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Commission**
Reforming the law

Insanity and Automatism Supplementary Material to the Scoping Paper

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Supplementary Material to the Scoping Paper (July 2012)

INSANITY AND AUTOMATISM

THE LAW COMMISSION
INSANITY AND AUTOMATISM

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GLOSSARY

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

STATUTES

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

REPORTS

| | |
|---|--|
| The Atkin report | Lord Justice Atkin’s Committee on Insanity and Crime (1923) Cmd 2005 |
| The Bradley report | Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system (April 2009) |
| The Butler report | Report of the Committee on Mentally Abnormal Offenders (1975) Cmnd 6244 |
| The CLRC’s third report | Criminal Law Revision Committee, Third Report, Criminal Procedure (Insanity) (1963) Cmnd 2149 |
| The CLRC’s fourteenth report | Criminal Law Revision Committee, Fourteenth Report, Offences Against the Person (1980) Cmnd 7844 |
| Royal Commission on Capital Punishment report | Report of the Royal Commission on Capital Punishment (1953) Cmd 8932 |
| Scot Law Com 195 | Report on Insanity and Diminished Responsibility, Scot Law Com No 195 (2004) |

LAW COMMISSION PUBLICATIONS

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

BOOKS

| | |
|--------------------------------------|--|
| Archbold | P J Richardson (ed), <i>Archbold: Criminal Pleading, Evidence and Practice</i> (2011) |
| Blackstone's | Lord Justice Hooper and D Ormerod (eds) <i>Blackstone's Criminal Practice</i> (2012) |
| Mackay (1995) | R D Mackay, <i>Mental Condition Defences in the Criminal Law</i> (1995) |
| McAuley | F McAuley, <i>Insanity, Psychiatry and Criminal Responsibility</i> (1993) |
| Principles of Criminal Law | A Ashworth, <i>Principles of Criminal Law</i> (6 th ed 2009) |
| Smith and Hogan's Criminal Law | D Ormerod, <i>Smith and Hogan's Criminal Law</i> (13 th ed 2011) |
| Simester and Sullivan's Criminal Law | A P Simester, J R Spencer, G R Sullivan and G J Virgo, <i>Simester and Sullivan's Criminal Law Theory and Doctrine</i> (4 th ed 2010) |

TERMS

“Mental disorder”

- 1 The statutory definition in the Mental Health Act 1983 is “any disorder or disability of the mind”: section 1(2) of the 1983 Act, as amended by section 1 of the Mental Health Act 2007.

- 2 At first glance, therefore, learning disabilities, being disabilities of the mind, fall within this definition of “mental disorder”. However, a person with a learning disability is expressly excluded from the definition of person suffering from mental disorder for the purposes of specific provisions in the 1983 Act, “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”. Those provisions confer a power on a court or tribunal to make an order for detention or treatment or to discharge a person from hospital or as a community patient.
- 3 A person with a learning disability “shall not be considered by reason of that disability to be ... suffering from mental disorder”, for the purposes of sections 3,¹ 7,² 17A,³ 20,⁴ 20A,⁵ 35 to 38,⁶ 45A,⁷ 47,⁸ 48,⁹ 51,¹⁰ 72(1)(b) and (c)¹¹ and 72(4)¹² of the 1983 Act, “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”.¹³ Some of the powers are not in this list: most notably admission to hospital for assessment (which is therefore available to those with a learning disability as well).
- 4 The Mental Health Act 1983 Code of Practice states that the “learning disability qualification” (referred to in the paragraph above) only applies to specific sections of the Act: “in particular, it does not apply to detention for assessment under section 2 of the Act” (para 3.15). Also, the qualification does not apply to autistic spectrum disorders including Asperger’s syndrome (para 3.16). That is, the definition of “mental disorder” in the 1983 Act includes the “full range of autistic spectrum disorders” (para 34.18).
- 5 Therefore, in assessing whether the definition of “mental disorder” at section 1(2) of the 1983 Act includes or excludes learning disabilities in any particular situation, one has to take account of which specific power set out in the Act is relevant, and also whether the disability is associated with particular kinds of conduct.
- 6 The relevance of dependence on alcohol or drugs is that:

¹ Admission to hospital for treatment.

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

³ A community treatment order.

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

⁵ Community treatment period.

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

⁷ Power of higher courts to order hospital admission.

⁸ Power to transfer a sentenced prisoner to hospital.

⁹ Power to transfer a prisoner on remand to hospital.

¹⁰ Further powers relating to detained persons.

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

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

¹³ Section 1(2A) of the 1983 Act.

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

“Mental illness”

- 7 “Mental illness” was one of the four categories of “mental disorder” under section 1(2) of the 1983 Act before the 2007 Act replaced the categorisation with a single definition of mental disorder.¹⁵ However, there was no statutory definition of mental illness in the 1983 Act.
- 8 The Mental Health Act 1983 Code of Practice defines “mental illness” as “an illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia” (Annex A).

“Mental distress”

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

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

“Personality disorder”

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

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

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

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

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

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

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

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

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

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

Antisocial and borderline personality disorders are the most common in criminal justice settings. People with antisocial personality disorder will exhibit “traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one’s behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others.” (NICE, 2009)²⁰

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

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

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

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

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

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

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

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

"Mentally disordered offenders"

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

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

who may be acutely or chronically mentally ill

who have neuroses, behavioural and/or personality disorders

who have a learning disability or learning difficulties

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

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

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

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

- 14 This broad definition reflects Nacro's concern to concentrate not just on a narrow group of offenders whose mental disorders fall within the Mental Health Act criteria. They also want to address the wider range of problems associated with people who have some degree of mental disturbance or learning disability and warrant a range of care, support and, in some cases, treatment.

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

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

- 15 The expression “offenders with mental health problems or learning disabilities” is used by the Crown Prosecution Service when referring to the wider policy context, but the statutory definition of “mentally disordered offender” (meaning an offender with a “mental disorder” as defined by section 1(2) of the 1983 Act) is referred to when discussing prosecutors’ decision-making.²⁵

Learning disabilities and learning difficulties

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

No One Knows has included in its scope people who find some activities that involve thinking and understanding difficult and who need additional help and support in their everyday living. The term learning disabilities or difficulties thus include people who: experience difficulties in communicating and expressing themselves and understanding ordinary social cues; have unseen or hidden disabilities such as dyslexia; experience difficulties with learning and/or have had disrupted learning experiences that have led them to function at a significantly lower level than the majority of their peers; [or] are on the autistic spectrum, including people with Asperger’s syndrome.²⁸

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

“Learning disability”

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

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

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

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

²⁷ The Bradley report, p 20.

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

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

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

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

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

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

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

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

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

22 The World Health Organisation uses the following definition:

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

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

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

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

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

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

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

“Learning difficulty”

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

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

- 25 The Prison Reform Trust states:

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

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

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

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

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

PART 1

INTRODUCTION TO THE SUPPLEMENT TO THE SCOPING PAPER

- 1.1 This Part introduces the material which supplements the scoping paper on the defences of insanity and automatism. The scoping paper seeks to discover how the defences of insanity and automatism are working in the criminal law of England and Wales, if at all.

BACKGROUND

- 1.2 This project, which formed part of our Tenth Programme of Law Reform in 2008¹ is about one aspect of the way that people with mental disorder are dealt with in the criminal justice system, namely improving the defences of “insanity” and “automatism”. The defence of insanity is contained in the so-called “M’Naghten Rules”, together with some statutory material and decisions of the higher courts. Automatism is also a common law defence and it is available for all crimes. The project is not about how people who are mentally ill at the time of trial should be dealt with,² nor is it about services which should be provided to defendants who have been convicted and are due to be sentenced, nor is it about whether or not some form of mental disorder should be a mitigating factor in sentencing if a person is convicted.
- 1.3 We were convinced, from our research, that there are significant problems with the law on insanity and automatism defences when examined from a theoretical perspective. However, in the absence of information on how the defences are operating in practice, it is impossible to produce meaningful law reform proposals. The limited empirical data available suggests that there are only a very small number of successful insanity pleas each year (around 30). We have no data on how often the plea is considered by practitioners as a possibility or entered formally at trial. We have no data whatsoever on the use of the automatism defence.
- 1.4 We have, therefore, decided to publish a scoping paper to understand how the defences operate in practice and what problems they pose. The scoping paper includes 76 questions that are designed to provide a full picture on the operation of the defences and the impact they have on people at various stages of the criminal justice system.

TERMINOLOGY

- 1.5 An important initial issue is the very name of the defence which is the primary subject of this paper. To criminal lawyers it is known as the “insanity defence”. We acknowledge that the use of the word “insanity” might be off-putting or even offensive to many people. One of the issues we address in this paper is the question of the appropriate label for a defence of this kind, whatever its scope.

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

² On this issue, see our consultation paper on unfitness to plead: CP 197.

- 1.6 Another difficulty with the label is that in terms of strict legal analysis it is arguably not a defence at all. Despite these objections, we will use the label “the insanity defence” in this paper and the scoping paper wherever we are referring to the test in the current law, because that is how it is known to those who work in the criminal law.
- 1.7 Turning to more modern terminology, we use the phrase “mental disorder” to encompass all mental illnesses, disorders and disabilities of the mind including learning disabilities and difficulties. Some of the definitions that are commonly used are set out in the glossary, including those of “mental disorder”, “learning disability” and “learning difficulty”. The glossary also includes full details of abbreviations used in this paper.

THE “INSANITY DEFENCE” IN OUTLINE

- 1.8 If a person with mental disorder at the time of an alleged offence is charged with that offence, it is possible that no prosecution will follow and that he or she will be dealt with by mental health services instead. If a prosecution does proceed, then the court may find, depending on the accused’s mental state at the date he or she is brought before the court, that he or she is not fit to plead. In that event, the trial does not proceed. Thus the defence of insanity may only be pleaded by someone who is being prosecuted and who is fit to plead.
- 1.9 The possibility that the accused will plead the insanity defence will, however, also play a part in decisions about which cases should proceed. In deciding whether to proceed with a prosecution the prosecuting authority will assess the likelihood of conviction and the public interest in proceeding. Thus the defence is significant in a wider range of cases than merely that small number where it is formally pleaded.
- 1.10 If the prosecution does proceed to trial, the accused might plead not guilty for a number of reasons³ including that he or she is “not guilty by reason of insanity”. The test which has to be satisfied for the accused to be able to rely on this defence was laid down in what are known as “the M’Naghten Rules” in 1843. In essence, the criteria are that the accused had such a “defect of reason from disease of the mind” that he or she did not know the nature and quality of his or her act, or the accused did not know that what he or she was doing was morally or legally wrong. If the plea is successful, then there is what is known as a “special verdict”, that of “not guilty by reason of insanity”. This special verdict is a form of acquittal; the accused has not been convicted of any offence.

“Disposal”

- 1.11 As a person who has been found not guilty by reason of insanity has not been convicted of any crime, he or she cannot be sentenced. The term “disposal” is therefore used to encompass the powers that a court has to deal with such a person. Although the special verdict is a form of acquittal, it is not the same as a simple acquittal because, following a special verdict, the court has the power to make an absolute discharge, a supervision order, or to order that the individual be detained in a hospital, possibly with a restriction order. The effect of a restriction order is that the person will not be released until authorised by a

³ For example, on the grounds of mistaken identification, or self-defence.

responsible clinician or hospital managers with the consent of the Secretary of State, or by the Secretary of State, or by an appropriate mental health tribunal. The criteria for release differ depending on whether release is authorised by the Secretary of State or the tribunal.

THE DEFENCE OF AUTOMATISM IN OUTLINE

- 1.12 A defendant may plead not guilty on the basis of automatism, or, in other words, that he or she had no voluntary control. The defence is regarded as a denial of the actus reus (the conduct element of an offence). Once the defence has called enough evidence to make it a live issue in the trial, if the prosecution cannot disprove the defence, the defendant will be acquitted.

WHY IS IT IMPORTANT TO REFORM THE DEFENCES?

- 1.13 We believe it is important as a matter of principle that criminal responsibility should be correctly ascribed. Doing so, through operation of the law, reflects society's judgment and attribution of blame. It is not just a matter of accurately communicating by means of a verdict what conclusion a court has reached about a person's culpability (what is described as "fair labelling"),⁴ though that is important too.
- 1.14 It is also important as a matter of practice, both for the individual and potentially for society as a whole.

The consequences of a criminal conviction as compared with a verdict of not guilty by reason of insanity

- 1.15 Dealing first with the impact on the individual, the outcome of the court proceedings will almost certainly differ depending on whether a person is convicted or found not guilty by reason of insanity. There is a variety of disposals available to a judge in criminal sentencing, including an order that the offender be detained in a psychiatric hospital. As we have described above, there is a different selection of disposals following a verdict of not guilty by reason of insanity, and one of those is also a hospital order.
- 1.16 A significant difference is that, if a defendant has been convicted, and the judge thinks that a hospital order is appropriate, the hospital does not have to agree to accept the offender. If, on the other hand, the accused has been found not guilty by reason of insanity then the judge may make a hospital order and the hospital cannot refuse to take the patient.⁵

⁴ See generally J Chalmers and F Leverick, "Fair Labelling in Criminal Law" (2008) 71(2) *Modern Law Review* 217.

⁵ Explanatory Notes to the 2004 Act, para 93. See s 37(4) of the 1983 Act where an order is made pursuant to s 5 of the 1964 Act, as substituted by s 5A of the 1964 Act.

- 1.17 An offender who has been convicted and is suffering from mental disorder might be transferred to hospital from prison,⁶ but this will not necessarily happen and it will not always happen in a timely way.⁷
- 1.18 It is true that the distinction between prison and a secure hospital is not a pure one: a prisoner might receive treatment, and a patient in a hospital who arrives via the criminal justice system is deprived of his or her liberty. Nevertheless, if a person is found not guilty by reason of insanity, he or she has not been convicted of any crime.
- 1.19 In some other respects, a special verdict has the same effect as a conviction. For example, the following penalties may be applied, or apply automatically, following either a conviction or a special verdict: in specified circumstances restrictions can be placed on the individual under a Violent Offenders Order, a Sexual Offences Prevention Order or a Foreign Travel Order, and notification requirements under the Sexual Offences Act 2003 or the Counter-Terrorism Act 2008 may be imposed. When it comes to the question of bail in any future criminal proceedings, a special verdict may have the same significance as a conviction.⁸
- 1.20 There are, however, significant consequences for a person who has been convicted of an offence which someone who has been found not guilty by reason of insanity does not have to face. A conviction can be cited in subsequent criminal proceedings. It can have an effect on a sentence for a subsequent offence.⁹ Unlike a conviction, a verdict of not guilty by reason of insanity cannot be relied upon as an aggravating factor when it comes to sentence in subsequent criminal proceedings.
- 1.21 Another important difference lies in what needs to be disclosed by law by the offender to third parties, such as prospective employers. There are three levels of disclosure of information for certain purposes (mainly employment). The lowest level of disclosure is a criminal convictions certificate and such a certificate only discloses details of any unspent convictions and conditional cautions.¹⁰ For the

⁶ As can be seen from Appendix A, it is not the case that a person has to be found “insane” in law before he or she can or will receive any treatment. An accused person might be the subject of a hospital order at various stages of the criminal process. He or she does not have to be found not guilty by reason of insanity in order to be sent to a psychiatric institution in the course of criminal proceedings.

⁷ On transfers to hospital, see para A.62 in Appx A below.

⁸ Bail Act 1976, s 2(1)(b).

⁹ Section 143(2) of the Criminal Justice Act 2003 provides that when considering the seriousness of an offence which has been committed by an offender with more than one previous conviction, each previous conviction – where it is recent and relevant – must be treated by the court as an aggravating factor. This provision replaces s 151 of the Powers of Criminal Courts (Sentencing) Act 2000 which still remains relevant for offences committed before 4 April 2005. Section 151 provides that a court may take into account any previous conviction of the offender or any failure to respond to previous sentencing. Under s 122 (partially in force) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, the court must impose a life sentence on a defendant who is convicted of an offence listed in sch 15B to the Criminal Justice Act 2003 and who has already been convicted of an offence listed in part 1 of sch 15B) and satisfies certain conditions, unless there are particular circumstances which would make it unjust to do so.

¹⁰ Police Act 1997, s 112. This is only partially in force. A basic certificate which details any unspent convictions is not yet available from the Criminal Records Bureau.

purposes of the Rehabilitation of Offenders Act 1974 a reference to a conviction does not include a “finding linked with a finding of insanity”.¹¹ Therefore, unlike a conviction, a verdict of insanity should not be disclosed for the purposes of a criminal convictions certificate or a criminal records certificate. It may, however, be disclosed under an enhanced criminal records check.¹²

The possible consequence for the public

- 1.22 Whether a defendant is convicted or receives a special verdict is significant for the general public, in particular in terms of the possible effect on the likelihood of that individual reoffending. There is a paucity of research on the reoffending rates of those who are released from a secure hospital, but such research as there is indicates a lower reoffending rate for those who are discharged from a secure hospital than for those who are released from prison.¹³ We have no evidence as to the relative reoffending rates following imprisonment as compared with the likelihood of reoffending by people with the same disorders committing similar offences who instead received treatment either in hospital or as part of a supervision order.

THE GOVERNMENTAL CONTEXT TO MENTAL ILLNESS AND CRIMINAL JUSTICE

The Bradley report

- 1.23 At the request of the then Lord Chancellor and Secretary of State for Justice, Lord Bradley led an independent inquiry into diversion of offenders with mental health problems or learning disabilities away from prison into other more appropriate services. His report was published in April 2009.¹⁴
- 1.24 The Bradley report recommended enhanced roles for Criminal Justice Mental Health Teams. They would serve as liaison and diversion services. They would be attached to each police station, so that a person’s mental disorder or learning disability might be identified at a much earlier stage in the criminal justice process than is currently the case. The information gathered by the CJMH Team would

¹¹ Rehabilitation of Offenders Act 1974, s 1(4).

¹² The Protection of Freedoms Act 2012 will make changes to the disclosure of criminal records when it comes into force. These changes would not prevent the disclosure of a finding of not guilty by reason of insanity in an enhanced criminal records certificate, but they may mean that it would be more difficult for a chief officer to justify its inclusion.

