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Epilepsy and the defence of insanity: time for change?

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R. v Sullivan (Patrick Joseph) [1984] A.C. 156; [1983] 6 WLUK 162 (HL)

R. v Quick (William George) [1973] Q.B. 910; [1973] 4 WLUK 81 (CA (Crim Div))

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***Crim. L.R. 782 Summary:** Epilepsy, perhaps more than any other condition, has had an impact on the development of the defence of insanity and its relationship to automatism having resulted in two appeals to the House of Lords. This paper, based on research generously commissioned by Epilepsy Action (The British Epilepsy Association), attempts to provide an insight into how the criminal justice process operates when epilepsy results in a successful defence of insanity by discussing 13 such cases. In addition we will critically analyse the development of the insanity defence with particular reference to epilepsy and in doing so make a call for reform.

The cases

Three empirical studies published in this Review have revealed how the defence of insanity operates in English criminal law. The first such study looked at all verdicts of "not guilty by reason of insanity" (NGRI) during the years 1975-88.¹ The next two empirical studies examined all verdicts of NGRI during the first five years (1992-96)² and second five years (1997-2001)³ of the new regime under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991⁴ which introduced flexibility of disposal.

It is clear from these studies that formal findings of NGRI based on epilepsy continue to be rare. But they do occur: the three empirical studies revealing that

		Table 1 --Sex/age distribution		
		Sex of accused		
		Male	Female	Total
Age range of accused	up to 19	1	0	1
	20-29	4	0	4
	30 -39	2	0	2
	40-49	4	1	5
	60-69	1	0	1
Total		12	1	13

**Crim. L.R. 783* there were 13 such findings between 1975 and 2001 out of a total of 179 special verdicts. This means that epilepsy accounted for 7.3 per cent of such verdicts.⁵

All the cases were identified as part of ongoing research into the operation of the M'Naghten Rules. The primary source of information used was the relevant court and post trial files together with files held by the Mental Health Unit of the Home Office and the Court Service.⁶

Introduction

Initially 14 cases were identified in which offenders were acquitted on the basis of "insane" automatism related to seizures. A review of the available medical reports, however, suggested that one of the defendants did not suffer from epilepsy but carried out the alleged offence during a non-epileptic (dissociative) seizure. Epilepsy was only considered as a much less likely differential diagnosis in this case. Accordingly, this case was removed from the following descriptive analysis.

All bar one of the cases were male (92.3 per cent, n=12). Table 1 above shows the age distribution of the defendants.

The ethnic breakdown of the defendants is presented in Table 2 and shows that 11 (84.6 per cent) were white with 11 (84.6 per cent) born in the United Kingdom. Out of the 13, 9 had previous convictions.

Table 3 below gives an overview of the offences charged and the relevant disposals. In this connection it must be remembered that all cases disposed of before enactment of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (the 1991 Act) resulted in mandatory and indefinite hospitalisation.

Table 2 --born UK * ethnic group cross-tabulation				
		Ethnic group		
		white	black	Total
Born UK	yes	11	0	11
	no	1	1	2
	Total	12	1	13

Table 3 --Overview of criminal offences, charges and disposals

No.	Date	Nature of Offence	Charge(s)	Disposal
1	1983	Surprised whilst attempting to steal money from neighbor's electricity meter. Killed neighbor with tool used to pries open meter.	Murder	Mandatory hospital order with restrictions

2	1985	Unpremeditated assault on brother-in-law.	GBH	Mandatory hospital order with restrictions
3	1985	Broke shop window in public place, took jacket.	Burglary	Mandatory hospital order with restrictions
4	1988	Stuffed paper into electric fire.	Attempted arson	Mandatory hospital order with restrictions
5	1991	Agitated, stabbed wife, locked daughter in cupboard, resisted arrest.	Wounding with intent, assault, false imprisonment	Mandatory hospital order with restrictions
6	1992	Assaulted person who did not want to pay gaming debt, attempted to set fire to victim.	ABH and attempted GBH	Supervision and Treatment Order
7	1995	Went to use neighbour's phone. Came to throttling neighbour with telephone cord.	Attempted murder	Hospital Order without restrictions
8	1996	Set fire to flat, oblivious to flames.	Arson with intent to endanger life	Supervision and Treatment Order
9	1996	Grabbed child in broad daylight in presence of mother.	Attempted kidnapping	Supervision and Treatment Order
10	1997	Attacked ambulance staff who wanted to remove defendant from the scene of a seizure.	ABH	Absolute Discharge
11	1999	Entered police station in confused state to enquire about extra directory telephone number. Resisted removal from the station, pulled out knife, throttled policeman.	GBH, possession of dangerous weapon	Absolute Discharge
12	2000	Grabbed child in broad daylight in presence of mother and other witnesses, resisted arrest.	Child abduction, ABH	Supervision and Treatment Order
13	2000	Accused victim of stealing from him and head-butted victim without provocation.	ABH	Supervision and Treatment Order

