.

105 *Loake v CPS [2017] EWHC 2855 (Admin) at [41]; [2018] Q.B. 998; [2018] Crim. L.R. 336*.

106 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.6.77*

107 *Dietschmann [2003] UKHL 10; [2003] 1 A.C. 1209* decided under the old law but applied in *Kay and Joyce [2017] EWCA Crim 647; [2017] 4 W.L.R. 121; [2017] Crim. L.R. 881* to the Homicide Act 1957 s.2 as amended by the Coroners and Justice Act 2009 s.52.

108 *Dowds [2012] EWCA Crim 281 at [35]; [2012] 1 W.L.R. 2576; [2012] Crim. L.R. 612*.

109 See the case of Gurjeet Lall at https://news.sky.com/story/allan-isichei-death-indefinite-hospital-order-for-man-who-killed-former-wasps-rugby-player-in-southall-12161370 [Accessed 24 October 2021].

110 *Lall [2021] EWCA Crim 404* at [44] (emphasis in original).

111 See the case of Eltiona Skana at https://www.manchestereveningnews.co.uk/news/greater-manchester-news/every-word-judge-said-gave-19418149 [Accessed 24 October 2021].

112 https://www.manchestereveningnews.co.uk/news/greater-manchester-news /every-word-judge-said-gave-19418149 [Accessed 24 October 2021].

113 See *Sentencing Council, Definitive Guideline on Manslaughter (London: The Sentencing Council, 2018), p.22* and *Sentencing Council, Definitive Guideline on Offenders with mental disorders, developmental disorders, or neurological impairments (London: The Sentencing Council, 2020), paras 13–15* both of which are cited in *Lall 2021] EWCA Crim 404* at [31] and [37] respectively.

114 An impairment is "substantial" if it is of "consequence or weight"—*Golds [2016] UKSC 61 at [29]; [2016] 1 W.L.R. 5231; [2017] Crim. L.R. 316*.

115 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), Ch.5*.

116 See *Ministry of Justice, The recall of conditionally discharged restricted patients (London: TSO, 2009), p.7* which deals with "Defaulting on medication".

117 *Law Commission, Unfitness to Plead Volume 1: Report (London: TSO, 2016) Law Com. No.364, HC Paper No.714-1, Ch.6*.

118 *Law Commission, Unfitness to Plead Volume 1: Report (2016) Law Com. No.364, HC Paper No.714-1, para.6.100*.

119 *Law Commission, Unfitness to Plead Volume 1: Report (2016) Law Com. No.364, HC Paper No.714-1, para.6.75*

 

120 *Law Commission, Unfitness to Plead Volume 1: Report (2016) Law Com. No.364, HC Paper No.714-1, para.6.97*.

121 The Commission considered and rejected enhancing supervision orders with powers similar to those attached by community treatment orders—see *Law Commission, Unfitness to Plead Volume 1: Report (2016) Law Com. No.364, HC Paper No.714-1, para.6.77—6.71*. Such orders permit a recall to hospital which as the Commission remarks (at para.6.67) is unavailable where for example "a person subject to a supervision order with a medical treatment requirement fails to attend hospital to receive, for example, a routine injection of anti-psychotic medication, the clinician has no power to act to ensure the individual receives that treatment or maintains contact with the hospital". However, supervision orders, unlike community treatment orders, have never included a power to compel the supervised person to submit to medical treatment and, in enhancing supervision orders in the manner suggested, the Commission correctly, in our view, eschewed the need to include compulsion in respect of treatment requirements. If such compulsion is needed, then it is more likely that a hospital order would be an appropriate disposal rather than a supervision order.

122 But what is to be done where, in a case of repeated medication non-adherence leading to such breach proceedings, the individual needs in-patient hospital treatment? Should the court in such proceedings not be able to give a hospital order? Presumably, by way of contrast, if the Commission's "fault"-based liability provisions were implemented then in this type of case, D would be convicted of the original (basic intent) offence which if imprisonable would permit a hospital order to be made. Is this an issue which needs reconsideration?

123 These are summarised in *Law Commission, Unfitness to Plead Volume 1: Report (2016), para.6.8*. Although these are described as relevant to a finding that D had done act in respect of unfitness to plead, they apply equally to an insanity verdict.

124 *Law Commission, Criminal Liability: Insanity and Automatism—A Discussion Paper (2013), para.2.58*.

 