¹³ Most recent figures suggest that 40% to 50% of offenders released from prison reoffend within a year, as compared with reoffending rates of 5.8% within two years for those discharged from hospital (figures for the period 2000 to 2008 and 1999 to 2007 respectively): Ministry of Justice, *Compendium of Reoffending Statistics and Analysis* (2010). These figures cannot be relied on too much because there could be a number of factors which differ from one group as compared with the other. Reoffending rates given by the Centre for Mental Health in 2007 for those released from hospital were 7%, but those figures covered people who had been prisoners and then transferred to hospital: M Rutherford and S Duggan, *Forensic Mental Health Services; Facts and Figures on Current Provision* (2007). There is also a study from 2004 which indicates a higher rate of reoffending following release from high security hospitals.

¹⁴ *Lord Bradley’s report on people with mental health problems or learning disabilities in the criminal justice system* (April 2009).

then be passed to the court for the accused's first appearance. Those same liaison and diversion services should

form close links with the judiciary to ensure that they have adequate information about the mental health and learning disabilities of defendants, and concerning local health and learning disability services.¹⁵

The Government has recently reiterated its commitment to the scheme and its intention that it should be operating in police custody suites and courts by 2014.¹⁶

Ministry of Justice Green Paper

1.25 The Government stated in its recent Green Paper that “the criminal justice system is not always the best place to manage the problems of less serious offenders where their offending is related to their mental health problems”¹⁷ and that it supports the proposals in the Bradley report for greater diversion from the criminal justice system of mentally disordered offenders.

1.26 The policy of promoting diversion is not a new one: Home Office Guidelines from 1990, which are still in force, state that:

Where there is sufficient evidence, in accordance with the principles of the Code for Crown Prosecutors, to show that a mentally disordered person has committed an offence, careful consideration should be given to whether prosecution is required by the public interest. It is desirable that alternatives to prosecution, such as cautioning by the police, and/or admission to hospital ... or support in the community, should be considered first before deciding that prosecution is necessary.¹⁸

1.27 In the Green Paper, the Government also continued to emphasise the importance of reducing reoffending rates.

“Healthy children, safer communities”

1.28 There is a particular emphasis on diverting young people from the criminal justice system. It is a key objective for the Department of Health to “ensure that more children and young people are appropriately diverted from the formal Youth Justice System”.¹⁹ To that end, the Department has developed Youth Justice Liaison and Diversion pilots which “aim to develop effective diversion approaches for young people with mental health problems or learning disabilities”.²⁰

¹⁵ The Bradley report, pp 74 and 140.

¹⁶ Speech by Lord McNally to the University of Hertfordshire, 5 Oct 2011.

¹⁷ Ministry of Justice, “Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders” (2010) Cm 7972, p 36.

¹⁸ Home Office, “Provision for Mentally Disordered Offenders” (1990) Circular 66/90 p 2.

¹⁹ HMG, *Healthy Children, Safer Communities* (Dec 2009) p 39.

²⁰ HMG, *Healthy Children, Safer Communities* (Dec 2009) p 41. Six pilots have been funded.

THE STRUCTURE OF THIS PAPER

- 1.29 We give an account of the various ways in which a mentally disordered defendant may be dealt with by the courts in Appendix A. Our description of the current law in Part 2 covers the defences of insanity and automatism. It is important for this project to be informed as to the way the defence of insanity is used, or not used, in the courts, and we set out what we know so far of the defence in practice in Part 3, drawing to a large extent on research conducted by Professor Ronnie Mackay, (see also Appendix E), and supplemented by the research by Professor Cheryl Thomas reported in Appendix B.
- 1.30 We set out our analysis of the problems arising from the current law and practice in Part 4. Part of the problem with the current law is that it does not reflect a coherent rationale for an “insanity” defence. We observe, in Part 4, that this lack of clarity about what justifies a criminal defence for a person with mental disorder leads to incoherence in the case law.
- 1.31 One of the principal difficulties is the distinction drawn in the case law between a state of “insane automatism” and a state of “sane automatism” on the basis of whether the cause can be ascribed to internal or external factors. This leads the law into ridiculous conclusions. An internal cause might be a medical condition such as epilepsy, or diabetes, with the result that a person who commits what would amount to an assault while experiencing an epileptic fit may not plead automatism but only a defence of insanity. A diabetic who falls into a hyperglycaemic coma similarly may be surprised and offended to hear a court rule that, following precedent, the cause of his or her loss of voluntary control was internal, namely the condition of diabetes, and therefore if he or she wishes to plead not guilty on the basis of the medical condition, it must be a plea of not guilty by reason of insanity.
- 1.32 We suspect that the defence is little used, in part no doubt because of its inaccurate, unfair and stigmatising label. The mismatch between the legal test and modern psychiatry is striking. Moreover, this mismatch may result in the law not being applied in practice. One of the strange categorisations which follows from the case law is that sleep-walking is classified as insanity, not automatism. Unsurprisingly, it appears that case law is not consistently applied and we are aware of some cases of sleep-walking being treated as cases of automatism.
- 1.33 Finally, the defence does not fairly identify those who ought not to be held criminally responsible as a result of their mental condition, and so some of those vulnerable people remain in the penal system, to their detriment, and to the detriment of society at large.
- 1.34 In Part 5 we review the relevant articles of the European Convention on Human Rights and Fundamental Freedoms and assess whether the insanity defence risks breaching any of those articles. We conclude that there are risks of violations of the presumption of innocence (article 6(2)) that arise from placing the burden of proving the defence of insanity on the accused.
- 1.35 We also have concerns about potential violations of the right to life (article 2), and to private and family life (article 8) of potential victims if the law does not adequately distinguish between those who may fairly be held responsible for what they do and those who, due to their condition, may not. In addition, the

unsuitability of the current definition of the insanity defence leads to some people being detained in custody when a fair test would lead to the conclusion that they were not criminally responsible. In consequence, they are at greater risk of imprisonment rather than treatment and hence at greater risk of suicide and self-harm, and the state, which owes duties to those held in custody, risks violations of their right to life (article 2) and the right not to be subjected to inhuman and degrading treatment (article 3).

1.36 We refer throughout the paper to the law in other jurisdictions, and that is briefly described in Appendix C.

1.37 To some degree, the ground covered by this paper has been covered by other groups before us, and we set out the proposals of previous reviews in Appendix D.

Questions for consultees

1.38 The scoping paper presents a number of questions and we would welcome responses on any or all of them. If there are aspects which we have not covered which consultees would like to draw to our attention, then that would also be welcome, as would accounts of any relevant experience of the operation of the defences of insanity or automatism.

ACKNOWLEDGEMENTS

1.39 We have already been helped very much by the following people who have been kind enough to respond to requests for information or to advise us, and we are very grateful to them. They are: Professor Andrew Ashworth, University of Oxford; His Honour Judge Atherton; Sally Averill, Crown Prosecution Service Policy; Professor Sue Bailey, University of Central Lancaster; Dr Jillian Craigie, University College London; Dr Enys Delmage; Dr Graham Durcan, Centre for Mental Health; Professor Nigel Eastman, St George's University of London, consultant psychiatrist; Kimmett Edgar, Prison Reform Trust; Anthony Edwards, solicitor, Visiting Professor, Queen Mary, University of London; Brian Evans, the Judicial College; The Recorder of Manchester His Honour Judge Gilbert QC; Philippa Goffe, Head of Team, Sentencing for under 18s, Youth Justice Policy Unit, Ministry of Justice; Dr Adrian Grounds, University of Cambridge; Toby Hamilton, Sentencing for under 18s, Youth Justice Policy Unit, Ministry of Justice; Dr Jeremy Kenny-Herbert, consultant psychiatrist; Graham Hooper, Justices' Clerks' Society; Ian Kelcey, solicitor; Professor Ronnie Mackay, De Montfort University; Lindsay McKean, Head of Mental Health Casework Section, Offender Management and Public Protection Group, NOMS; Shirley Meehan, the Judicial College; Dave Spurgeon, NACRO; Jenny Talbot, Prison Reform Trust; Professor Cheryl Thomas, University College London; Kathleen Turner, the Judicial College; Dr Eileen Vizard CBE, University College London; Adrian Waterman QC; District Judge Susan Williams; and Dr Sarah Young.

PART 2

THE LAW

INTRODUCTION

- 2.1 In this Part we give an account of the current law of the related defences of insanity and automatism. A flowchart to represent the current law is included at the end of this Part. If a defendant pleads insanity, the test applied is that contained in the M’Naghten Rules of 1843 (fully described below). If a defendant pleads not guilty on the basis that he or she was in a state of automatism the court will inquire as to what lay behind the conduct, and if it was a “disease of the mind”, then the court will treat the defence as a plea of insanity, not automatism.
- 2.2 A significant difference between the two defences is the possible outcome: if an insanity defence succeeds in the Crown Court, the accused does not obtain a simple acquittal but may be subject to various disposal powers including detention in a secure hospital. If an automatism defence succeeds (in the Crown Court or in the magistrates’ court) then the accused is simply acquitted. This difference has affected the evolution of the defences because the courts are mindful of the risk of recurrence of the circumstances resulting in harm. The courts may therefore be more inclined to see the defendant’s circumstance as one amounting to “insanity” because the court will then have the power to deal with the accused.
- 2.3 To distinguish between insanity and automatism, the courts examine whether the accused’s abnormal state was caused by an “internal” factor, or an “external factor”. If the cause was an internal factor, reliance on that state as an excuse at trial will amount to an insanity defence. If the cause was an external factor, the defence being advanced will be automatism. The rationale is that an internal factor is more likely to recur, entailing future risk to the public, and the courts’ powers of disposal could be used to mitigate that risk if the case is one of “insanity”.
- 2.4 The law governing this area is also influenced by another relevant set of principles in the criminal law: those relating to prior fault. It is easy to see that if a defendant has been culpable in producing his or her state of automatism at the time of the alleged offence, then the courts will not permit that state to excuse him or her. It is therefore necessary to mention briefly in this Part how that doctrine affects the availability of the defences.
- 2.5 One particular kind of “prior fault” is voluntary intoxication. As is well known, the common law has developed rules to impose criminal responsibility in circumstances where the accused had not, because of his or her intoxicated state, formed the relevant mens rea for the offence. Those rules therefore also need to be borne in mind when considering the defences of insanity and automatism. There are overlaps between all three areas.

STRUCTURE OF THIS PART

- 2.6 We describe the case law on the defences, starting with insanity. We turn to the case law on automatism from paragraphs 2.60 to 2.80 below. Our description of

the case law includes discussion of which party bears the burden of proof for each defence.

- 2.7 If the defendant is charged with murder, and at the time of the alleged offence he or she suffered from an abnormality of mental functioning arising from a recognised medical condition resulting in a partial loss of a relevant capacity which caused or contributed to the killing, he or she may plead diminished responsibility instead of, or as well as, insanity. We note the relationship between the defences at paragraphs 2.49 to 2.50 below.
- 2.8 We explain how voluntary and involuntary intoxication may bear on the defence of insanity at paragraphs 2.51 to 2.59 below.
- 2.9 While the content of the defence of insanity is a matter of common law, the procedure, and the powers of the court to deal with the accused, are governed by legislation. From paragraph 2.81 we describe how the insanity defence may be pursued, first, in the magistrates' courts, and secondly in the Crown Court. We treat them separately because of the important difference: if successful, the defence of insanity leads to a complete acquittal in the magistrates' courts, but to a special verdict in the Crown Court.

Unfitness to plead and to stand trial

- 2.10 Before embarking on the analysis of the law on insanity, it is important to mention a related issue: the question of whether a defendant is fit to plead and to stand trial. Unlike insanity, the issue of fitness to plead is concerned with the question of the defendant's mental state at the time of trial and not at the time of the offence. While a successful insanity plea acts as a substantive defence to a charge, a finding of unfitness to plead acts as a bar to trial. The statutory procedure for dealing with unfitness is only available in the Crown Court.
- 2.11 If a person is unfit to plead, he or she will not face a trial but instead a hearing will take place¹ in which the accused person cannot be convicted, but can be acquitted or found to have done the act or made the omission charged. A person who is fit to be tried and pleads the insanity defence is subjected to the normal criminal trial process. A successful plea of insanity in the Crown Court leads to a special verdict.²
- 2.12 A person found unfit to plead and to have done the act or made the omission charged and a person found not guilty by reason of insanity may be subject to the same disposals: namely, a hospital order (with or without a restriction order), a supervision order or an absolute discharge.³
- 2.13 As the issue of fitness to plead is not a defence, we do not discuss it further.⁴

¹ In accordance with ss 4 and 4A of the 1964 Act.

² See para 2.93 below.

³ Section 5 of the 1964 Act, as amended by the 2004 Act.

⁴ See CP 197.

THE DEFENCE OF INSANITY: THE M'NAGHTEN RULES⁵

2.14 The defence of insanity is a creation of the common law:

There is no statutory definition of insanity and there never has been one for the purposes of the criminal law. The answers given by the judges to the House of Lords following M'Naghten's Case (1843) ... were not given in the course of any judicial proceedings.⁶

2.15 Daniel M'Naghten assassinated the Prime Minister's secretary but was acquitted of murder on the grounds that he was "insane at the time of the commission of the offence". By virtue of the Criminal Lunatics Act 1800 he was detained until his death some 22 years later. The fact that he was acquitted, however, caused a public outcry. A House of Lords debate followed and it was decided that the judges should be summoned to give their opinion "as to the law respecting crimes committed by persons afflicted with insane delusions".⁷ The reference to "delusions" arose from the fact that M'Naghten had committed the assassination while under the delusion that he was being persecuted by the Prime Minister, Robert Peel. He killed the latter's secretary in the mistaken belief that the secretary was the Prime Minister. The judges were asked to answer certain questions, and those questions together with the answers given constitute the M'Naghten Rules. The Rules have been treated as authoritative for more than a century and continue to form the definitive statement of the insanity defence in English law.⁸

2.16 The Rules consist of the judges' answers to five questions. Question 5 is not relevant to this project. Three of the other four questions are predicated on the defendant being either "afflicted with" or "under" an insane delusion. The answers to the questions are not confined to cases of insane delusions,⁹ although M'Naghten must have been the case the judges had in mind.

2.17 Questions 2 and 3 were:

"What are the proper questions to be submitted to the jury when a person alleged to be afflicted with insane delusion respecting one or more particular subjects or persons, is charged with the commission of a crime (murder, for example), and insanity is set up as a defence?"

"In what terms ought the question to be left to the jury as to the prisoner's state of mind at the time when the act was committed?"

2.18 The key passage of the answer states:

⁵ *M'Naghten's Case* (1843) 10 Clark and Finnelly 200, (1843) 8 ER 718, [1843-60] All ER Rep 229.

⁶ *Sullivan* [1984] AC 156, 170 to 171, by Lord Bridge.

⁷ R Moran, *Knowing Right from Wrong: The Insanity Defense of Daniel McNaughtan* (1981) p 168.

⁸ Approved by Lord Diplock in *Sullivan* [1984] AC 156.

⁹ *Windle* [1952] 2 QB 826, 833 to 834; *Sullivan* [1984] AC 156.

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

- 2.19 When following the case law interpreting the Rules, it is worth bearing the historical context in mind, in particular that the interpretation of the words was affected by the possible outcomes for those found “not guilty by reason of insanity”. Until 1991 a person found not guilty by reason of insanity would be detained in a mental hospital for an indefinite period. Until 1957, if charged with murder, there was no defence of diminished responsibility to reduce the offence to manslaughter. Until November 1965 (when the Murder (Abolition of Death Penalty) Act 1965 came into force) a person charged with murder would, therefore, face the death penalty if convicted or indeterminate detention as a psychiatric patient if insane. After that date, the possibilities were detention in prison or in a psychiatric hospital. Any person with a mental disorder had, therefore, a strong incentive to seek an outright acquittal by relying on sane automatism. The courts, by contrast, sought to limit the scope of sane automatism, in part to distinguish the genuine plea from the fraudulent,¹⁰ and in part to avoid the release of people who were dangerous and who might commit further violent offences.

The presumption of sanity

- 2.20 The judges’ answer to the questions in M’Naghten opens with a statement of the presumption of sanity: “the jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction”.¹¹

“At the time of committing the act”

- 2.21 The defence is of course founded on the accused’s condition at the time of the alleged offence.

“Defect of reason, from disease of the mind”

- 2.22 An abnormality of mind which does not reflect impaired powers of reasoning, such as an inability to control one’s emotions or resist impulses,¹² is not capable of constituting a “defect of reason”. The powers of reasoning have to be impaired. A mere failure to use powers of reasoning is not enough.¹³ Momentary failure of

¹⁰ *Hill v Baxter* [1958] 1 QB 277, by Devlin J; *Cooper v McKenna* [1960] Qd LR 406, 419, by Stable J: “‘black-out’ is one of the first refuges of a guilty conscience and a popular excuse”.

¹¹ See *Layton* (1849) 4 Cox’s Criminal Cases 149.

¹² *Kopsch* (1927) 19 Cr App Rep 50; *A-G of South Australia v Brown* [1960] AC 432.

¹³ *Clarke* [1972] 1 All ER 219, 221, by Ackner J.

concentration, even where caused by mental illness, is not insanity within the M’Naghten Rules. A defendant in such a case would rely on the evidence of mental illness to negative mens rea. For example, in *Clarke* the charge was one of theft, and, had the accused contested the case, she would have argued that, because of her depression, she did not form the intention necessary for the offence of theft.¹⁴

- 2.23 “Disease of the mind” is not limited to diseases of the brain: “it means a disease which affects the proper functioning of the mind”.¹⁵ “Mind” here means, in the words of Lord Diplock, “the mental faculties of reason, memory and understanding”.¹⁶ What matters is the effect of the impairment, as he explained:

If the effect of a disease is to impair these faculties so severely as to have either of the consequences referred to in the latter part of the rules, it matters not whether the aetiology of the impairment is organic, as in epilepsy, or functional, or whether the impairment itself is permanent or is transient and intermittent, provided that it subsisted at the time of commission of the act.¹⁷

- 2.24 Whether the disease which produces the impairment is physical or mental does not matter. This interpretation is consistent with the view held by Mr Justice Devlin in the Assizes case of *Kemp*,¹⁸ and with the opinion of the House of Lords in *Bratty v Attorney-General for Northern Ireland*.¹⁹ These cases were influential in the House of Lords in *Sullivan*²⁰ reaching its controversial interpretation of disease of the mind, so brief discussion of them is warranted.

Kemp

- 2.25 The defendant was an elderly man of good character, who made an apparently motiveless and irrational attack on his wife. He was charged with causing grievous bodily harm with intent.²¹ The medical evidence was that he suffered from arteriosclerosis (hardening of the arteries) which resulted in a congestion of blood on the brain. The condition had not reached the stage where he was exhibiting any general signs of mental trouble, other than that he was depressed because of his poor physical state of health. Experts agreed that his condition had resulted in a temporary lapse of consciousness during which he perpetrated the attack. He was not conscious that he had picked up a hammer, nor that he had struck his wife with it. Afterwards, he had no recollection of the event. The

¹⁴ *Clarke* [1972] 1 All ER 219.