***Crim. L.R. 784** This accounts for five (the sole murder charge, two GBH/wounding, one burglary and one attempted arson charge) of the 13 cases (38.5 per cent) which in turn means that the judge had discretion as to disposal in only the remaining eight cases. Accordingly, Table 3 reveals that only one of those eight cases, a charge of attempted murder, resulted in the equivalent of a hospital order without restrictions. The remaining cases (n=7) all resulted in non-custodial disposals. The significance of this should not be underestimated for what it means is that all except one of those eight defendants found NGRI as a result of epileptic automatism (87.5 per ***Crim. L.R. 786** cent, n= 7) since the passing of the 1991 Act were not sent to hospital but instead were dealt with in the community. This despite the fact that some of the relevant charges, such as GBH and arson, can scarcely be described as minor.

The results of our review of the medical information held in the court and Home Office papers are summarised in Table 4. Two offences were possibly not directly related to epileptic automatism: In case (4), the offender had a history of emotional problems, epilepsy and significant cognitive deficits after an attempted self-poisoning with carbon monoxide and was accused of fire-setting (not described as temporally related to a seizure). Epilepsy was mentioned as one of the factors contributing to a lack of insight into the criminal nature of the offence and the continuing dependence of the offender after the act. In case (5), the offence was committed whilst the offender with a history of epilepsy was in a paranoid state (perhaps related to alcohol withdrawal but possibly ictal or postictal).

In one further case (6), the records do not contain any evidence demonstrating that the index offence was committed during a period of automatism. A man with a history of temporal lobe epilepsy was arrested after a fight outside a pub which had been triggered by an argument over gaming debts. He had a seizure in the police station whilst being questioned. The medical reports do not mention a seizure before the fight.

The most striking medical observations relating to those offences which were committed during epileptic automatism were, that many offenders had a history of psychiatric conditions suggesting that they were at higher risk of carrying out aggressive acts (especially personality disorder and alcohol dependence or intermittently excessive alcohol intake), and that in 12 out of 13 (92.3 per cent) cases epileptic neuronal activity was not the only factor causing impairment of consciousness, judgment or self-control at the time of the offence. Alcohol intoxication (7 out of 13, 53.8 per cent) and alcohol withdrawal (2 out of 13, 15.4 per cent) were the commonest potential contributing factors.

The insanity defence and epileptic automatism

The first epilepsy case to be decided by the House of Lords was of course *Bratty v Attorney General for Northern Ireland* ⁷ where D, in answer to a murder charge, put forward defences of insanity and automatism based on a black-out due to psychomotor epilepsy. In the course of his judgement, Lord Denning famously remarked:

"The major mental diseases which doctors call psychoses, such as schizophrenia, are clearly diseases of the mind. But in *Charlson*⁸ Barry J. seems to have assumed that other diseases such as epilepsy or cerebral tumours are not diseases of the mind, even when they are such as to manifest themselves in violence. I do not agree with this. It seems to me that any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind."⁹

As a result it was accepted that, since the only explanation for D's automatism was his epilepsy, then, if it was found that he was in a state of automatism at the time of the killing, this in turn must result in a verdict of insanity. In essence,