¹⁵ *Hennessy* [1989] 1 WLR 287, 292, by Lord Lane CJ.

¹⁶ *Sullivan* [1984] AC 156, 172. The defendant claimed that he had committed the alleged assault while suffering a seizure caused by psychomotor epilepsy. He argued that his defence of “non-insane automatism” ought to have been left to the jury. The Court of Appeal rejected the appeal, as did the House of Lords.

¹⁷ *Sullivan* [1984] AC 156, 172.

¹⁸ [1957] 1 QB 399.

¹⁹ *Bratty v A-G for Northern Ireland (“Bratty”)* [1963] AC 386.

²⁰ [1984] 1 AC 156.

²¹ [1957] 1 QB 399.

Crown conceded that the defendant was suffering from a “defect of reason” and that he did not know the “nature and quality” of his act.

2.26 In pleading not guilty, the defendant submitted that the defect of reason was a result not of “disease of the mind” but of a purely physical condition. The submission was that the arteriosclerosis, until it caused the brain cells to degenerate, was a temporary interference with the working of the brain just like a concussion; it was a physical disease which only became a “disease of the mind” when the brain cells degenerated.

2.27 The submission was emphatically rejected by Mr Justice Devlin. He said that acceptance of the submission would result in:

a very difficult test to apply for the purposes of the law. I should think it would be a matter of great difficulty medically to determine precisely at what point degeneration of the brain sets in, and it would mean that the verdict depended upon a doubtful medical borderline.²²

2.28 According to Mr Justice Devlin:

The law is not concerned with the brain but with the mind, in the sense that “mind” is ordinarily used, the mental faculties of reason, memory and understanding ... the condition of the brain is irrelevant, and so is the question whether the condition of the mind is curable or incurable, transitory or permanent.²³

2.29 Mr Justice Devlin stressed that the phrase “disease of the mind” had to be judicially interpreted so as to reflect the purpose intended for it by the answer given to question 3 in M’Naghten’s Case:

The words “from disease of the mind” are not to be construed as if they were put in for the purpose of distinguishing between diseases which have a mental origin and diseases which have a physical origin, a distinction which in 1843 was probably little considered. They were put in for the purpose of limiting the effect of the words “defect of reason”. A defect of reason is by itself enough to make the act irrational and therefore normally to exclude responsibility in law.²⁴

2.30 The effect of this ruling is that words, which the judge maintained were inserted for the purpose of limiting the ambit of the defence of insanity, receive an extremely wide interpretation. As a result, the defence of insanity is capable of incorporating mental conditions which have a physical cause and which may result in a defect of reason for a very short period. This occurred in *Sullivan* where the accused committed an involuntary assault in the throes of an epileptic

²² [1957] 1 QB 399, 407.

²³ [1957] 1 QB 399, 407. Approved by Lord Diplock in *Sullivan* [1984] AC 156, 172.

²⁴ [1957] 1 QB 399, 408.

fit, and more recently when a driver caused a serious road traffic accident, also as a result of suffering an epileptic seizure.²⁵

Bratty

- 2.31 In this case,²⁶ the defendant was convicted of murder by strangling his victim. He claimed that he had not known what he was doing, and called evidence that he was suffering from psychomotor epilepsy, but that evidence was weak and his defence of automatism failed. In the House of Lords, Lord Denning said:

In *Charlson's case*, Barry J seems to have assumed that other diseases such as epilepsy or cerebral tumour are not diseases of the mind, even when they are such as to manifest themselves in violence. I do not agree with this. It seems to me that any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind. At any rate it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal.²⁷

- 2.32 This definition has been criticised as being both under- and over-inclusive. It is under-inclusive in the sense that a disease may manifest itself in wrongful acts other than violence (such as theft).²⁸ More importantly, the definition can be criticised as over-inclusive and, taken at face value, “alarmingly wide”²⁹ since it includes people with conditions such as epilepsy, brain tumours, arteriosclerosis and diabetes whom common sense suggests should not be labelled as “insane”.

- 2.33 This can be explained by the fact that the definition appears to be based primarily on concerns for public safety rather than legal principle or indeed any definitions used by medical professionals. This has been explicitly recognised in later cases. For example, Lord Diplock in *Sullivan* said that the “purpose of the legislation relating to the defence of insanity ... [is] to protect society against recurrence of the dangerous conduct”.³⁰ However he went on to say that the court need not consider either the likelihood of recurrence or the possibility of remedial treatment in deciding on the verdict since these matters were the concern of the Home Secretary “to whom the responsibility for how the defendant is to be dealt with passes after the return of the special verdict”. Thus in *Burgess*,³¹ although the Court of Appeal noted that “the absence of the danger of recurrence is not a reason for saying that it cannot be a disease of the mind”, it held that “if there is a

²⁵ Southern Daily Echo, “Man Sentenced Despite Not Guilty Verdict” (8 Jan 2012) http://www.dailyecho.co.uk/news/9459324.Driver_spared_after_mayhem_on_M27/ (last visited 20 Mar 2012).

²⁶ [1963] AC 386.

²⁷ [1963] AC 386, 412.

²⁸ N Walker, *Crime and Insanity in England* (1968) vol 1, p 117. See also para 3.44 below.

²⁹ Mackay (1995) p 99.

³⁰ [1984] 1 AC 157, 172. The legislation he was referring to was that providing for a special verdict where insanity is proved, namely the Trial of Lunatics Act 1883, on which see para 2.93 below.

³¹ [1991] 2 QB 92, 99.

danger of recurrence that may be an added reason for categorising the condition as a disease of the mind". This view:

explains why these innocuous categories of defendants, who are unlikely to be considered medically insane, and who present little or no threat to society, now fall within the legal definition of insanity.³²

- 2.34 The defendant, Burgess, who had committed the violent assault while sleepwalking, was thus found to be legally insane, despite evidence that there was no real possibility of recurrence.³³

The two limbs of the Rules

- 2.35 There are two aspects to the Rules. The cognitive aspect is represented by the words "as not to know the nature and quality of the act he was doing". The wrongfulness aspect is represented by the words "or, if he did know it, that he did not know he was doing what was wrong".

The cognitive aspect

"AS NOT TO KNOW THE NATURE AND QUALITY OF THE ACT HE WAS DOING"

- 2.36 In *Codère*, it was argued on behalf of the defendant that "nature" of the act referred to its physical aspect and "quality" to its moral aspect. The Court of Criminal Appeal did not accept this argument and held that "nature and quality" have to do only with the physical aspects of the act.³⁴ As Lord Diplock explained in the House of Lords in 1984:

The audience to whom the phrase in the M'Naghten Rules was addressed consisted of peers of the realm in the 1840's when a certain orotundity of diction had not yet fallen out of fashion. Addressed to an audience of jurors in the 1980's it might more aptly be expressed as "He did not know what he was doing."³⁵

- 2.37 If the accused was conscious but did not know what he or she was doing, in a case in which the offence involves mens rea, the defence might be advanced simply on the basis that the relevant mens rea is lacking.³⁶

The wrongfulness aspect

"HE DID NOT KNOW HE WAS DOING WHAT WAS WRONG"

- 2.38 The issue of interpretation that has troubled the courts on this second limb is whether "wrong" here means contrary to law, or morally wrong. The current law is that if it can be shown that the accused knew either that the act was morally

³² P Sutherland and C Gearty, "Insanity and the European Court of Human Rights" [1992] *Criminal Law Review* 418, 421.

³³ The risk the court had in mind was probably the risk of violence arising from sleep associated automatism, but there is some ambiguity in the judgment.

³⁴ *Codère* (1917) 12 Cr App Rep 21, 27.

³⁵ *Sullivan* [1984] AC 156, 173.

³⁶ See *Blackstone's* para A3.18.

wrong or that the act was against the law, then it cannot be said that he did not know he was doing what was wrong.³⁷

- 2.39 Arguably there should be a connection between the cognitive aspect of the Rules and the wrongfulness aspect such that if, as a result of the nature of the mental illness, the accused's thinking was distorted to the extent that he or she thought the act was warranted then the accused would be able to rely on the insanity defence. Something approaching this argument was put forward in *Codère* but then withdrawn, and the defence conceded that "the standard to be applied is whether according to the ordinary standard adopted by reasonable men the act was right or wrong".³⁸

Windle

- 2.40 The defendant was tried for the murder of his wife.³⁹ She had herself frequently expressed a desire to die, and one day the defendant supplied her with a large number of aspirin. She died of the overdose. At trial, the defence called some evidence that the defendant was suffering a defect of reason known as "folie à deux" whereby the "insanity" suffered by his wife was communicated to him. Mr Justice Devlin, who heard the trial at the Assizes, refused to let the defence of insanity go to the jury because he thought there was no sufficient evidential basis. The issue for the Court of Criminal Appeal was whether there was enough evidence of insanity, within the meaning of the M'Naghten Rules, such that the trial judge ought to have left the issue of insanity to the jury. Lord Goddard CJ thought that there was enough evidence on whether he was suffering a defect of reason (though it was "exceedingly vague") but there needed also to be an evidential basis for the second limb of the test in the M'Naghten Rules, namely, whether the accused knew what he was doing was wrong.

- 2.41 It was beyond doubt that the defendant knew, when he gave his wife a large number of aspirin that he was doing something which was against the law. Lord Goddard CJ held:

Courts of law can only distinguish between that which is in accordance with law and that which is contrary to law.⁴⁰

- 2.42 The admission that the defendant knew that what he did was against the law, meant that the insanity defence was not available.

³⁷ *Codère* (1917) 12 Cr App Rep 21 and *Windle* [1952] 2 QB 826.

³⁸ *Codère* (1917) 12 Cr App Rep 21. The argument ran: the defendant knows that murder is against the law and could not therefore have thought it was not morally wrong. It cannot therefore be said that he did not know he was doing what was wrong. Whatever his cognitive abilities, he cannot rely on the insanity defence. According to this reasoning awareness that an act is against the law entails awareness that it is morally wrong.

³⁹ [1952] 2 QB 826.

⁴⁰ *Windle* [1952] 2 QB 826, 833. Lord Goddard CJ emphasised the concept of "responsibility according to law", but, with respect, it is not entirely clear what he meant by this in *Windle* nor in *Rivett* (1950) 34 Cr App Rep 87.

Johnson

- 2.43 *Windle* was followed recently in *Johnson*.⁴¹ The defendant was suffering from paranoid schizophrenia, including delusions. It was argued that these affected his perception of what was morally right and wrong such that he should be able to rely on the insanity defence even though he knew that what he did was wrong as a matter of law. The Court of Appeal, while acknowledging that *Windle* has not been followed in other jurisdictions,⁴² held reluctantly that *Windle* correctly states the position in England.

Who may raise the issue of insanity

- 2.44 The issue of insanity may be raised by the defendant, and in some circumstances it may also be raised by the prosecution. In *Bratty* the House of Lords held that if the defendant denies mens rea, and relies on evidence of mental disorder to do so, the prosecution may also adduce evidence of “insanity”, and seek a verdict of not guilty by reason of insanity.⁴³ If neither the prosecution nor the defence raise the issue of insanity, the judge may do so, if there is a sufficient basis,⁴⁴ in other words, if there is medical evidence relevant to all the factors in the M’Naghten Rules.⁴⁵
- 2.45 If the charge is murder and the defendant pleads diminished responsibility, then the prosecution may adduce or elicit evidence that the defendant is insane, in the legal sense.⁴⁶

Burden and standard of proof if the insanity defence is raised

- 2.46 If the defendant pleads insanity, then the burden of proof lies on the defence. If the prosecution is seeking to prove insanity – for example where the defendant denies mens rea on evidence of mental disorder – then the burden lies on the prosecution.⁴⁷ We are unaware of any research identifying how often this happens.

⁴¹ [2007] EWCA Crim 1978, [2008] *Criminal Law Review* 132.

⁴² *Stapleton* (1952) 86 CLR 358 (High Court of Australia). The court in *Johnson* described the judgment in *Stapleton* as “highly persuasive”: [2007] EWCA Crim 1978, [2008] *Criminal Law Review* 132 at [21]. *Chaulk* [1990] 3 SCR 1303 (Supreme Court of Canada) [1991] LRC (Crim) 485 See paras 4.67 to 4.74 below.

⁴³ *Bratty* [1963] AC 386, 411 to 412, by Lord Denning. At the time the special verdict was “guilty but insane”, but the point is the same.

⁴⁴ See *Bratty* [1963] AC 386, 411 to 412, by Lord Denning.

⁴⁵ *Dickie* [1984] 1 WLR 1031, by Watkins LJ.

⁴⁶ Criminal Procedure (Insanity) Act 1964, s 6.

⁴⁷ Although it may be rare in practice for the prosecution to seek to prove insanity. See *Bratty* [1963] AC 386, 411 to 413.

- 2.47 The standard of proof of insanity depends on which party is seeking to prove it. If it is the prosecution which is seeking to prove that the defendant is insane within the meaning of the law, then it must do so to the criminal standard.⁴⁸ The standard of proof for the defence is the balance of probabilities.⁴⁹
- 2.48 If the case is being heard in the Crown Court, then expert evidence is required by statute, on which see paragraph 2.94 below.

The legal relationship between diminished responsibility and insanity

- 2.49 As we explained in our Murder report, insanity is a complete defence:

In theory, the definition of insanity means that whether a defect of reason (stemming from a disease of the mind) amounts to insanity in law is an “all or nothing” matter. Either D shows that the defect of reason led him or her not to know the nature or quality of his or her act, or that the act was wrong, or the defect of reason did not have that effect.⁵⁰

- 2.50 The “insane” defendant is “not guilty” in law. We would argue that the “insane” defendant should simply not be held criminally responsible at all for what he or she is alleged to have done. If, however, the accused’s ability was “substantially impaired” in particular respects, then he or she may be able to plead diminished responsibility in response to a charge of murder.⁵¹ If successful, the partial defence means the defendant is convicted of manslaughter by reason of diminished responsibility (which does not carry a mandatory life sentence, unlike a conviction for murder).

INTOXICATION AND INSANITY⁵²

- 2.51 Generally, a malfunctioning of the mind will not amount to a “disease of the mind” within the M’Naghten Rules where it has been caused by “the application to the body of some external factor such as violence, drugs, including anaesthetics, alcohol, and hypnotic influences”.⁵³ The issue of insanity arising from intoxication is not, of course, restricted to alcohol and there are several cases involving other types of drugs and intoxicating substances.⁵⁴

⁴⁸ *Podola* [1960] 1 QB 325.

⁴⁹ *Woolmington v DPP* [1935] AC 462; *Sodeman* [1936] 2 All ER 1138; *Carr-Briant* [1943] KB 607.

⁵⁰ Law Com 304, para 5.142.

⁵¹ Homicide Act 1957, s 2 as inserted by s 52 of the Coroners and Justice Act 2009.

⁵² For the pre-2010 law on intoxication and diminished responsibility as a partial defence to murder, see: Partial Defences to Murder (2003) Law Commission Consultation Paper No 173, pp 149 to 154 (and, most recently, *Wood* [2008] EWCA Crim 1305, [2009] 1 WLR 496; *Stewart* [2009] EWCA Crim 593, [2009] 1 WLR 2507, and *Stewart No 2* [2010] EWCA Crim 2159). For an account of the new law see *Smith and Hogan’s Criminal Law* ch 15.

⁵³ *Quick* [1973] QB 910.

⁵⁴ See eg *Peltier* [2008] EWCA Crim 3210, [2009] Mental Health Law Reports 130; *Gwaza* [2009] EWCA Crim 1101.

- 2.52 A person under the influence of any such external factor cannot usually plead insanity. Intoxication in itself therefore cannot found a plea of insanity.
- 2.53 If, however, the accused's use of alcohol or other drugs results in a condition amounting to a "disease of the mind"⁵⁵ affecting his or her ability to reason at the time of the alleged offence, the accused may plead the defence of insanity.⁵⁶ This is the case even where the insanity is only temporary.
- 2.54 It is not the state of intoxication which allows the accused to plead insanity; it is the mental condition caused by the previous intake of intoxicants which gives rise to the defence, not any prevailing state of intoxication itself.⁵⁷ This is clear from *Davis*⁵⁸ where it was held that delirium tremens, can be the basis of an insanity defence even where that disease is brought on by earlier drunkenness. In that case there was undisputed evidence that the accused knew what he was doing, but it was beyond his power to control his actions. Mr Justice Stephen said that:

Drunkenness is one thing and the diseases to which drunkenness leads are different things; and if a man by drunkenness brings on a state of disease which causes such a degree of madness, even for a time, which would have relieved him from responsibility if it had been caused in any other way, then he would not be criminally responsible.

- 2.55 By contrast, if the accused is a psychopath who, though generally capable of controlling his behaviour and conforming to the criminal law, has an explosive outburst when intoxicated because of the reduced level of self-control, the defence of insanity cannot be relied on to avoid liability.⁵⁹
- 2.56 If the accused had a defect of reason and was intoxicated at the time he or she allegedly committed the offence charged, it will be necessary for the tribunal of fact to determine whether the accused's incapacity may have been caused by the intoxicant or by the defect of reason arising from the (possibly temporary) disease of the mind. If the accused proves on the balance of probabilities that it was the disease of the mind, the accused is entitled to an acquittal on the ground of insanity. If the cause of the incapacity was the intoxicant, the accused cannot be liable for an offence of "specific intent" but may be liable for a related offence of "basic intent" if there is one available to charge. Specific intent offences are those for which the predominant mens rea is one of knowledge, intention or dishonesty, and basic intent offences are all those for which the predominant mens rea is not intention, knowledge or dishonesty (this includes offences of recklessness and belief) as well as cases of negligence and strict liability. It is, of course, also open to the accused to prove that he or she was probably "insane" at the time of the alleged offence due to some unrelated cause which was unaffected by the

⁵⁵ For example, delirium tremens or alcohol dependence syndrome.

⁵⁶ *DPP v Beard* [1920] AC 479, 500 to 501; *A-G for Northern Ireland v Gallagher* [1963] AC 349, 375 and 381; and *Kingston* [1995] 2 AC 355, 369.

⁵⁷ Although in the case of a condition known as "acute intoxication", the disease and the intoxication are in fact one and the same thing.

⁵⁸ *Davis* (1881) 14 Cox's Criminal Cases 563, 564; approved by Lord Birkenhead LC in *Beard* [1920] AC 479, 501.

⁵⁹ *A-G for Northern Ireland v Gallagher* [1963] AC 349.

intoxication, although the more common scenario is that the accused's mental state was caused by a combination of these factors.⁶⁰

Involuntary intoxication

- 2.57 Being involuntarily intoxicated at the time of committing a crime does not provide an automatic excuse. Intoxication induced by the act of a third party, for example, is irrelevant to the question of the accused's criminal liability if the accused acts with the fault required for liability, even if he or she would not have acted in that way if sober.⁶¹ If the accused was involuntarily intoxicated such that he or she did not form the required mens rea, then this may be an excuse whether the crime is one of specific intent or basic intent.⁶²

Alcohol dependency syndrome

- 2.58 A related question is whether alcoholism can in itself give rise to a defence of insanity. Tolmie⁶³ argues that this depends on which of two ways of understanding alcoholism is adopted. Under the first model alcoholism is regarded as a disease; an abnormal mental condition over which the sufferer has no meaningful control. Intoxication can, on this view, be seen as a symptom of this underlying mental disorder and it would therefore be unfair to hold the person responsible for actions committed while he or she is drunk. Alternatively, alcoholism can be viewed as a habit; a form of learned behaviour arising because of bad choices on the part of the sufferer. On this model, the alcoholic's control over his or her drinking is only ever impaired rather than totally absent. It is therefore fair to hold the sufferer responsible for actions committed while in a state of intoxication which could, albeit with difficulty, have been resisted.
- 2.59 The courts have favoured the former approach and tend towards the view that at least some of the drinking done by a person with alcohol dependence syndrome may be "a direct result of his illness or disease" and therefore involuntary.⁶⁴ More recently the Court of Appeal has further recognised that it is unrealistic to try to separate such drinking into "voluntary" and "involuntary" instances, since "at some levels of severity what may appear to be 'voluntary' drinking may be inseparable from the defendant's underlying syndrome".⁶⁵ In *Wood*⁶⁶ and *Stewart (No 1)*⁶⁷ and *Stewart (No 2)*⁶⁸ the Court of Appeal, following *Dietschmann*,⁶⁹ took this more liberal approach when determining the application of the pre-2009 Act

⁶⁰ *Burns* (1974) 58 Cr App R 364 suggests that automatism might be available in such cases, but that decision is impossible to reconcile with subsequent authority.

⁶¹ *Kingston* [1995] 2 AC 355.

⁶² *DPP v Majewski* [1977] AC 443.

⁶³ J Tolmie, "Alcoholism and Criminal Liability" [2001] 64 (5) *Modern Law Review* 688. Cited with approval in *Wood* [2008] EWCA Crim 1305, [2009] 1 WLR 496 at [38].

⁶⁴ *Wood* [2008] EWCA Crim 1305, [2009] 1 WLR 496 at [41].

⁶⁵ *Stewart* [2009] EWCA Crim 593, [2009] 1 WLR 2507 at [28].

⁶⁶ [2008] EWCA Crim 1305, [2009] 1 WLR 496.

⁶⁷ [2009] EWCA Crim 593, [2009] 1 WLR 2507.

⁶⁸ [2010] EWCA Crim 2159.

⁶⁹ [2003] UKHL 10, [2003] 1 AC 1209.

diminished responsibility defence. It was held that that old form of the defence could be available despite the fact that the accused's responsibility was only impaired due to apparently voluntary drinking, and the accused was not required to prove that, had he not been intoxicated, he still would have killed. This suggests a more lenient approach towards drug use by those who are addicted, although of course the accused's level of fault will still be taken into account at the sentencing stage.

AUTOMATISM

- 2.60 A person will not generally be held criminally liable for an involuntary act or omission (unless he or she has culpably brought about the state of involuntariness). An act done when the person was not consciously in control of his or her body might amount to an involuntary act, referred to as automatism. Four definitions of "automatism" can be found in the case law.⁷⁰

action without any knowledge of acting, or action with no consciousness of doing what was being done;⁷¹

an involuntary movement of the body or limbs of a person following a complete destruction of voluntary control;⁷²

connoting the state of a person who, though capable of action, is not conscious of what he is doing... it means unconscious voluntary action and it is a defence because the mind does not go with what is being done;⁷³

and

an act which is done by the muscles without any control by the mind, such as a spasm, a reflex action or a convulsion; or an act done by a person who is not conscious of what he is doing, such as an act done whilst suffering from concussion or whilst sleep-walking.⁷⁴

- 2.61 The common theme of each of these definitions is that the person must be suffering from either a lack of consciousness or awareness of, or lack of control over, his or her actions. *Archbold* defines it as "no wider or looser a concept than an involuntary movement of the body or limbs of a person"⁷⁵ while Ashworth explains that "it is not merely a denial of fault ... more a denial of authorship ... it is fair to say that this was not D's act, but something which happened to D".⁷⁶

⁷⁰ As summarised on behalf of the Attorney General in *A-G's Reference (No 2 of 1992)* [1994] QB 91.

⁷¹ *Cottle* [1958] NZLR 999, 1020, by the President of the Court of Appeal of New Zealand.

⁷² *Watmore v Jenkins* [1962] 2 QB 572, 586, by Winn J.

⁷³ *Bratty* [1963] AC 386, 401, by Viscount Kilmuir LC.

⁷⁴ *Bratty* [1963] AC 386, 409, by Lord Denning. Though sleep-walking was subsequently held to be a "disease of the mind": see *Burgess* [1991] 2 All ER 769, [1991] 2 QB 92.

⁷⁵ *Archbold* para 17–84.

⁷⁶ *Principles of Criminal Law* pp 87 to 88.

- 2.62 Classic examples given in the case law are where a person “became unconscious while driving; for example, if he were struck by a stone or overcome by a sudden illness; or the car was temporarily out of control by his being attacked by a swarm of bees”.⁷⁷ Similar situations would be acts done while suffering concussion, under hypnosis, or while under the effect of anaesthetic.⁷⁸ The case law has also included a diabetic who suffered a blood sugar crash (hypoglycaemia),⁷⁹ and a defendant who acted while in a dissociative state while suffering from Post Traumatic Shock Disorder.⁸⁰

The degree of conscious control required

- 2.63 The law is unclear on the extent to which the defendant must have lost conscious control of his or her actions and how long the loss of control must have lasted in order to be able to rely on a defence of sane automatism. There are two questions: first, whether there must have been a “complete destruction of voluntary control”⁸¹ or whether the case law supports a less strict approach.
- 2.64 Our view is that, although the case law is not entirely consistent in requiring a total loss of control, the overwhelming weight of the recent authority supports the stricter view.
- 2.65 The second issue is whether this stricter view is applicable no matter what kind of offence is charged or whether it applies only with regard to road traffic offences.

Relationship with insane automatism

- 2.66 The test of whether a condition is treated in law as sane or insane automatism has traditionally been whether the malfunctioning of the mind had an internal or an external cause or factor. If the involuntary nature of the act can be ascribed to an “external factor”, then it is called non-insane automatism and, provided it was not self-induced, is a complete defence to all crimes and results in an outright acquittal.
- 2.67 One authority goes against this interpretation. In *Charlson*,⁸² the defendant hit his 10-year-old son over the head and then threw him out of the window. He was charged with causing grievous bodily harm. He was permitted to raise the defence of automatism, and was ultimately found not guilty, on the grounds that he may have been suffering from a brain tumour which could cause sudden violent outbursts which he could not control. The defendant’s brain tumour was

⁷⁷ *Kay v Butterworth* [1958] 1 QB 277, by Humphreys J.

⁷⁸ See *Quick* [1973] QB 910, 922, by Lawton LJ.

⁷⁹ For example, *Quick* [1973] QB 910. Other conditions may also lead to hypoglycaemia: “those with liver disease and poor nutrition are prone to low blood sugar”. Dr J Rumbold, “Diabetes and Criminal Responsibility” (2010) 174(3) *Criminal Law and Justice Weekly* 21. Recent press reports about the case of Norris, a nurse convicted of murder and attempted murder by injecting patients with insulin, have discussed the possibility that hypoglycaemia may be caused by a range of conditions.

⁸⁰ *T* [1990] *Criminal Law Review* 256. See para 2.71 below.

⁸¹ *Watmore v Jenkins* [1962] 2 QB 572, 587, by Winn J; *A-G’s Reference (No 2 of 1992)* [1994] QB 91, 105, by Lord Taylor CJ.

⁸² [1955] 1 WLR 317.

not held to be a disease of the mind, which would have led to a finding of insanity and not sane automatism, but this aspect of the judgment was subsequently disapproved by the House of Lords in *Bratty*.⁸³

- 2.68 Involuntary conduct caused by an “internal factor” which amounts to a disease of the mind (meaning an impairment of normal mental functioning) can only found a defence of insane automatism. If a defence of sane automatism is ruled out by the judge then in practice the defendant may well plead guilty to the offence rather than pursue a defence of insanity. The judge may rule out sane automatism if there is not enough evidence to found a plea of sane automatism (for example, if the loss of control is not complete) or where the evidence actually raises insanity.
- 2.69 The policy behind the internal/external distinction was developed by the courts, as Ashworth explains, for reasons of “social protection”.⁸⁴ In other words, where automatism occurs due to a mental illness or other internal disorder it is likely that the public need to be protected from the risk of further harm. That protection is achieved by ensuring that a complete acquittal is not available and that some kind of protective order can be made.⁸⁵ Such cases are treated as insanity (in the form of insane automatism).
- 2.70 Whatever the policy reasons behind the distinction between internal and external causes of loss of control it has given rise to a number of odd decisions. It leads to the label of insanity being applied to those suffering epilepsy,⁸⁶ hyperglycaemia caused by failing to take a prescribed dose of insulin,⁸⁷ and sleepwalking.
- 2.71 A further difficulty has arisen in so-called “psychological blow” cases where the accused enters into a dissociative state following a traumatic event. In *T*⁸⁸ it was argued that the defendant had been raped three days prior to the robbery with which she was charged and that this had caused her to enter a dissociative state in which she had no control over her actions. The trial judge relied on the Canadian case of *Rabey*⁸⁹ in which it was held that the reaction of a normal person to external factors which were part of “the ordinary stresses and disappointments of life” could not give rise to a defence of sane automatism and that Rabey’s actions (attacking a young woman who had rejected his advances) must therefore be have been caused by a disease of the mind. Rape, on the other hand, “could have an appalling effect on any young woman, however well-balanced normally” and thus could be classified as an external factor giving rise to a defence of sane automatism. Justice Dickson in *Rabey*, however, dissented on the basis that is not acceptable that “whether an automatic state is an insane reaction or a sane reaction may depend upon the intensity of the shock”.

⁸³ *Bratty* [1963] AC 386. See para 2.31 above.

⁸⁴ *Principles of Criminal Law* p 143.

⁸⁵ See Lord Denning in *Bratty* [1963] AC 386, 410; *Sullivan* [1984] AC 156, 172, by Lord Diplock.

⁸⁶ *Sullivan* [1984] AC 156.

⁸⁷ *Hennessy* [1989] 1 WLR 287.

⁸⁸ [1990] *Criminal Law Review* 256.

⁸⁹ [1980] 2 SCR 513.

Self-induced automatism

2.72 If the defendant was responsible for the state of automatism, then he or she may be prevented from relying on the defence of automatism. The so called prior fault principle provides:

A self-induced incapacity will not excuse, nor will one which could have been reasonably foreseen as a result of either doing or omitting to do something, as for example taking alcohol against medical advice after using certain prescribed drugs, or failing to have regular meals while taking insulin ...⁹⁰

2.73 However, there are situations when a self-induced incapacity will excuse. The first is in relation to crimes of specific intent. Where the accused's automatism was self-induced and the offence is one of specific intent, the accused will be entitled to be acquitted provided that he or she satisfies all the other elements of the automatism defence.

2.74 Where the crime is one of basic intent, the accused may rely on the defence if he or she was not subjectively reckless as to the risk that his or her actions would result in a loss of control. Thus the accused will be entitled to an acquittal where he or she has taken a substance in a way which was, or which he or she honestly believed was, in compliance with a medical prescription. However, if the accused's incapacity arose out of taking dangerous drugs or drinking alcohol there will be a presumption of recklessness due to the fact that the effects of these substances are well known. In all other cases of self-induced incapacity the accused will be entitled to an acquittal, providing he or she has not been reckless as to losing capacity.

2.75 A defendant will be reckless where he or she foresees the risk that doing or omitting to do something is likely to result in a loss of control. The accused need only appreciate the risk; the test does not go so far as to require that he or she knows the behaviour *will* cause such harm.

2.76 The test is one of *subjective* recklessness, that is, whether the accused knew about the risk that he or she might lose control and not merely whether he or she ought to have known of that risk. However the court in *Bailey*,⁹¹ in reaching its conclusion that the accused was not reckless, highlighted the fact that there was no evidence that he knew of the risk since the fact that not taking food after insulin could have such effects was "not ... common knowledge, even among diabetics". Thus if the risk is obvious or "common knowledge" the accused will not be able to rely on the defence in relation to a basic intent crime, even if he or she was not in fact aware of that risk. It seems reasonable to assume that, unlike in *Bailey*, this matter would be common knowledge among people with diabetes.

⁹⁰ *Quick* [1973] QB 910, 922, by Lawton LJ. See also C [2007] EWCA Crim 1862, [2007] All ER (D) 91.

⁹¹ [1983] 1 WLR 760, 764 to 765.

The burden and standard of proof

- 2.77 When the issue of sane automatism is raised, the judge must determine whether a proper evidential foundation for the defence has been laid before leaving the issue to the jury.⁹² The judge may also have to consider whether the defence should be put as one of insanity, rather than sane automatism.
- 2.78 Once an evidential basis has been laid for a denial of voluntariness, the onus is on the prosecution to disprove the defence, to the criminal standard.⁹³

The burden of proof where both the defences of insanity and sane automatism are in issue

- 2.79 As we have noted, if the defence being pleaded is one of sane automatism, the defendant must satisfy an evidential burden in raising the defence, but the burden lies on the prosecution to disprove it, to the criminal standard. If, however, the defendant raises the defence of insanity (including insane automatism), then the burden of proving that defence falls on the defendant, on the balance of probabilities.⁹⁴
- 2.80 In practical terms, this can make a direction to the jury complicated, as in *Roach*.⁹⁵ The defendant, who was charged with causing grievous bodily harm with intent to do so, raised the defence of automatism while the prosecution argued that, if there was any automatism it was of the insane kind. Psychiatrists called by the defence gave their opinion that the defendant had no mental illness but was suffering from an anti-social personality disorder. In their view the most likely diagnosis was "insane automatism of psychogenic type". It was held on appeal that both forms of defence should have been left to the jury, from which it follows that the trial judge should have directed the jury that:
- (1) in considering the defence of (sane) automatism the burden was on the prosecution to disprove, but in considering the defence of insane automatism the burden was on the defence to prove, and different standards of proof applied, so that:
 - (2) if the prosecution had not made the jury sure that the defendant was not acting in a state of automatism, the jury should acquit;
 - (3) if the prosecution had made them sure that the defendant caused the grievous bodily harm but the defendant had persuaded them that it was more probable than not that he was acting in a state of automatism caused by a disease of the mind then they should give a verdict of not guilty by reason of insanity; and

⁹² *Stripp* (1979) 69 Cr App Rep 318; *Bratty* [1963] AC 386, 413; and see *Moses v Winder* [1981] RTR 37.

⁹³ See *Bratty* [1963] AC 386; *Burns* (1973) 58 Cr App Rep 364; *Roach* [2001] EWCA Crim 2698, [2001] All ER (D) 98.

⁹⁴ *Quick* [1973] QB 910, 922.

⁹⁵ [2001] EWCA Crim 2698, [2001] All ER (D) 98.

- (4) if the prosecution had made them sure that the defendant caused the grievous bodily harm and that he intended to do grievous bodily harm, then they should convict.

THE DEFENCE OF INSANITY IN THE MAGISTRATES' COURTS

- 2.81 We now turn to the way in which the insanity defence is handled by the courts.
- 2.82 The current state of the law is confused and unsatisfactory. It appears that a defence of insanity may be raised in the magistrates' courts.⁹⁶ There is, however, no procedure for a special verdict of not guilty by reason of insanity in the magistrates' courts. The result is that where the defence succeeds, the defendant is acquitted.
- 2.83 It has been held that, in the magistrates' courts, insanity may not be raised as a defence to offences of strict liability. In *DPP v Harper*,⁹⁷ where the defendant was charged with driving with excess alcohol, the Divisional Court stated that the defence of insanity may only be run in cases where mens rea is an element in the offence, and that the law is as stated in *ex parte K*.
- 2.84 We believe that the court was mistaken in its interpretation of *ex parte K* and that neither *ex parte K* nor *Harper* is sound authority for the assertion that insanity is not available as a defence if the offence is one of strict liability.⁹⁸

Disposal in the magistrates' court: section 37(3) of the 1983 Act

- 2.85 Powers for the magistrates' courts to deal with defendants with a mental or physical condition are found at section 37(3) of the 1983 Act and section 11(1) of the Powers of Criminal Courts (Sentencing) Act 2000 ("the 2000 Act"). Section 37 reads:

(1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be,

⁹⁶ *R v Horseferry Road Magistrates' Court, ex p K* [1997] QB 23, confirmed in *R (Singh) v Stratford Magistrates' Court* [2007] EWHC 1582 (Admin), [2007] 1 WLR 3119 by Hughes LJ and Treacy J. The prosecution submitted that the defence of insanity was not available in the magistrates' court. The court was not persuaded. Lord Justice Hughes considered *ex p K* and concluded, "There is no reason whatever why insanity should be excluded from the consideration of the magistrates' court and every reason why it should not." *Singh* at [14], by Hughes LJ.

⁹⁷ [1997] 1 WLR 1406. Followed in *Bartram v Southend Magistrates Court* [2004] EWHC 2691 (Admin), [2004] All ER (D) 326 where Collins J said that the defence of insanity was not open to the accused on a summary only charge where there was no mental element in the offence (causing unnecessary suffering to an animal).

⁹⁸ See further: *Principles of Criminal Law* p 144 which noted that the decision is difficult to support; *Simester and Sullivan's Criminal Law* pp 186 to 187 which said that the decision was wrong, and Case Comment "Trial: Unfitness to Plead" [2000] *Criminal Law Review* 621, 626 which referred to the decision as "dubious" and "puzzling".

place him under the guardianship of a local social services authority or of such other person approved by a local social services authority as may be so specified.