Table 4 --Overview of medical findings						
No.	Epilepsy syndrome	History of seizures before offense	NPS ¹⁰ impairments	Psychiatric history	Offence temporally associated with seizure	Potential medical co-factors
1	Focal	Yes	Low IQ	Substance abuse, depression, parasuicide, alcohol dependence, PD ¹¹	Yes	Alcohol withdrawal
2	Focal	Yes	Memory impairment, normal IQ	High alcohol intake, aggression related to alcohol	Yes	Possible alcohol intoxication, amphetamines
3	Focal	Yes	NR ¹²	Alcohol dependence	Yes	Alcohol intoxication
4	Focal	Yes	Memory impairment	Depression, parasuicide, PD	No	Sedative AED ¹³
5	Unclassifiable	Yes	NR	Alcohol dependence, PNES ¹⁴ , PD	Probably not	Possible alcohol withdrawal
6	Focal	Yes	Memory impairment, normal IQ	Depression, parasuicide, PNES, high alcohol intake, PD	Probably not	Alcohol intoxication
7	Focal	No	Memory impairment	Depression, parasuicide, PD	Yes	Alcohol intoxication
8	Focal	Yes	Confused, perseveration	High alcohol intake	Yes	Alcohol intoxication
9	Focal	Yes	NR	No psychiatric history	Yes	
10	Unclassifiable	Yes	NR	Agoraphobia, parasuicide, high alcohol intake, PD	Yes	Alcohol intoxication
11	Focal	Yes	NR	Parasuicide, high alcohol intake	Yes	Alcohol intoxication, AED ¹⁵
12	Focal	Yes	Global cognitive impairment	No psychiatric history	Yes	Dementia
13	Focal	Yes	Low IQ	Parasuicide, high alcohol intake	Yes	Alcohol intoxication

*Crim. L.R. 789 therefore, this decision accepted and endorsed two forms of automatism, namely the insane and non-insane varieties. However, little more is said in *Bratty* to explain why epilepsy should be classed as a "disease of the mind" within the M'Naghten Rules, other than that psychomotor epilepsy was said by the three medical witnesses to be a functional disorder (i.e. a disorder not dependant on macroscopic structural changes in the brain) which should be so classified. It is abundantly clear that the medical witnesses themselves accepted that this was so as Lord Denning stated:

"All the doctors agreed that psychomotor epilepsy, if it exists, is a defect of reason due to disease of the mind: and the judge accepted this view. No other cause was canvassed."¹⁶

But some years later in the second House of Lords' decision in *Sullivan*¹⁷ the medical experts emphatically did not support such an approach. There D, who had had epilepsy since early childhood, claimed in answer to an assault charge that he was in the final stage of recovery from a minor epileptic seizure at the time the offence was committed. Lord Diplock summarised the medical evidence as follows:

"The evidential foundation that counsel laid before the jury in the instant case consisted of the testimony of two distinguished specialists from the neuropsychiatry epilepsy unit at the Maudsley Hospital, Dr Fenwick and Dr Taylor, as to the pathology of the various stages of a seizure due to psychomotor epilepsy. Their expert evidence, which was not disputed by the prosecution,

was that the appellant's acts in kicking Mr Payne had all the characteristics of epileptic automatism at the third or post-ictal stage of petit mal, and that, in view of his history of psychomotor epilepsy and the hospital records of his behaviour during previous seizures, the strong probability was that the appellant's acts of violence towards Mr Payne took place while he was going through that stage.

The evidence as to the pathology of a seizure due to psychomotor epilepsy can be sufficiently stated for the purposes of this appeal by saying that after the first stage, the prodrome, which precedes the fit itself, there is a second stage, the ictus, lasting a few seconds, during which there are electrical discharges into the temporal lobes of the brain of the sufferer. The effect of these discharges cause him in the post-ictal stage to make movements which he is not conscious that he is making, including, and this was a characteristic of previous seizures which the appellant had suffered, automatic movements of resistance to anyone trying to come to his aid. These movements of resistance might, though in practice they very rarely would, involve violence.¹⁸

The trial judge ruled, following *Bratty*, that if the jury accepted this unanimous medical evidence they must return an insanity verdict whereupon D, in order to prevent this, changed his plea to guilty. Interestingly, neither of the expert witnesses was prepared to classify D's condition as a "disease of the mind". The point was summarised by Lord Diplock:

***Crim. L.R. 790** "First, it is submitted the medical evidence in the instant case shows that psychomotor epilepsy is not a disease of the mind, whereas in *Bratty's* case it was accepted by all the doctors that it was. The only evidential basis for this submission is that Dr Fenwick said that in medical terms to constitute a "disease of the mind" or "mental illness", which he appeared to regard as interchangeable descriptions, a disorder of brain functions (which undoubtedly occurs during a seizure in psychomotor epilepsy) must be prolonged for a period of time usually more than a day, while Dr Taylor would have it that the disorder must continue for a minimum of a month to qualify for the description "a disease of the mind"."¹⁹