...

(2) The conditions referred to in subsection (1) above are that—

(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners,⁹⁹ that the offender is suffering from mental disorder and that either—

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or

(ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.

(3) Where a person is charged before a magistrates' court with any act or omission as an offence and the court would have power, on convicting him of that offence, to make an order under subsection (1) above in his case as being a person suffering from mental illness or severe mental impairment, then, if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him.

2.86 Further to this, section 11(1) of the 2000 Act empowers the magistrates' court to order a medical report on a defendant's physical or mental condition when he or she is being tried for a summary offence and the court is satisfied that he or she did the act or made the omission charged. This of course assumes that the defendant is being tried or is about to be tried at the time the disorder is, or becomes, apparent.¹⁰⁰ There is now some authority that a trial can be converted to a fact-finding exercise under the 2000 Act.¹⁰¹

⁹⁹ At least one medical practitioner must be on the list of those approved by the Secretary of State under s 12(2) of the 1983 Act "as having special experience in the diagnosis or treatment of mental disorder".

¹⁰⁰ The wording of s 11(1) is clear: "if, on a *trial* ... the court shall adjourn the case" (emphasis added).

¹⁰¹ *Crown Prosecution Service v P* [2007] EWHC 946 (Admin), [2008] 1 WLR 1005, by Smith LJ. See CP 197, paras 8.32 to 8.43 for a discussion of this decision.

- 2.87 The power to order medical reports under the 2000 Act and the power to make a hospital order under section 37(3) of the 1983 Act both depend merely on the court being satisfied that the accused committed the conduct elements of the offence. Where there is no mens rea element in the offence, this poses no difficulty.¹⁰² It is less clear what needs to be proved to satisfy section 37(3) where the offence does contain a mens rea element, but it is probable that the courts would follow *Antoine*,¹⁰³ namely that the prosecution need to prove the conduct element of the offence only.¹⁰⁴
- 2.88 If the issue of insanity is raised, the magistrates may make a hospital order under section 37(3) of the 1983 Act without trying the defendant. There need not always be a trial.¹⁰⁵
- 2.89 An order under section 37(3) does not depend on a finding of insanity or unfitness. It does depend upon a finding of mental illness or severe mental impairment.
- 2.90 It is uncertain whether a section 37(3) order can be made *after* an acquittal.¹⁰⁶ It is also unclear whether there can be a section 37(3) order which is then *followed* by an acquittal.¹⁰⁷
- 2.91 It has been held that, where the conditions of section 37 of the 1983 Act¹⁰⁸ are satisfied, the magistrates' court has the power to impose a hospital order in circumstances where an accused has elected trial in the Crown Court.¹⁰⁹

Disposal in the magistrates' court: a missing power?

- 2.92 The absence of a special verdict in the magistrates' courts means that the court has no powers of disposal in respect of a person who has been found not guilty by reason of insanity; he or she is simply acquitted. The magistrates also lack the power to commit a person to the Crown Court to determine whether a restriction

¹⁰² *Bartram v Southend Magistrates' Court* [2004] EWHC 2691 (Admin), [2004] All ER (D) 326 at [6].

¹⁰³ *Antoine* [2001] 1 AC 340, [2000] 2 WLR 703.

¹⁰⁴ For difficulties in proving only the conduct element of some offences, see paras 4.36 to 4.47 below.

¹⁰⁵ *R (Singh) v Stratford Magistrates' Court* [2007] EWHC 1582 (Admin), 1 WLR 3119 at [33] where Hughes LJ said "I do not say that it will never be right to decide that the issue of insanity ought to be determined as a freestanding issue, and I can envisage situations in which it should be. But what these cases show is that there is no entitlement to such trial of an issue; rather the interests of justice and of the defendant must be considered individually in each case."

¹⁰⁶ There are some grounds for thinking this point is not settled: compare *R v Horseferry Road Magistrates' Court, ex p K* [1997] QB 23 with *R v Kesteven Justices, ex p O'Connor* [1983] 1 All ER 901, 904 and see the commentary on *ex p K* at [1996] 3 *Archbold News* 1 and 3.

¹⁰⁷ *R (Singh) v Stratford Magistrates' Court* [2007] EWHC 1582 (Admin), 1 WLR 3119 at [37], by Hughes LJ.

¹⁰⁸ See s 37(2) of the 1983 Act.

¹⁰⁹ *R v Ramsgate Justices, ex p Kazmarek* (1985) 80 Cr App Rep 366.

order needs to be imposed even where they deal with him or her by way of section 37(3) of the 1983 Act.¹¹⁰

THE DEFENCE OF INSANITY IN THE CROWN COURT: THE “SPECIAL VERDICT”

2.93 In the Crown Court there is a special procedure and verdict. By virtue of section 2(1) of the Trial of Lunatics Act 1883, as amended, if at the trial of a defendant:

it is given in evidence on the trial... that he was insane, so as not to be responsible, according to law, for his actions at the time when the act was done or the omission made, then, if it appears to the jury before whom such person is tried that he did the act or made the omission, but was insane as aforesaid at the time when he did or made the same, the jury shall return a special verdict that the accused is not guilty by reason of insanity.

2.94 “Insane, so as not to be responsible, according to law” means insane within the meaning of the M’Naghten Rules. The application of the common law test is supplemented by the requirement of section 1 of the 1991 Act which states that there must be oral or written evidence from two or more registered medical practitioners, and at least one of those practitioners must be “duly approved”.¹¹¹ “Duly approved” means that at least one of them must be approved for the purposes of section 12 of the 1983 Act by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder.¹¹²

2.95 A defendant may plead not guilty by reason of insanity but the plea does not settle the verdict: it must be given by the jury.¹¹³ There must therefore be a trial of the issue whether the defendant did the act or made the omission. If this is not proved, then there is an acquittal.

Proving that he did the act or made the omission

2.96 The question, “What has to be proved when an inquiry is embarked upon under the Trial of Lunatics Act 1883, to determine whether the defendant ‘did the act or

¹¹⁰ Magistrates can commit a person to the Crown Court for a restriction order to be attached in respect of a hospital order following a conviction: s 43 of the 1983 Act.

¹¹¹ Where a “disease of the mind” is merely raised as evidence of an absence of mens rea, however, expert evidence may not be admissible. In *Masih* [1986] *Criminal Law Review* 395 the Court of Appeal held that where an accused has an IQ of less than 70, he or she will be classified as mentally defective and an expert’s opinion will therefore be deemed sufficiently probative to justify its admission. Where the accused has an IQ of 70 or above, on the other hand, the jury are assumed to be capable of forming their own opinion of the matter and their fact-finding role should not be undermined by admitting expert evidence. See, eg, *Henry* [2005] EWCA Crim 1681, [2005] All ER (D) 352 in which evidence relating to the mental functioning of an accused with an IQ of approximately 71 was declared inadmissible. Dr Sajid Muzaffar comments, “Such a black and white distinction between normality and abnormality may help to have a clear cut-off for the courts and statisticians but it does not reflect the modern dimensional view of the working of the mind (or brain)”. “Psychiatric Evidence in Criminal Courts: The Need for Better Understanding” (2011) 51(3) *Medicine, Science and the Law* 141, 143.

¹¹² Section 6(1) of the 1991 Act.

¹¹³ *R v Maidstone Crown Court, ex p Harrow LBC* [2000] QB 719.

made the omission charged'?" was addressed by the Court of Appeal in *Attorney General's Reference (No 3 of 1998)*, and answered:

When determining whether "the defendant did the act or made the omission charged" for the purposes of the Trial of Lunatics Act 1883, and assuming insanity, (a) the Crown is required to prove the ingredients which constitute the actus reus of the crime. Although different language is used to describe this concept, for present purposes, we respectfully adopt the suggestion in *Smith and Hogan's Criminal Law*, 8th ed (1996), p 29, that it must be shown that the defendant: "has caused a certain event or that responsibility is to be attributed to him for the existence of a certain state of affairs, which is forbidden by criminal law ..." (b) The Crown is not required to prove the mens rea of the crime alleged, and apart from insanity, the defendant's state of mind ceases to be relevant.¹¹⁴

2.97 This answer was emphatically approved by the Court of Appeal in *Antoine*:

The correctness of this answer is, in our respectful judgment, inescapable: in a case where the M'Naghten test is satisfied, it cannot conceivably be incumbent upon the prosecution to prove the mental ingredients of the offence charged against the defendant.¹¹⁵

2.98 Although it may be simply stated that the prosecution need only prove the actus reus and that mens rea is irrelevant, if one looks closely at what this might mean in a particular case, it can be seen that it may not be possible to distinguish the act from the fault element. We discuss this difficulty in Part 4 below.

THE CONSEQUENCES FOR A DEFENDANT OF A SPECIAL VERDICT

Disposal

2.99 By virtue of sections 5 and 5A of the 1964 Act, the only disposals open to the Crown Court where a verdict of not guilty by reason of insanity is returned are: a hospital order (with or without a restriction), a supervision order, or an absolute discharge.

2.100 If the offence is one where the sentence is fixed by law,¹¹⁶ then, if the conditions for making a hospital order are met, the only available disposal is a hospital order

¹¹⁴ *A-G's Reference (No 3 of 1998)* [2000] QB 401, 411.

¹¹⁵ *Antoine* [2001] 1 AC 340, 345, [2000] 2 WLR 703.

¹¹⁶ The statute does not specify that "an offence the sentence for which is fixed by law" refers to murder only. Paragraph 92 of the explanatory notes and para 12 of the Government circular to the 2004 Act (Home Office, "The Domestic Violence, Crime and Victims Act 2004: Provisions for Unfitness to Plead and Insanity" (2005) Circular 24/2005) refer to murder as an offence for which the sentence is fixed by law, but to no other offence. Although custodial sentences for certain drugs and firearms offences with a minimum fixed term could, arguably, also fall within the definition of "sentences fixed by law", s 174(3) of the Criminal Justice Act 2003 refers to an offence with such a sentence in a way which suggests that it does not fall within the category of an offence the sentence for which is fixed by law.

with a restriction.¹¹⁷ If the conditions for making a hospital order are not met, then the court may make a supervision order or an absolute discharge. The relevant section is section 5(3) of the 1964 Act as inserted by section 24(1) of the 2004 Act. Section 5(3) reads:

Where—

(a) the offence to which the special verdict or the findings relate is an offence the sentence for which is fixed by law, and

(b) the court have power to make a hospital order,

the court shall make a hospital order with a restriction order (whether or not they would have power to make a restriction order apart from this subsection).

2.101 “Hospital order” under section 5 of the 1964 Act has the same meaning as a hospital order under section 37 of the 1983 Act.¹¹⁸

2.102 The court may *require* the hospital to admit the person in respect of whom it makes a hospital order (which is not the case where a hospital order is made following a conviction).¹¹⁹

Other penalties

2.103 The following penalties may be applied, or apply automatically, for a person who has been found not guilty by reason of insanity as for a person who has been convicted. In this respect, the verdict of not guilty by reason of insanity is more like a conviction than an acquittal.

(1) A person found not guilty by reason of insanity of an offence listed in Schedule 3 to the Sexual Offences Act 2003 will be subject to notification requirements.¹²⁰

(2) A person found not guilty by reason of insanity of an offence carrying a term of imprisonment of 12 months or more to which Part 4 of the Counter-Terrorism Act 2008 applies and made the subject of a hospital order will be subject to notification requirement.¹²¹

¹¹⁷ Prior to the 2004 Act, a hospital order with a restriction order was mandatory in this circumstance. This statutory change has had the effect of avoiding a potential incompatibility with art 5(1)(e) of the ECHR: see para 5.14 below.

¹¹⁸ See s 5(4) of the 1964 Act as inserted by s 24(1) of the 2004 Act. For s 37, see para 2.85 above.

¹¹⁹ See the 1964 Act, s 5A and the substituted subsection (4) which applies to s 37 of the 1983 Act where a hospital order is made following a verdict of not guilty by reason of insanity.

¹²⁰ Sexual Offences Act 2003, s 80.

¹²¹ Section 45(1)(b) of the Counter-Terrorism Act 2008.

- (3) A court may make an exploitation proceeds order against a defendant who has been found not guilty by reason of insanity under Part 7 of the Coroners and Justice Act 2009 in the same way as if he or she had been convicted.¹²²
- (4) A person found not guilty by reason of insanity of a specified offence (broadly speaking, an offence of serious violence) and in respect of whom a hospital order or a supervision order was made may be the subject of a Violent Offender Order.¹²³
- (5) A court may make a Sexual Offences Prevention Order against a person who has been found not guilty by reason of insanity.¹²⁴
- (6) He or she may also be the subject of a Foreign Travel Order.¹²⁵

On the grant of bail in future criminal proceedings

- 2.104 A verdict of not guilty by reason of insanity is also equivalent to a conviction when it comes to the issue of bail.¹²⁶ So, for example, if the defendant is charged with a subsequent offence, there might be a presumption that bail is refused (as opposed to the usual presumption in favour of bail).¹²⁷

RIGHTS OF APPEAL FROM THE CROWN COURT AGAINST A SPECIAL VERDICT AND DISPOSAL

- 2.105 The Criminal Appeal Act 1968 provides rights of appeal for a person who is found not guilty by reason of insanity against the verdict and against the disposal.¹²⁸
- 2.106 Where a defendant has been convicted of an offence at the Crown Court and appeals against the conviction, the Court of Appeal may, if satisfied on the evidence of two or more registered medical practitioners,¹²⁹ substitute a verdict of

¹²² See the definition of “qualifying offender” in s 156 of the Coroners and Justice Act 2009.

¹²³ See Part 7 of the Criminal Justice and Immigration Act 2008.

¹²⁴ Sexual Offences Act 2003, s 104(1) and (3)(a).

¹²⁵ Sexual Offences Act 2003, s 114 and 116(1)(b).

¹²⁶ Bail Act 1976, s 2(1)(b).

¹²⁷ See Criminal Justice and Public Order Act 1994, s 25.

¹²⁸ There is a comparable right of appeal by a person who has been tried by Court Martial and found not guilty by reason of insanity. He or she may, with leave, appeal to the Court Martial Appeal Court: Court Martial Appeals Act 1968, s 21.

¹²⁹ At least one of the practitioners must be approved by the Secretary of State under s 12(2) of the 1983 Act “as having special experience in the diagnosis or treatment of mental disorder”.

not guilty by reason of insanity or, if appropriate, a finding of disability and that the accused did the act or made the omission as charged.¹³⁰

- 2.107 If the Court of Appeal considers that the appellant should be dealt with differently, it may quash any order that the appellant is seeking to appeal and make any order that it considers appropriate and that the trial court had the power to make.¹³¹

THE RELATIONSHIP TO POLICY IN THE CIVIL LAW

Civil claims

- 2.108 In civil cases, the law will not help a person obtain a benefit from his or her own illegal act. This public policy may come into play in civil claims in contract or tort, or in intestacy.
- 2.109 In the case of claims in tort, there is an inconsistency between holding someone responsible for his or her act – such as the commission of a criminal offence – and compensating that person for loss or damage suffered as a result.¹³² A defendant to a claim in civil proceedings may therefore raise the defence of illegality and argue that, since the damage caused to the claimant was a result of his or her own illegal act, the law should not hold the defendant liable to compensate him or her for that damage.
- 2.110 It should be noted, however, that wrongdoing by the claimant does not necessarily bar any claim for compensation. The court will usually consider the proportionality of the loss to the seriousness of the unlawful conduct and will “[seek], where possible, to see that genuine wrongs are righted, so long as the court does not thereby promote or countenance a nefarious object or bargain which it is bound to condemn”.¹³³
- 2.111 The case law¹³⁴ strongly suggests that where a person has been found to be not guilty by reason of insanity, a claim by him or her for loss or damage incurred as a result of his or her illegal act may succeed since he or she bears no criminal responsibility for that act. This is supported by the decision of the Court of Appeal in *Worrall v British Railways Board*¹³⁵ in which Lord Justice Bedlam said:

¹³⁰ Criminal Appeal Act 1968, s 6. See, eg, *Shulman* [2010] EWCA Crim 1034, [2010] Mental Health Law Reports 172 where D had been convicted, and very probably was seriously mentally ill at the time of the offences, but the Court of Appeal accepted he had probably been unfit to plead and stand trial, and so they substituted that finding instead. The Court accepted an undertaking from the prosecution that, in the event of D becoming well enough to stand trial, he would not be prosecuted. A comparable provision exists in relation to appeals from the Court Martial: Court Martial (Appeals) Act 1968, s 16 as amended.

¹³¹ Criminal Appeal Act 1968, s 16B(1).

¹³² As we argued in *The Illegality Defence in Tort* (2001) Law Commission Consultation Paper 160, para 4.100.

¹³³ *Saunders v Edwards* [1987] 1 WLR 1116, by Bingham LJ at 1134.

¹³⁴ See *Gray v Thames Trains* [2009] UKHL 33, [2009] 1 AC 1339 and *Clunis v Camden and Islington Health Authority* [1998] QB 978.

¹³⁵ [1999] EWCA Civ 1312, [1999] CLY 1413.

In my view that part of the statement of claim upon which the plaintiff relied to establish the vast majority of his loss was founded upon his commission of serious criminal offences for which he was fully responsible in law The plaintiff's responsibility in this case was undiminished in any respect and I consider it would be contrary to public policy to allow him to recover damages consequent upon the commission of those offences.

- 2.112 This, again, suggests that had he not been fully responsible in law, by reason of insanity or any other reason, it would not be contrary to public policy to allow him to recover damages.

Insurance claims

- 2.113 Generally, an insured person may not recover first party losses on an insurance claim where the losses are due to his or her own serious criminal act. In *Porter v Zurich Insurance Company*,¹³⁶ the question arose whether this public policy applied where the insured suffered from mental disorder which played a part in his committing the criminal act.

- 2.114 In *Porter* the claimant set his house on fire and then claimed under the house insurance policy. At the time he set the fire he had been drinking heavily and was suffering from a persistent delusional disorder. Mr Justice Coulson endorsed the following statement of the law¹³⁷ in *MacGillivray on Insurance Law*:

If the assured is so insane as not to be legally responsible for his actions, an act of incendiarism will not prevent him from recovering under the policy. The question of the assured's insanity will probably have to be decided with reference to the M'Naghten Rules.¹³⁸

- 2.115 In the event, the evidence made clear that the claimant both knew what he was doing and knew that it was wrong, and his mental state was not, on its own, sufficiently causative of the fire to meet the test of insanity.

Inheritance

- 2.116 A person may not benefit from his or her own criminal act. Therefore, if D murders V, D may not inherit from V; this is known as the "forfeiture rule". The rule may apply even if the successor has not been convicted,¹³⁹ but the fact of unlawful killing must be established on a balance of probabilities.¹⁴⁰ Even if the rule does apply on the face of it, in the case of an unlawful killing which is not murder, the court has the discretion not to apply the forfeiture rule.¹⁴¹

¹³⁶ [2009] EWHC 376 (QB), [2009] 2 All ER (Comm) 658.

¹³⁷ [2009] EWHC 376 (QB), [2009] All ER (Comm) 658 at [17].

¹³⁸ N Legh-Jones QC, J Birds and D Owen QC (eds), *MacGillivray on Insurance Law* (11th ed) para 26–025.

¹³⁹ *Re Houghton* [1915] 2 Ch 173; *Re Sigsworth* [1935] Ch 89.

¹⁴⁰ *Gray v Barr* [1971] 2 QB 554.

¹⁴¹ By virtue of the Forfeiture Act 1982.

- 2.117 The rule does not apply, however, where D has been found “not guilty by reason of insanity”¹⁴² since this verdict necessarily implies that D was not responsible for his or her act and is entitled to an acquittal. In these circumstances, therefore, D may inherit.

Criminal injuries compensation

- 2.118 Paragraph 10 of the Criminal Injuries Compensation Scheme (2008),¹⁴³ which governs the Criminal Injuries Compensation Authority (CICA), states:

It is not necessary for the assailant to have been convicted of a criminal offence in connection with the injury. Moreover, even where the injury is attributable to conduct within paragraph 8¹⁴⁴ in respect of which the assailant cannot be convicted of an offence by reason of age, insanity or diplomatic immunity, the conduct may nevertheless be treated as constituting a criminal act.

- 2.119 Therefore, the fact that the assailant has been found not guilty by reason of insanity, or indeed has never been charged with any offence due to his or her mental state, does not preclude the victim from applying for or receiving compensation for their injuries. The injury is still classed as a “criminal injury” despite the fact that no person has been or could be convicted of a criminal offence in respect of it.

THE CONNECTION WITH INQUEST VERDICTS

- 2.120 The legal test for insanity in criminal law is relevant to an inquest verdict in the following way. An inquest verdict may not determine a person’s criminal liability; that is not its function. As was confirmed recently by the Divisional Court, “a coroner’s verdict of unlawful killing necessarily predicates a finding equivalent to that required for a conviction of at least manslaughter in a criminal trial”.¹⁴⁵ If the person who caused the death was legally insane, then the verdict of unlawful killing is not available to the inquest.
- 2.121 When considering whether insanity might be made out, the standard of proof at an inquest is not the same as that in a criminal court. As described above, if insanity is raised by the defence at trial, it has to be proved on the balance of probabilities. In the coroner’s court, however, the situation is different. The Divisional Court put the issue as follows:

Are the jury to be directed that, if the evidence would otherwise surely establish unlawful killing, that verdict is not available if the evidence shows on the balance of probabilities that at the time of the killing the

¹⁴² *Re Houghton* [1915] 2 Ch 173; R Martin and others (eds), *Theobald on Wills* (17th ed) para 12–009.

¹⁴³ Made pursuant to the Criminal Injuries Compensation Act 1995.

¹⁴⁴ A crime of violence (including arson, fire-raising or an act of poisoning); an offence of trespass on a railway; or the apprehension or attempted apprehension of an offender or a suspected offender, the prevention or attempted prevention of an offence, or the giving of help to any constable who is engaged in any such activity.

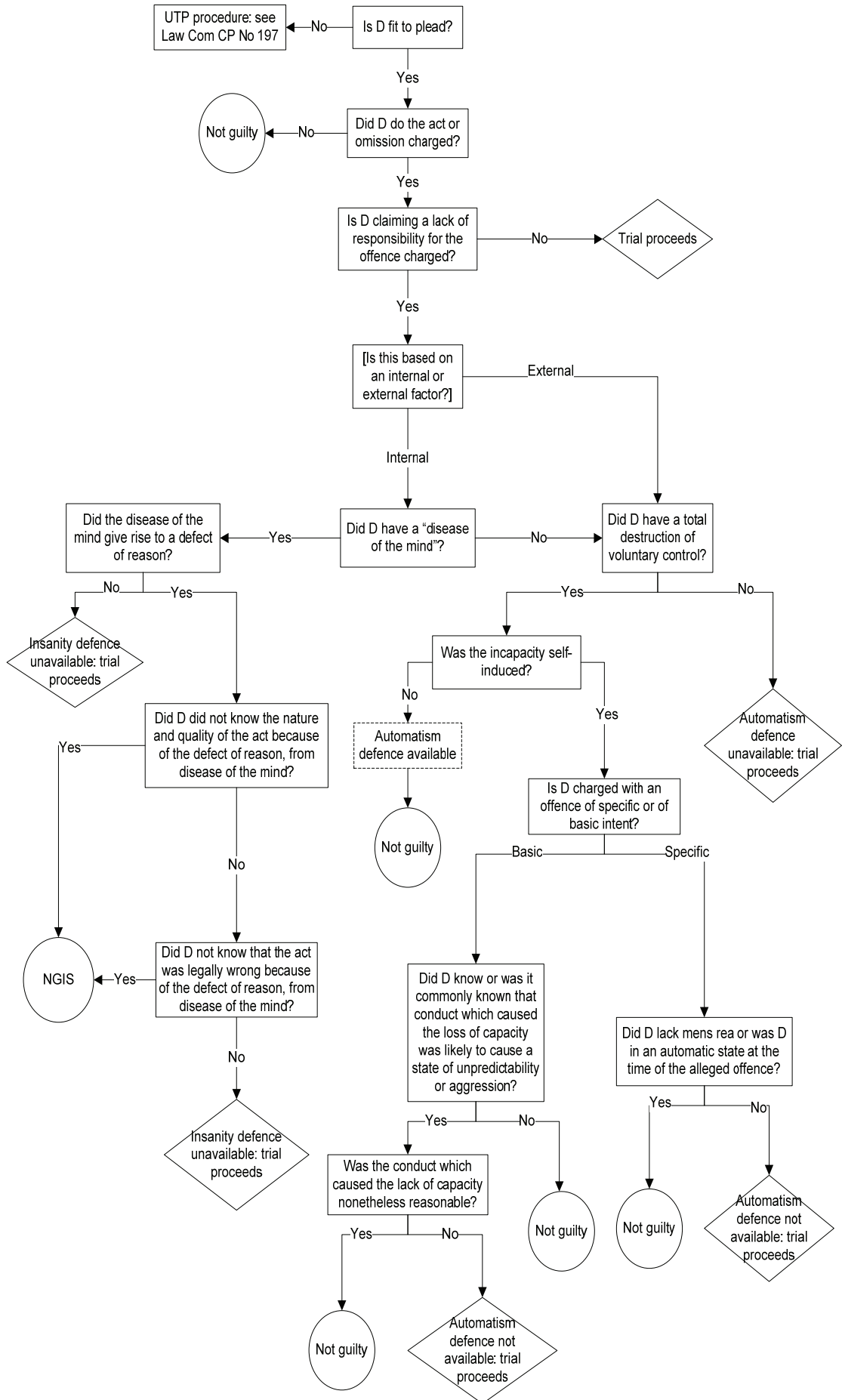
¹⁴⁵ *R (O’Connor) v Avon Coroner* [2009] EWHC 854 (Admin), [2011] QB 106 at [9].

perpetrator was legally insane? Or are the jury to be directed, where insanity is properly raised on the evidence, that insanity must be disproved and the other ingredients of unlawful killing proved, both to the criminal standard, before the jury could consider a verdict of unlawful killing?¹⁴⁶

- 2.122 With some hesitation, the court concluded that insanity must be disproved to the criminal standard for there to be a verdict at the inquest of unlawful killing. It did so because a “defendant” (the person who caused the killing) does not have the safeguards at an inquest that he or she would have in a criminal trial, but a verdict of unlawful killing itself carries a stigma.¹⁴⁷

¹⁴⁶ *R (O'Connor) v Avon Coroner* [2009] EWHC 854 (Admin), [2011] QB 106 at [20].

¹⁴⁷ *R (O'Connor) v Avon Coroner* [2009] EWHC 854 (Admin), [2011] QB 106 at [26].



PART 3

THE INSANITY DEFENCE IN PRACTICE

- 3.1 In this Part we explain the circumstances in which insanity pleas are entered in practice, the frequency of such pleas and the common outcomes. We approach the matter in terms of the progress of a case through the criminal justice system. We do so to demonstrate the criminal justice system's range of possible responses to an accused person who is known to be, or shows signs of, suffering from a mental disorder.¹

SUMMARY

- 3.2 There are no data on the use of the insanity defence in the magistrates' courts. We understand it is infrequently used. In the Crown Court, there are in the region of 20 to 30 special verdicts each year. Most of those cases involve "purposeful"² violence against a person.
- 3.3 The "wrongfulness" limb of the M'Naghten Rules³ is more frequently relied upon than the "cognitive" limb in psychiatrists' expert reports for the court. Their interpretation of that limb does not necessarily accord with the interpretation in case law.
- 3.4 The introduction by the 1991 Act of disposals other than hospital orders⁴ was followed by an increase in use of the insanity defence in the Crown Court. Hospital orders make up almost half of all disposals given following a verdict of not guilty by reason of insanity. Studies also show an increasing use of absolute discharges, which have been given in relation to serious offences as well as less serious offences.
- 3.5 Insofar as our research reveals what happens in practice, the most striking feature of the insanity defence is the mismatch between what the law provides ought to happen and what actually happens. The legal test of insanity laid down in case law is often not applied by psychiatrists; the defence is available in the magistrates' courts but is apparently rarely used; and there is a surprising gulf between the number of offenders who are mentally disordered and the prevalence of the plea being advanced. An aversion to pleading "not guilty by reason of insanity" was readily understandable when the result of a successful plea inevitably meant indefinite detention in a psychiatric hospital, but as that has

¹ A fuller account of the various points at which a person may be diverted from the criminal justice system, and the court's powers to deal with a mentally disordered person who appears in the criminal courts, is at Appx A. In this Part we are concentrating on the verdict of not guilty by reason of insanity.

² See para 3.41 below.

³ See paras 2.38 to 2.43 above.

⁴ The 1991 Act increased the range of disposals available to the court. Prior to the 1991 Act a mandatory disposal of "indefinite and indeterminate hospitalisation" followed a special verdict of not guilty by reason of insanity.

not been the case for 20 years, the reluctance of defendants to plead “insanity” must also have other causes. No doubt the label is one. Other causes may be that the mental condition of mentally disordered offenders was not part of the reason they committed crimes, or the legal test of insanity bears such little relation to the mental condition of even the most mentally disordered offenders that it is largely useless.

PRE-COURT

3.6 A person who has been charged with an offence and is showing signs of mental disorder and/or learning disabilities might be diverted out of the criminal justice process.

3.7 The term “diversion” can be used to mean different things. In a review in October 2009 the Office for Criminal Justice Reform (the “OCJR”) described diversion in the following way:

NACRO (2004) describes diversion as a process of decision making, which results in MDOs [mentally disordered offenders]⁵ being diverted away from the Criminal Justice System towards health and social care. Diversion may occur at any stage of the criminal justice process: before arrest; after proceedings have been instigated; in place of prosecution; or when a case is being considered by the courts. If a prosecution is initiated, the Crown Prosecution Service might decide to discontinue or, if the offender is prosecuted because prosecution is appropriate, the court might opt for a relevant disposal under the Mental Health Act 1983/2007, such as a hospital order, in place of a criminal justice disposal, such as imprisonment.⁶

3.8 The OCJR then noted “however, the process of diverting individuals away from prison but not out of the Criminal Justice System altogether can be termed diversion as well”. For example, an accused person may be given a formal warning, a Penalty Notice, a caution, or a conditional caution; in all these cases, the matter never reaches the court.

3.9 Government policy is to increase diversion of people with mental illness from the criminal justice system and a national liaison and diversion service should be in place by 2014. This policy direction was decided upon in 1990 by the Home

⁵ Defined in OCJR’s report as “Those who come into contact with the Criminal Justice System because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically mentally ill It also includes those in whom a degree of mental disturbance is recognised, even though that may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983” at p 1. The OCJR were using a NACRO definition: NACRO, *Liaison and Diversion for Mentally Disordered Offenders: A Mental Health Good Practice Guide* (2006).

⁶ OCJR, *Provision of Mental Health Services to Individuals Passing through the Criminal Justice System: A Qualitative Literature Review* (Oct 2009) p 13. The reference to “NACRO (2004)” is to NACRO, *Findings of the 2004 Survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for Mentally Disordered Offenders in England and Wales* (2004).

Office.⁷ The practice became more widespread following the publication of the Reed review.⁸ The Joint Committee of Human Rights reported in 2004 that the Government's general approach to mental health care in prisons included trying to ensure that people are not sent to prison inappropriately through court diversion schemes and wider sentencing options for judges.⁹

3.10 Steps are currently being taken to facilitate screening of defendants at an early stage in proceedings to identify those for whom an expert medical report is necessary. Such a report may point the court towards diversion, or assist the court in sentencing. It may highlight the possibility of a defence of insanity being raised.

3.11 The CPS attitude to diversion was described in a Criminal Justice Joint Inspection report in 2009 as follows:

The approach currently adopted was a twin track one whereby offenders were dealt with in accordance with the judicial process whilst, at the same time, encouraged to enter into treatment and we found little appetite for increasing the numbers diverted from prosecution. Many of the mental health professionals we met during the course of the inspection expressed the view that most offenders with mental disorders should be dealt with by the criminal justice system in order to ensure justice should be seen to be done and that the individual was, where possible, held responsible for their actions.¹⁰

3.12 One of the points at which a suspect may be diverted out of the criminal justice system is when the charge is considered by the Crown Prosecution Service or other prosecuting agency. The Code for Crown Prosecutors is applied in all cases.

3.13 The Code for Crown Prosecutors states that, for a prosecution to proceed, the case must meet the evidential test and then, if that test is met, the public interest test. The evidential test requires the prosecutor to consider whether there is sufficient evidence to provide a realistic prospect of conviction, in other words, the likelihood of the actus reus and mens rea (where applicable) being proved and defences rebutted. Prosecutors may also stop prosecutions without fully

⁷ Home Office, "Provision for Mentally Disordered Offenders" (1990) Circular 66/90.

⁸ Department of Health and Home Office, *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (1992).

⁹ Deaths in Custody, Joint Committee on Human Rights Third Report (2004-05) para 196.

¹⁰ As noted in the Criminal Justice Joint Inspection Report: HM Crown Prosecution Service Inspectorate, HMI Courts Administration and HMI Constabulary, *Work Prior to Sentence with Offenders with Mental Disorders* (Dec 2009) para 20.

http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmiprob/MDO_Joint_Report-rps.pdf (last visited 30 Dec 2011).

assessing the strength of the evidence where the public interest clearly does not require a prosecution.¹¹

- 3.14 The public interest test requires the prosecutor to take account of factors which indicate that the prosecution should proceed, and factors which indicate it should not. Included in the factors tending against prosecution in the public interest test is the following:

The suspect is, or was at the time of the offence, suffering from significant mental or physical ill health, unless the offence is serious or there is a real possibility that it may be repeated. Prosecutors apply Home Office guidelines about how to deal with mentally disordered offenders and must balance a suspect's mental or physical ill health with the need to safeguard the public or those providing care services to such persons.¹²

- 3.15 Thus a case may be discontinued before it even reaches court if the prosecutor thinks there will be difficulties in proving the mental element of the offence.¹³

MAGISTRATES' COURTS

- 3.16 All criminal cases start in a magistrates' court, although the more serious cases may be sent¹⁴ from the magistrates' court to the Crown Court.

- 3.17 There are, so far as we are aware, no data on the prevalence of pleas of not guilty by reason of insanity in the magistrates' courts. Discussion with practitioners and judges reveals that it is rare for this plea to be entered in the magistrates' courts. However, it is worth noting that magistrates' courts have a way of dealing with a mentally disordered offender without convicting him or her. Under section 37(3) of the 1983 Act, if the court is satisfied that he or she did the act or made the omission charged, the court may make a hospital order.¹⁵

¹¹ CPS, *Code for Crown Prosecutors* (2010) http://www.cps.gov.uk/publications/code_for_crown_prosecutors/ (last visited 3 Jan 2012). See para 3.3. See further paras A.4 to A.6 in Appx A.

¹² CPS, *Code for Crown Prosecutors* (2010) http://www.cps.gov.uk/publications/code_for_crown_prosecutors/ (last visited 3 Jan 2012). See para 4.17(j).

¹³ As noted in CPS, *Prosecution of Offenders with Mental Health Problems or Learning Disabilities* (June 2010) http://www.cps.gov.uk/publications/research/offenders_with_mental_health_problems.html (last visited 30 Dec 2011). This report presents the findings from the research into the role of the CPS in cases involving offenders with mental health problems or learning disabilities.

¹⁴ There are three different ways in which a case may move from the magistrates' court to the Crown Court: a case may be sent, or committed or transferred. We use "sent" to cover all these.

¹⁵ This is discussed in more detail at para 2.85 above. The Ministry of Justice does not publish statistics on the number of persons detained under s 37(3) of the 1983 Act.

- 3.18 If the offence is triable either way and the defendant's mental condition is likely to be an issue in the case, then the case is likely to be dealt with in the Crown Court instead of the magistrates' court.
- 3.19 If the offence is summary only, the public interest in prosecuting might be lower, and if the accused has a mental condition it is more likely that the prosecution will be dropped. The issue of whether the defendant should be held criminally responsible may not reach the court where, for example, the offence appears to have been committed at a time when the defendant was not taking medication for the mental illness, the offence is summary only, and the medical professionals are confident that the defendant will take the medication reliably in the future. In such a case, even where the prosecution believe that they can prove all elements of the offence, they are likely to discontinue the proceedings because the prosecution is not perceived to be in the public interest (in light of the defendant's health, or where it is not in the complainant's interests).¹⁶
- 3.20 This is not invariably what happens however, as in the case of A,¹⁷ a man of previous good character, who was delusional and psychotic. He went to a shop with a knife and his wife phoned the police to warn them. No one was hurt. A was arrested, and was compliant and co-operative. His medication needed to be adjusted. The probation report recommended a conditional discharge. He received a supervision order.
- 3.21 Consider also the case of B,¹⁸ who was prosecuted for assaulting a paramedic. The emergency services had been called (before the assault) by B's relative, who was concerned that B's condition was deteriorating as he had not been taking his medication.¹⁹ B assaulted a paramedic attending him and resisted arrest. He was distressed, violent, and unfit to be interviewed at the police station. The case was dropped several months later following a report obtained by the defence from the psychiatric hospital where B received treatment after the incident. The report stated that B was "acutely psychotic, confused and disoriented at the time of the attack on the medical technician. He remained in this state for several days [It was] clear he would have been unable to form the necessary intent, nor would he have been able to foresee the result of his action." He pleaded guilty to one of the charges, but this plea was set aside once the psychiatric report was received.
- 3.22 In some cases, particularly less serious ones, a defendant may prefer to plead guilty, in anticipation of a conditional or absolute discharge given the mitigation that will be made on the basis of his or her mental ill health. Defendants may perceive that outcome as preferable, or be advised such, because it avoids the

¹⁶ See para A.5 in Appx A.