His Lordship roundly rejected this line of medical opinion stating:

"The nomenclature adopted by the medical profession may change from time to time; *Bratty* was tried in 1961. But the meaning of the expression "disease of the mind", as a cause of a "defect of reason" remains unchanged for the purposes of the application of the M'Naghten Rules. I agree with what was said by Devlin J. in *Kemp*²⁰ that "mind" in the M'Naghten Rules is used in the ordinary sense of mental faculties of reason, memory and understanding. If the effect of a disease is to impair these faculties so severely as to have either of the consequences referred to in the latter part of the rules, it matters not whether the aetiology is organic, as in epilepsy, or functional, or whether the impairment itself is permanent or is transient and intermittent, provided that it subsisted at the time of the commission of the act. The purpose of the legislation relating to the defence of insanity, ever since its origin in 1880, has been to protect society against the recurrence of dangerous conduct. The duration of a temporary suspension of the mental faculties of reason, memory and understanding ... cannot on any rational ground be relevant to the application by the courts of the M'Naghten Rules."²¹

Such insanity verdicts are open to considerable criticism and caused Lord Diplock to conclude:

"My Lords it is natural to feel reluctant to attach the label of insanity to a sufferer from psychomotor epilepsy of the kind to which the appellant was subject....But the label is contained in the current statute, it has appeared in the statute's predecessor ever since 1800. It does not lie within the powers of the courts to alter it. Only Parliament can do that. It has done so twice; it could do so again."²²

This reluctance felt by Lord Diplock is understandable, for to label such persons as "insane" is surely inappropriate and deeply stigmatic. Despite this it is clear that *Sullivan* favours an expansionary definition of "disease of the mind" in order to ensure protection of the public. Taken at face value the scope of "disease of the mind" seems alarmingly wide and the only thing which stops it from encompassing every conceivable form of temporary mental impairment has been the recognition by the courts that it would be "an affront to common sense" to equate all forms of ***Crim. L.R. 791** "disordered mental condition"²³ with legal insanity. This concession was expressly made by Lord Diplock in *Sullivan* when he remarked that the defence of non-insane automatism (unconscious involuntary action arising from a condition other than a "disease of the mind") should not be excluded "... in cases where temporary impairment ... results from some external physical factor such as a blow on the head causing concussion or the administration of an anaesthetic for therapeutic purposes".²⁴ By implication his Lordship is admitting that such conditions are not proper candidates for "disease of the mind" classification, provided they are "temporary" and the result of "some external physical factor". However, this "external factor" approach to distinguishing sane and insane automatism, first

used by Lawton L.J. in *Quick* ²⁵ as a way of cutting down the width of Lord Denning's definition of "disease of the mind" in *Bratty*, ²⁶ has led to the creation of a complex body of law which is manifestly unsatisfactory.

The external factor doctrine and epilepsy

A great many organic conditions can cause cerebral impairment leading to involuntary action. Some may result from the type of clear external physical factors described above by Lord Diplock in *Sullivan*, while others may be purely internal as in the case in a spontaneous epileptic seizure. ²⁷ But often it is not so straightforward; in the sense that a number of interrelated factors may be involved. The criminal law has not only been reluctant to recognise this but has also failed to develop any clear principles as to how to deal with such problems. Some of these problems were highlighted recently in this Review with particular reference to sleepwalking. ²⁸ Strangely, although soon after it was decided, *Sullivan* attracted much comment, ²⁹ unlike sleepwalking, ³⁰ epilepsy does not seem to have been the subject of continued litigation. Indeed with regard to the former condition yet another case of somnambulism has recently resulted in an outright acquittal. In *Pooley* ³¹ the accused was charged with sexual assault. In his ruling on the issue of sleepwalking precipitated by alcohol consumption and environmental change H.H. Judge Tyrer stated that "Concurrent causes can allow for the defence of non-insane automatism to be left to the jury even if one of the concurrent causes is self-induced intoxication".

***Crim. L.R. 792** If in some sleepwalking cases external factors such as alcohol and a change of environment are capable of attracting verdicts of acquittal on the basis of sane automatism then why should such an approach not also apply in some instances of epileptic automatism? A suggested answer on the basis of the normality of sleep was not accepted in *R. v Burgess*.