¹⁷ A case reported to us by a Probation Officer.

¹⁸ This case is from CPS files on cases which were not proceeded with. We are grateful to the CPS for allowing us access to those files.

¹⁹ He suffered from self-neglect and delusions, and was said to be psychotic at the time of the incident.

stress of a trial which would follow if a plea of not guilty by reason of insanity were entered.²⁰

- 3.23 Another factor reducing the likelihood of a plea of insanity in the magistrates' courts is funding difficulties on obtaining psychiatric reports.²¹

AT THE CROWN COURT

Findings of empirical research on pleas of insanity in the Crown Court

- 3.24 In order to probe further into the reasons behind the low rates of insanity plea it is useful to examine research on those cases where the defence has been relied upon. Mackay has completed an empirical study on the use of the insanity defence between 2002 and 2011.²² This follows his previous empirical studies spanning the period from 1975 to 2001, thus covering years before and after statutory changes were made to available disposals on a successful plea of insanity.²³ The studies disclose the numbers of verdicts of not guilty by reason of insanity that are recorded each year and disposals used as a result as well as other data relating to the offenders.

Findings of not guilty by reason of insanity

- 3.25 The most significant finding from empirical studies on the use of the insanity defence in criminal proceedings is how few verdicts of not guilty by reason of insanity are returned. The numbers of cases are so low (around 30 each year) that one has to be cautious about extrapolating patterns from them.²⁴
- 3.26 From 1975 to 1991, before changes to the law made by the 1991 Act came into force, there was an annual average of fewer than four verdicts of not guilty by reason of insanity.²⁵ This increased in the five years preceding the introduction of the 1991 Act to an annual average of nearly nine.²⁶ This increase continued

²⁰ Some of these points were made to us by practising solicitors.

²¹ This was suggested to us by Anthony Edwards, a very experienced defence solicitor.

²² R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission.

²³ See para 3.4 above. See R D Mackay, "Fact and Fiction about the Insanity Defence" [1990] *Criminal Law Review* 247; R D Mackay and G Kearns, "More Fact(s) about the Insanity Defence" [1999] *Criminal Law Review* 714; R D Mackay, B J Mitchell and L Howe, "Yet More Facts about the Insanity Defence" [2006] *Criminal Law Review* 399.

²⁴ Similarly, the research in Appx B shows considerable regional variation in the incidence of the special verdict. We should be interested to hear if any consultees have suggestions why this might be.

²⁵ Figures obtained from R D Mackay, "Fact and Fiction about the Insanity Defence" [1990] *Criminal Law Review* 247 and R D Mackay and G Kearns, "More Fact(s) about the Insanity Defence" [1999] *Criminal Law Review* 714.

²⁶ 8.8 for 1992 to 1996: "More Fact(s) about the Insanity Defence" [1999] *Criminal Law Review* 714, 716. This period showed a gradual increase in number of verdicts of not guilty by reason of insanity from 6 verdicts in 1992 to 13 verdicts in 1996.

between 1997 to 2001, during which time there were 72 successful pleas of insanity – giving an annual average of 14.4.²⁷

Table 1: Number of findings of not guilty by reason of insanity

| Year | Frequency |
|-------|-----------|
| 2002 | 23 |
| 2003 | 16 |
| 2004 | 19 |
| 2005 | 20 |
| 2006 | 23 |
| 2007 | 13 |
| 2008 | 28 |
| 2009 | 27 |
| 2010 | 20 |
| 2011 | 34 |
| Total | 223 |

3.27 Between 2002 and 2011, there were 223 successful pleas of insanity. This period shows “a gradual but steady rise in the number of [not guilty by reason of insanity] verdicts. ... In essence ... the annual average number of [not guilty by reason of insanity] verdicts has now reached over twenty for the first time, with the total for 2011 having exceeded 30, also for the first time.”²⁸ The greatest number of insanity verdicts for any one year in that research period was 34 in

²⁷ See table 1 in R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 400.

²⁸ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, paras E.5 and E.6.at Appendix E.

2011.²⁹ However, this does not reflect a trend of gradual increase between that period; rather, there were fluctuations throughout.³⁰

- 3.28 This general trend of increasing numbers of special verdicts does, however, reflect earlier predictions that the insanity defence would be used more often as a result of the introduction of more flexible disposals once practitioners became aware of them.³¹ It continues the trend in earlier research findings that successful pleas of insanity increased in the first five years following the implementation of the 1991 Act (which introduced a wider range of possible disposals).
- 3.29 It is also consistent with the research presented at Appendix B. That research covers a different period from the Mackay research. It covers 1 October 2006 to 31 January 2009, which is a shorter period. It records 89 verdicts (reflecting multiple charges) out of 40 cases of not guilty by reason of insanity in that period.
- 3.30 The number of people found not guilty by reason of insanity remains low considering the number of offenders with mental disorder in prison.³² The upturn in the use of the insanity defence has coincided with an increase in the number of findings of accused people who are unfit to plead.³³ It is possible that defendants who have been found unfit to plead and to have done the act would have been found not guilty by reason of insanity had they not been found unfit. If that were the case, one might expect an increase in findings of unfitness to plead to lead to a lower number of verdicts of not guilty by reason of insanity. This does not, however, appear to be the trend. Rather, the statistics reflect an overall increase in both.
- 3.31 This increase might reflect a more formalised system for dealing with mentally disordered offenders, and also the fact that sentencing is less a matter for the discretion of the individual judge than it used to be, and that sentencing has become harsher with regard to offences such as burglary and knife-crime. It might also reflect the incidence of mental illness in society in general, or in offenders specifically; we cannot be sure as to the cause of the increase.

²⁹ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission. See table 2a at para E.6 at Appendix E.

³⁰ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission. See table 2a at para E.6 at Appendix E.

³¹ “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714.

³² Although we recognise that not all who have such a disorder in prison will have had it at the time of offending.

³³ Between 2002 and 2008, the annual average number of unfitness to plead findings reached 100 for the first time: R D Mackay, *Unfitness to Plead – Data on Formal Findings from 2002 to 2008*, published in Appx C of CP 197, pp 207 to 208. A qualitative study found that “significant numbers of mentally ill continue to undergo trial and may be doing so unfairly”: T P Rogers, N J Blackwood, F Farnham, G J Pickup and M J Watts, “Reformulating Fitness to Plead: A Qualitative Study” (2009) 20(6) *Journal of Forensic Psychiatry and Psychology* 815, 817. For further discussion, see paras 2.60 to 2.63 of CP 197.

Accounting for the gaps in the numbers

3.32 Of the approximately 90,000 people tried in the Crown Court each year, a proportion of those will be seriously mentally ill. If the proportion used reflects the incidence of serious mental illness in the prison population – say 10%, being the estimated proportion of the prison population which is seriously mentally ill³⁴ – then that would mean that 9,000 of those tried are seriously mentally ill. In fact, fewer than 30 people each year who choose to plead the defence in the Crown Court are so mentally ill that they are found to be “insane” at the time of the offence,³⁵ which is only 0.03% of the total number committed for trial. There are the following possible explanations for this disparity:

- (1) Many people were well at the time of the offence but become seriously mentally ill following the prosecution. This is indeed possible, especially if they are sent to a custodial institution.
- (2) Many more people are so mentally ill that they ought to be found unfit to plead and to be tried than is happening currently. This is also highly likely to be true.
- (3) Some of those who plead guilty do so because of their mental disorder.³⁶
- (4) There are many people with serious mental illness at the time they commit offences who could raise the defence of insanity but do not. Again, this is quite likely.
- (5) There are many people with serious mental illness at the time they commit offences who would not be found not guilty by reason of insanity even if insanity were raised as a defence under the law as it stands.
- (6) There may be gaps in the data because successful defences of not guilty by reason of insanity might go unrecorded.
- (7) The proportion of people in custody with learning difficulties is higher than the proportion of people in the general population with learning

³⁴ This was the figure used by Michael Spurr, Operational Head of HM Prison Service in BBC Radio 4 (2008) “Life on the Inside at HMP Liverpool” Evan Davis interviews Alan Brown and Michael Spurr, cited by K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009) p 6.

³⁵ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, E.6 at Appendix E. This is the highest annual average found to date (from 2002 to 2011) in empirical studies on verdicts of not guilty by reason of insanity. See above.

³⁶ See eg *Murray* [2008] EWCA Crim 1792. Studies suggest that mentally disordered defendants are more likely to make self-incriminating statements, even where they may not be true: A D Redlich and others, “Self-reported False Confessions and False Guilty Pleas Among Offenders with Mental Illness” (2010) 34 *Law and Human Behavior* 79 and G Gudjonsson, *The Psychology of Interrogations, Confessions and Testimony* (1992) but we note that the studies are not conclusive due to insufficient research in this area.

difficulties.³⁷ We are not aware of any detailed research on the point, but a valid question would be whether some of those people should not be held criminally responsible because of their learning disability.

Behind the verdict: how the M’Naghten Rules are applied

- 3.33 A plea of not guilty by reason of insanity may only succeed where there is evidence from at least two approved medical experts. It is helpful, therefore, to know how the experts are applying the legal test to the cases referred to them.
- 3.34 Unfortunately, information on the application of the M’Naghten Rules is only available from pre-2002 research.³⁸ That research consistently found that the “wrongfulness” limb of the insanity defence was referred to in psychiatric reports more often than the “cognitive” limb. Further, the studies found that a wider interpretation of the “wrongfulness” limb was used than the official legal definition which requires that the defendant did not know that what he or she did was legally wrong.³⁹ Once again, we can see that the law lays down one thing, and the practitioners do another, to achieve what they feel is the right result.
- 3.35 From 1975 to 1989, a total of 52 successful pleas of insanity was recorded.⁴⁰ The “wrongfulness” limb formed the basis of the plea of insanity in 23 of the 52 cases and in a further six cases in conjunction with the “cognitive” limb.⁴¹ Mackay comments that his empirical research supports the contention that an “unofficial” version of the insanity defence is used in practice, in which the defence is limited to those who would be “popularly considered crazy”:⁴²

³⁷ The proportion of people in the general population with learning disabilities can be assumed to be around 2%: study commissioned by the Department of Health cited by E Emerson and C Hatton, *People with Learning Disabilities in England* (Centre for Disability Research Report, 2008) p i. A study of three prisons found that just under 7% of the prison population were assessed as learning disabled and over one quarter as borderline learning disabled: K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009) p 29. See also “amongst young people in custody the incidence of mental disorder is far higher (31%) than in the general population (10%). In addition, it has been reported that one in five young offenders have an IQ of less than 70.” Sentencing Advisory Panel, *CP on Principles of Sentencing for Youths* (2008) p 77. An IQ of less than 70 is part of the diagnosis of learning disability. The Department of Health’s figures show that over a quarter of young people in custody have a learning disability, and over a third have a diagnosed mental disorder. (Source: HMG, *Healthy Children, Safer Communities* (Dec 2009) p 14).

³⁸ Access to court files and psychiatric reports was unavailable for the study of 2002 to 2011: R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2008*. Work commissioned by the Law Commission, E.4 at Appendix E.

³⁹ *Windle* [1952] 2 QB 826 (cited in R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 722).

⁴⁰ For further details see Mackay (1995) p 102.

⁴¹ Mackay (1995) p 103.

⁴² Mackay (1995) p 90 quoting M Moore, “Causation and the Excuses” (1985) 73 *California Law Review*, 1091, 1139.

Both judges and juries do appear to be approaching the interpretation of the M’Naghten Rules in a liberal manner: the “wrongness limb” is not only more frequently used than the “nature and quality limb” but also seems to be applied in cases where the accused believed that what they were doing was morally right. Why is this? Could it be that judges and juries simply consider such mentally ill persons to be “crazy”?⁴³

- 3.36 An analysis of psychiatric reports for cases between 1992 and 1996 shows that the “wrongfulness” limb remained the limb most commonly relied upon. From the total of 44 verdicts of not guilty by reason of insanity, in 25 cases the wrongfulness limb was referred to in at least one psychiatric report (although not necessarily explicitly).⁴⁴ But, continuing earlier reports of a liberal approach to “wrongfulness”, Mackay and Kearns comment that “it is safe to say that the vast majority of these reports made no reference to knowledge of legal wrongness”.⁴⁵ In these cases:

The overwhelming impression is that the question the majority of psychiatrists are addressing is: if the delusion that the defendants was experiencing at the time of the offence was in fact reality, then would the defendant’s actions be morally justified.⁴⁶

- 3.37 Similarly, an analysis of psychiatric reports for cases from 1997 to 2001 where the insanity defence succeeded demonstrates that the wrongfulness limb was used more regularly than the cognitive limb, although many reports referred to both.⁴⁷ Further the wrongfulness limb was not being considered as limited to knowledge of legal wrong. This suggests that psychiatrists were adopting a pragmatic approach in widening the scope of the M’Naghten Rules, and that their approach was being accepted by the judges.⁴⁸

- 3.38 Information on the use of the different limbs of the M’Naghten Rules is not available for cases beyond 2001. However, the only significant changes to the law relating to insanity were made by the 2004 Act which made some changes to

⁴³ Mackay (1995) p 90.

⁴⁴ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 722.

⁴⁵ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 722.

⁴⁶ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 723.

⁴⁷ R D Mackay, B L Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 407.

⁴⁸ R D Mackay, B L Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 407. Although in *Johnson* [2007] EWCA Crim 1978, [2008] *Criminal Law Review* 132 this was not the case: see para 2.43 above. Mackay provides a categorisation of cases in which “moral/unspecified wrongfulness” is relied upon in psychiatric reports in “Righting the Wrong – Some Observations on the Second Limb of the M’Naghten Rules” [2009] *Criminal Law Review* 80, 83.

disposals following a special verdict.⁴⁹ For this reason, it is probably safe to draw inferences from these findings, subject to the caveats stated above, about the current use of the insanity defence despite the fact that they are fairly dated.

Offences committed for which verdicts of not guilty by reason of insanity are returned

- 3.39 In the study for the period 1992 to 1996 Mackay⁵⁰ categorised the offences charged which led to special verdicts as being either directed or non-directed violence against person or property (some offences had more than one constituent element). Mackay does not give a definition for these categorisations, but it appears that “directed violence” means an offence where *purposeful* violence is used by the defendant.⁵¹ In 34 cases (77.3%) a major part of the offence was purposeful violence against the person. When including cases of directed violence against property, the number of cases where purposeful violence is used reaches 38 (86.4%) of cases.⁵² A similar analysis conducted by Mackay in respect of the study for the period 1997 to 2001 shows directed violence against the person in 50 out of the 72 cases (69.4%) which increases to 76.3 per cent when cases of directed violence against property are added (n=5). In addition, in seven of the cases there was no information about the facts of the case. If these seven cases are ignored the figures rise to 76.9 per cent for directed violence against the person and 82.1 per cent for both types of directed violence.
- 3.40 As regards the period 1997 to 2001, Mackay reported that “[not guilty by reason of insanity] verdicts continue to be returned mainly for offences of violence”. He notes that “schizophrenia is clearly the most prevalent diagnosis”⁵³ in those cases.

⁴⁹ The 2004 Act made a further, more subtle, change to the disposals available if the offence charged is murder. Under the disposal regime effected by the 2004 Act a judge must impose a restriction order with a hospital order if the offence charged is murder, but is only permitted to do so if a hospital order is available.

⁵⁰ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714.

⁵¹ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 719.

⁵² See Table 6 of R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 719. Research into prisoners with psychosis (not correlated with any defence pleaded) revealed that psychotic prisoners were more likely to have been charged with criminal damage and less likely to have been charged with drugs offences than non-psychotic prisoners. However, when previous offending was taken account of there was no significant difference between psychotic and non-psychotic prisoners: J Coid and S Ullrich, “Prisoners with Psychosis in England and Wales: Diversion to Psychiatric Inpatient Services?” [2011] 34 *International Journal of Law and Psychiatry* 99, 104.

⁵³ R D Mackay, B L Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 410.

- 3.41 Mackay also states, “as in previous studies ... offences against the person (including robbery, kidnap/child abduction, false imprisonment and child cruelty) remain the most common type of offence with a total of 130 (58.3%) non-fatal and only 5 (2.2%) fatal offences”.⁵⁴
- 3.42 However, Mackay has found an increased proportion of offences of causing grievous bodily harm and actual bodily harm combined from 27.8% of all successful pleas of insanity in 1998 to 2001 to 33.2% in 2002 to 2011.⁵⁵ This is followed by damage to property (including arson, criminal damage) amounting to 34 cases (15.2%). There are 19 cases of threatening behaviour 17 of sexual offences, 9 of dishonesty and 8 cases of driving offences.⁵⁶
- 3.43 The empirical research reveals that the insanity defence is generally used in serious offences, but not only in such cases. Drawing on the research on cases from 1975 to 1989, Mackay concluded that: “more often than not [the insanity defence] is used in cases of offences against the person, usually, but by no means always, of a serious nature”.⁵⁷ However, the offences do seem to be restricted to those for which there could be a potentially long sentence on conviction and/or where there is an element of dangerousness and an identifiable victim. We infer from this that if the accused is facing a lengthy period of imprisonment on conviction and if he or she is perceived to be dangerous to others, then the insanity defence is more likely to be used. The data in the research presented in Appendix B is not conclusive on the point.