³² Rather the court was adamant that "sleepwalking, and particularly violence in sleep, is not normal". ³³ Clearly, therefore, the "abnormal" mental state at the time of the somnambulistic episode was enough to ensure that the defendant in *Burgess* should be classed as an insane automaton. It is also clear from the ruling in *Pooley* that the trial judge was not refusing to apply *Burgess* but was rather giving the jury the opportunity to avoid its implications by applying the external factor doctrine; an opportunity of which the jury took ample advantage by acquitting the accused.

To return to epilepsy; in much the same way as with diabetes an episode of automatism can result either from the organic condition alone or can be, in part at least, the result of external triggers. Indeed, it seems logical that if diabetes and sleepwalking can in some cases fall within sane automatism then the same should be equally true for epilepsy. In short, why should insulin or alcohol and stress, etc. be able to achieve this result in respect of the former conditions alone? One suspects that the argument that epilepsy sufferers may be unusually susceptible ³⁴ in some instances to seizures may be used to support classifying such episodes as insane automatism, whether or not an external factor was involved. But the same is true for both the diabetic and the sleepwalker. Indeed it is noteworthy that in *Quick* the defendant had "on 12 or more occasions ... been admitted to hospital either unconscious or semi-conscious due to hypoglycaemia". ³⁵ Thus the fact that *Quick* was unusually susceptible to such episodes and only had to take insulin because he suffered from diabetes did not prevent his automatism from being classed as sane; in which case the same should be true for epilepsy. For example, it is well known that flashing lights or flash photography may trigger epileptic seizures. This is known as "photosensitive epilepsy", ³⁶ a subject of recent controversy in relation to the new London Olympic logo. ³⁷ If say, such had been the case in *Sullivan* then why should such an external factor not ensure a classification of sane automatism? ³⁸ Indeed the Court of Appeal in *Sullivan* did mention in relation to the drugs regimen

***Crim. L.R. 793** to which the defendant was subject that "there were medical reasons to believe that he had not been taking the full dosage which had been prescribed for him, but this may have been due to a misunderstanding between him and the hospital". ³⁹ If it could be shown that the seizure causing the automatism had been caused by the impact of subtherapeutic antiepileptic medication then again why should the automatism not be regarded as being of the sane variety?

Of course, what the arguments briefly rehearsed above demonstrate is just how unsatisfactory the "external factor" doctrine is and has led to calls for it to be abandoned. ⁴⁰ Indeed, it seems pertinent to ask whether it is not time go further and to call for the insanity defence in its entirety to be considered as a candidate for reform. In particular, it is surely no longer acceptable to use the label "insanity" for any case of epileptic automatism or indeed for any other conditions which give rise to the special verdict. Although in the 13 cases discussed in this paper it is clear that all of the defendants had pathologies other than epilepsy it is not at all clear in what way, if at all, these other conditions may have impacted at the time of the alleged offences. In any event whatever impact they might have had, this in no way justifies using the term "insanity". In that connection a call to destigmatise the nomenclature of the special verdict could be used as a stepping stone towards a full scale consideration of the "insanity"

defence for the purposes of reform. In short, is it not time for the Law Commission to take up this challenge and to rid the law of an "insanity" defence which in its current form has no place in the 21st century?

Footnotes

- 1 See R.D.Mackay "Fact and Fiction about the Insanity Defence" [1990] Crim. L.R. 247. The year 1975 is included in R.D. Mackay, "Mental Condition Defences in the Criminal Law", (Oxford University Press, Oxford, 1995), p.103. This year did not contain any epilepsy cases. The same is true of the three-year period 1989-1991 briefly referred to in Mackay and Kearns at p.716, see below at fn.2.
- 2 See R.D. Mackay and G. Kearns "More Fact(s) about the Insanity Defence" [1999] Crim. L.R. 714.
- 3 See R.D. Mackay, B.J. Mitchell and Leonie Howe "Yet More Facts about the Insanity Defence" [2006] Crim. L.R. 399.
- 4 As amended by the Domestic Violence, Crime and Victims Act 2004.
- 5 The most prevalent diagnosis leading to a verdict of insanity is schizophrenia which accounts for 51.4 per cent of such verdicts.
- 6 Grateful thanks go to the following: Epilepsy Action and the Nuffield Foundation whose combined funding made this research possible. The Department for Constitutional Affairs (now the Ministry of Justice) for authorising the research and to Jacqui O'Riordan and Carole Burry of Records Management Service, the Court Service for their kind and generous help in raising the case files from numerous Crown Courts. The Mental Health Unit and Statistics Directorate of the Home Office, now the Ministry of Justice.
- 7 *Bratty v Attorney General for Northern Ireland* [1963] A.C. 386; [1961] 3 W.L.R. 965; [1961] 3 All E.R. 523; (1962) 46 Cr. App. R. 1.
- 8 [1955] 1 All E.R. 859; (1955) 39 Cr. App. R. 37.
- 9 See above, fn.7, at 412.
- 10 Neuropsychological
- 11 Personality Disorder
- 12 Not recorded
- 13 Antiepileptic drugs
- 14 Psychogenic Non-Epileptic Seizures
- 15 Antiepileptic drugs
- 16 See above, fn.7, at 415.
- 17 [1984] A.C. 156; [1983] 3 W.L.R. 123; [1983] 2 All E.R. 673; [1983] Crim L.R. 740
- 18 See above, fn.11, at 675.
- 19 See above, fn.11, at 675.
- 20 [1957] 1 Q.B. 399 at 406.
- 21 See above, fn.11 at 677-78.
- 22 See above, fn.11 at 678.
- 23 *R. v Quick* [1973] Q.B. 910; [1973] 3 All E.R. 347 at 352.
- 24 *R. v Sullivan* [1983] 2 All E.R. at 678.
- 25 See above, fn.17.
- 26 See above, fn.7.
- 27 A convulsive but non-purposive movement during such a seizure is surely inappropriate for an "insanity" verdict. See D. Ormerod, *Smith and Hogan Criminal Law*, 11th edn, (OUP, Oxford, 2005) at p.261.
- 28 R.D. Mackay and B.J. Mitchell "Sleepwalking, Automatism and Insanity" [2006] Crim. L.R. 901.
- 29 See in particular P. Fenwick and E. Fenwick (eds), *Epilepsy and the Law--a medical symposium on the current law* (Royal Society of Medicine, Oxford University Press, 1985).
- 30 See Ebrahim *et al.* "Violence, Sleepwalking and the Criminal Law: (1) The Medical Aspects" [2005] Crim. L.R. 601; Wilson *et al.* "Violence, Sleepwalking and the Criminal Law: (2) The Legal Aspects" [2005] Crim. L.R. 614 and R.D. Mackay and B.J. Mitchell "Sleepwalking, Automatism and Insanity" [2006] Crim. L.R. 901.
- 31 *R. v Pooley*, unreported, January 16, 2007, Aylesbury Crown Court. See also Daily Mail, January 12, 2007.

32 [1991] 2 All E.R. 769 at 775.

33 [1991] 2 All E.R. 769 at 775.

34 See *Rabey* (1980) 2 SCR 513 at 519 where Martin J.A.'s reference to "weakness internal to the accused" is cited with approval in *Burgess* [1991] 2 All E.R. at 772. This line of reasoning was also used by the Court of Appeal in *R. v Hennessy* [1989] 2 All E.R. 9 at 14 to confirm that if the automatism can be traced to the accused's diabetes rather than to a distinct external factor then the condition in question must be classed as a "disease of the mind".

35 [1973] 3 All E.R. 347 at 350.

36 See G. Harding and P. Jeavons, "Photosensitive Epilepsy", Clinics in Developmental Medicine No.133, (MacKeith Press, 1994).

37 See Epilepsy Action's Press Release of June 6, 2007 citing numerous reports of epileptic seizures as a result of seeing the animated footage used to launch the new logo. It is also of interest to note that in his comment on the logo Dr Berge Minassian states that this can happen "to normal people who wouldn't have seizures otherwise", see <http://sympatico.msn.ca/> "New London Olympic Logo triggers Epilepsy Scare".

38 For discussion of cases where epilepsy has resulted in outright acquittals on this basis see R.D. Mackay, "Mental Condition Defences in the Criminal Law", (Oxford University Press 1995) at pp.38-39.

39 [1983] 1 All E.R. 577 at 579.

40 See above, fn.22, Mackay and Mitchell at pp.904-905.