⁵⁴ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, E.11 at Appendix E. Note that indecent/sexual assault is not included in the category of offences against the person. If it were, the figure would increase to 65.7% (152 cases out of 223). From 2002 to 2011, the offences with which the defendants who successfully pleaded insanity had been charged were, in decreasing proportion: grievous bodily harm, attempted murder, arson, assault occasioning actual bodily harm, indecent/sexual assault, robbery, burglary, affray, causing death by dangerous driving, murder, having a bladed article threats to kill, racially aggravated assault, indecent exposure, false imprisonment, possession of an offensive weapon, and one incidence of each of the following offences: manslaughter, possession/importation/supply of drugs, endangering aircraft, theft, bomb hoax, child cruelty, aid/abet reckless driving, breach of anti-social behaviour order, breach of restraining order and blackmail.

⁵⁵ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission at E.11, Appendix E.

⁵⁶ See table 7 in R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, table 7 at E.11, Appendix E.

⁵⁷ Mackay (1995) p 105.

MURDER

- 3.44 The number of verdicts of not guilty by reason of insanity for offences of murder remains low. In 2002 to 2011, there were only 4 cases (1.8%).⁵⁸ Earlier empirical studies also show similarly low frequencies for murder.⁵⁹
- 3.45 In relation to the study of successful pleas of insanity between 1997 to 2001, Mackay concluded that the continued requirement for judges to impose a restriction order in the cases of murder charges continues to deter defendants from pleading insanity.⁶⁰ Mackay has also described the plea of diminished responsibility as leading to the “demise of the insanity defence in murder cases”.⁶¹

Disposals

- 3.46 Mackay’s empirical research into disposals for not guilty by reason of insanity cases in 2002 to 2011 found that nearly half (48.4%) of all disposals made were hospital orders (with or without restrictions). This is similar to the findings of the study on cases from 1997 to 2001 (47.2%). There was, however, a decrease in the proportion of restriction orders made, with the figure falling from 37.5% to 28.7% with a marked increase in those without restrictions from 9.7% to 19.7%.⁶²

Table 2: Disposals given following a not guilty by reason of insanity verdict

| Disposal | Frequency | % |
|--|-----------|------|
| Hospital order (with restriction order) | 64 | 28.7 |
| Hospital order (without restriction order) | 44 | 19.7 |
| Guardianship order | 2 | .9 |
| Supervision order | 82 | 36.8 |
| Absolute discharge | 30 | 13.5 |
| Defendant discharged-hung jury | 1 | .4 |
| Total | 223 | 100% |

⁵⁸ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, E.10 at Appendix E.

⁵⁹ Four cases (9.1%) between 1992 and 1996 and 7 (9.7%) between 1997 and 2001: R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 718 and R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 409 respectively.

⁶⁰ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 402.

⁶¹ Mackay (1995) p 100.

⁶² R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, E.12 at Appendix E.

- 3.47 Community-based disposals⁶³ account for 51.2% of all disposals made.. Similarly, in 1997 to 2001, the overall percentage for community-based disposals was 52.9%.
- 3.48 There were 82 supervision orders made between 2002 and 2011 on a successful plea of insanity, accounting for 36.8% of all disposals made. Examination of the results of the previous empirical studies shows that there has been a gradual decrease in the proportion of supervision orders used. In 1997 to 2001, the overall percentage was 42.7%. In 1992 to 1997, soon after the introduction of flexibility of disposals, this was higher yet at 47.7%.
- 3.49 However, there has been an increased use of absolute discharges which accounted for 13.5% of all disposals in 2002 to 2011.⁶⁴ In 1992 to 1996, this figure was only 4.4%.⁶⁵ Similarly, there was a marked increase in the proportion of absolute discharges to 9.7% between 1997 and 2001. They have been used even for serious offences, for example, in one case for attempted murder and one for kidnapping/child abduction.⁶⁶

IMPACT OF THE 2004 ACT

- 3.50 The 2004 Act removed guardianship orders as an available disposal on a verdict of not guilty by reason of insanity or finding of unfitness to plead. It also introduced a subtle change in the law in relation to disposals for murder. If a defendant is found not guilty by reason of insanity, a judge must impose a restriction order with a hospital order, but only if a hospital order is an available disposal.
- 3.51 The most recent empirical study covers the period before and after the implementation of the 2004 Act.⁶⁷ Considering the impact of the 2004 Act, Mackay notes that “the pattern of offences has remained fairly consistent”. However, the percentage of cases of attempted murder has fallen in the post 2004 Act period by around a third while cases of GBH have risen by 50% from 12.1 per cent to 24.2 per cent. There could be a number of reasons for these changes.
- 3.52 When it comes to post-2004 Act disposals, Mackay notes that there has been an increase in the use of hospital orders rising from 43.9% during the period studied

⁶³ Community based disposal refers to supervision orders, absolute discharges and guardianship orders. (Guardianship orders are no longer available as a disposal following a verdict of not guilty by reason of insanity.)

⁶⁴ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, table 8a, E.12 at Appendix E.

⁶⁵ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review*, 723, table 8.

⁶⁶ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 724, table 9.

⁶⁷ In force on 31 Mar 2005.

before the 2004 Act was in force to 50.3% during the period since the 2004 Act came into force, with a marked increase in the use of hospital orders without restrictions from 10.6% to 23.6%.⁶⁸

- 3.53 There were two reported cases of defendants who succeeded on the insanity defence for murder in the post-2004 Act period. One defendant received a restriction order without limit of time, while the other was given supervision order. In respect of the latter it is interesting to note that this is the first case where the insanity defence in a murder charge has resulted in disposal other than a restriction order. It is too early to say whether the revised partial defence of diminished responsibility has had any impact.

The role of the jury

- 3.54 Whereas a plea of guilty may be accepted by the prosecution without the need for the jury to consider a verdict at all, a verdict of “not guilty by reason of insanity” must be delivered by the jury. However, figures from 1997 to 2001, among cases in which the information was available, suggest that in over half of the cases the jury had little deliberative role if any.⁶⁹ In over 60% of the cases in that period, the jury was formally directed by the judge to return a verdict of not guilty by reason of insanity or they were presented with a situation where all parties agreed beforehand that the case was one of not guilty by reason of insanity.⁷⁰ Further, in one case, a verdict of not guilty by reason of insanity was returned without the jury being empanelled. This is despite the statutory requirement that the jury should return a special verdict.
- 3.55 The findings from cases from 1997 to 2001 are reflected in the study of cases between 1992 to 1996. Between 1992 and 1996, in cases where the information was available, special verdicts were returned without a jury in eight cases,⁷¹ and the jury had a real deliberative role in less than one in seven trials.⁷² Thus both suggest that the jury has “little real deliberative role” in insanity.⁷³
- 3.56 This prompts the question “whether it might not be time to consider giving the prosecution and the court the power to accept a plea of not guilty by reason of

⁶⁸ R D Mackay, *The Insanity Defence – Data on Verdicts of Not Guilty by Reason of Insanity from 2002 to 2011*. Work commissioned by the Law Commission, E.18 at Appendix E.

⁶⁹ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 404.

⁷⁰ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 402.

⁷¹ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 720.

⁷² R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 721.

⁷³ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 404.

insanity (much as in cases of diminished responsibility) without the need for a trial by jury”.⁷⁴

Diagnosis of those found not guilty by reason of insanity

- 3.57 Between 1975 and 1988, the most frequently found diagnosis in those found not guilty by reason of insanity verdicts was schizophrenia.⁷⁵ That group represented just over half of all such verdicts.⁷⁶ This pattern is mirrored in subsequent research where the diagnosis was available.⁷⁷
- 3.58 Between 1975 and 1988, there were three cases where the diagnosis was a personality disorder. The later research does not disclose a successful plea of insanity due to a personality disorder.
- 3.59 Mood disorders were consistently present among the verdicts of not guilty by reason of insanity across all research periods: ranging approximately between 12% and 15%.
- 3.60 In 1975 to 1988, there were five not guilty by reason of insanity verdicts where the main diagnosis is recorded as alcohol or drug abuse.⁷⁸ Although this was not recorded as a diagnosis for other periods, there were two reported verdicts where the primary diagnosis was drug-induced psychosis from 1992 to 1996 and three cases from 1997 to 2001.⁷⁹ Further, between 1997 and 2001 there was one special verdict arising out of a diagnosis of delirium tremens (an acute episode following withdrawal from alcohol).⁸⁰
- 3.61 Diagnoses of epilepsy were present across all research periods. Between 1975 and 1988 there were three verdicts where epilepsy was reported as the main diagnosis – representing approximately 12% of cases.⁸¹ From 1992 to 1996, this

⁷⁴ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 404.

⁷⁵ R D Mackay, “Fact and Fiction about the Insanity Defence” [1990] *Criminal Law Review* 247, 248.

⁷⁶ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714.

⁷⁷ See table 2 in R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 717 and table 2 in R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 400. Unfortunately, this information is not available for the latest research period between 2002 and 2011.

⁷⁸ R D Mackay, “Fact and Fiction about the Insanity Defence” [1990] *Criminal Law Review* 247, 248.

⁷⁹ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 717; R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 400.

⁸⁰ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 400.

⁸¹ R D Mackay, “Fact and Fiction about the Insanity Defence” [1990] *Criminal Law Review* 247, 249.

dropped to 6.8% where there were three verdicts of a diagnosis of epilepsy or postictal state (altered state of consciousness experienced following a seizure).⁸² In the latest research period where data was available, in 9.7% of cases of not guilty by reason of insanity there was a primary diagnosis of epilepsy or postictal state.⁸³

Subsequent re-offending

- 3.62 The relationship between mental disorder and criminal activity might have an impact on the effectiveness of mental health treatment on reoffending. We are not aware of any specific data on the reoffending rates of those who are found not guilty by reason of insanity. Studies of reoffending rates do not distinguish between offenders with mental illness who committed offences due to their mental illness and a wider population of offenders with mental illness. It is arguable that treatment (in hospital or in the community) is likely to have a bigger impact on lowering reoffending rates for prisoners who offended as a result of their mental disorder than on a more general category of convicted offenders with mental health problems.

⁸² R D Mackay and G Kearns, "More Fact(s) about the Insanity Defence" [1999] *Criminal Law Review* 714, 717.

⁸³ R D Mackay, B J Mitchell and L Howe, "Yet More Facts about the Insanity Defence" [2006] *Criminal Law Review* 399, 400.

PART 4

PROBLEMS ARISING FROM THE CURRENT LAW AND PRACTICE

- 4.1 So far in this paper we have described the law and reviewed what is known about how the defence is relied upon in practice. In this Part we explore the problems with the law and practice.
- 4.2 The insanity defence may be criticised on the grounds that:
- (1) the foundation of the defence is not reflected in the law;
 - (2) the law is incoherent;
 - (3) the legal test of insanity is out of step with medical and psychiatric understanding;
 - (4) in practice the law is not applied;
 - (5) the label of “insanity” is inaccurate, unfair and stigmatising;
 - (6) the defence is underused;
 - (7) it is wrong in principle for the burden of proof of the insanity defence to fall on the defendant;
 - (8) the law may lead to breaches of the ECHR; and
 - (9) the law has a potentially unfair impact on both adults and children with mental disorder.

THE FOUNDATION OF THE DEFENCE IS NOT REFLECTED IN THE CURRENT LAW

- 4.3 The New Zealand Law Commission (“NZLC”) recently identified two quite separate bases for the defence of insanity:
- (1) In some cases, the accused’s defence amounts to a lack of mens rea because he or she is incapable of understanding the nature and quality of the act or omission;
 - (2) In other cases all elements of the offence can be proved, but because of his or her mental disorder the accused is not to be blamed.¹

¹ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) pp 21 to 22.

- 4.4 These two bases of the defence raise a fundamental question: is the defence of insanity essentially a denial of mens rea, as some authorities suggest,² or is it a denial of responsibility for the crime? Our view is that the true rationale of the insanity defence is to deny criminal responsibility, not merely to deny mens rea. Our conclusion is based on consideration of the fundamental question: when is it unfair, because of a person's condition, to hold him or her criminally responsible for an act or omission? The answer is, in our view, that people should not be held criminally responsible for their conduct if, through no fault of their own, they lacked the capacity to obey the law.
- 4.5 In summary, capacity is the key to responsibility: where a person is unable to conform to the law and has not culpably produced the loss of capacity, it is fair to hold him or her non-responsible. The classic statement of this foundation of responsibility was made by Hart:

What is crucial is that those whom we punish should have had, when they acted, the normal capacities, physical and mental, for doing what the law requires and abstaining from what it forbids, and a fair opportunity to exercise these capacities. Where these capacities and opportunities are absent, as they are in different ways in the varied cases of accident, mistake, paralysis, reflex action, coercion, insanity, etc, the moral protest is that it is morally wrong to punish because "he could not have helped it" or "he could not have done otherwise" or "he had no real choice".³

Or as Wilson put it more recently, "Enforcing rules, in any rule-system, presupposes a basic ability to follow them".⁴

- 4.6 The foundation of the defence is not merely a denial of mens rea but a denial of having been accountable at the time. The defence of insanity is therefore not really an excuse, because excuses depend on the accused's rational explanations of reasons he or she acted on.⁵ For example, the defendant who pleads duress will offer the rational explanation that he perceived a threat of death or serious injury and acted to avoid that harm. Insanity, however, "denies responsibility".⁶

² See, eg, G Williams, *Textbook of Criminal Law* (2nd ed 1983) pp 642 to 645. The argument was raised in *Felstead* [1914] AC 534 but the House of Lords' answer was ambiguous.

³ H L A Hart, *Punishment and Responsibility* (1968) p 152. The context is an argument about whether strict liability is fair.

⁴ W Wilson, *Central Issues in Criminal Theory* (2002) p 115.

⁵ J Gardner, "The Mark of Responsibility" (2003) 23 *Oxford Journal of Legal Studies* 157, 161.

⁶ R A Duff, *Answering for Crime* (2000) p 285. See also "only those who are responsible in the basic sense can offer excuses": J Gardner, "The Mark of Responsibility" (2003) 23 *Oxford Journal of Legal Studies* 157, 161.

- 4.7 A person who is so mentally disordered as to lack capacity is not responsible for his or her conduct. He or she is exempt from responsibility. This exemption is not, however, a continuing or permanent status but relates to the accused's condition at the time of the alleged offence. It is neither a general exemption nor a statement about the accused's capacities generally.
- 4.8 An "insanity" defence, as reformed, should be founded on this fundamental exemption from responsibility. It should reflect the idea that a person should not be held criminally responsible if, due to that person's condition, he or she lacked the capacity to think rationally, or to control his or her physical actions. This rationale is not reflected in the M'Naghten Rules themselves, nor in the case law interpreting them.

DEFECTS IN THE CURRENT LAW

- 4.9 There are three significant defects in the current law:
- (1) on one interpretation the defence is not available where the offence is one of strict liability or negligence;
 - (2) the dependence on the distinction between internal and external causes is not viable; and
 - (3) the distinction between mens rea and actus reus is not sustainable.

Defence not available if there is no mens rea element

- 4.10 This defect in the case law follows from the fundamental misunderstanding of the rationale for the insanity defence.
- 4.11 In offences which do require proof of mens rea, the offence can involve any one or more of a number of mental states: intention, knowledge, recklessness, malice, suspicion and so on. If the defendant was mentally disordered at the time of the offence, then he or she may not have been able to form the mens rea in question. The aspects of the mind which are in issue in the common law test of insanity are not necessarily on all fours with a mens rea requirement.
- 4.12 Where the offence charged is one of strict liability or negligence, or the mens rea requirement is not one based on the defendant's cognition, the first limb of the M'Naghten Rules⁷ might not be relevant.
- 4.13 A plea based on the second limb (that the accused did not know that the act was wrong) is clearly nothing to do with mens rea. As Sir John Smith pointed out, "awareness of 'wrongness' is not an element in mens rea", and the prosecution does not, generally speaking, have to prove that the defendant knew the act was wrong.⁸

⁷ See para 2.36 above.

⁸ J C Smith, *Smith & Hogan, Criminal Law* (9th ed 1999) p 206.

- 4.14 A lack of awareness that the act is wrong is accepted to be part of the legal test of insanity exempting the defendant. In such cases, the law is prepared to treat as not guilty someone who has mens rea and has performed the actus reus of the offence. It is clear therefore that in such cases criminal responsibility cannot be encapsulated in proof of the actus reus and of the mens rea alone; it is more than that. The view that proof of insanity is a denial of criminal responsibility was advanced by Sir John Smith:

It was recognised from early times that a person who is so insane as not to know what he is doing cannot be guilty of a crime. In *Reniger v Fogossa* (1548) 1 Plow 1 at 19, Serjeant Pollard argued: "So if a man *non sanae memoriae* kills another, although he has broken the words of the law, yet he has not broken the law because he had no memory or understanding, but meer ignorance which came to him by the hand of God." Stephen in his *Digest of the Criminal Law* (4th ed, 1887), Article 27, wrote "No act is a crime if the person who does it is at the time [insane within the meaning of the M'Naghten Rules]." If the act is not a crime, then the actor cannot be convicted of crime in any court.⁹

- 4.15 If the defence of insanity is only about absence of mens rea, then, amongst other consequences, the defence will not be available for crimes where no mens rea element need be proved (in other words, crimes of strict liability or negligence). The point was made by Wells in an article almost 30 years ago:

[Insanity negatives mens rea] if mens rea consists of a subjective mental element. Where it is an objective form of recklessness or negligence, or where there is a crime of strict liability, then the argument that it precludes mens rea breaks down.¹⁰

- 4.16 Despite this, in *DPP v Harper*¹¹ the High Court relied on *R v Horseferry Road Magistrates' Court, ex parte K*, and concluded that the defence is not available in respect of crimes of strict liability. This judgment has been cogently criticised by leading academics,¹² and we think it is mistaken.
- 4.17 In *ex parte K* the defendant was charged with affray and common assault, and argued that insanity is a defence in the magistrates' courts as much as in the Crown Court, even though the special verdict procedure¹³ applies only to trials in the Crown Court. The prosecution did not disagree.

⁹ J C Smith, "Criminal Law: Insanity - Available as Defence in Summary Trial" [1997] *Criminal Law Review* 129, 132, commenting on *R v Horseferry Road Magistrates' Court, ex p K* [1997] QB 23.

¹⁰ C Wells, "Whither Insanity?" [1983] *Criminal Law Review* 787, 794. The point is echoed by A Loughnan almost 30 years later: A Loughnan, *Manifest Madness* (2012) p 121.

¹¹ [1997] 1 WLR 1406.

¹² See paras 4.21 and 4.22 below.

¹³ On which, see para 2.93 above.

4.18 The court accepted as “clearly established” that the defence of insanity was available in all kinds of cases prior to 1800¹⁴ and agreed with defence counsel that subsequent statutory innovations did not affect the availability of the defence.

4.19 Defence counsel submitted:

[Insanity] is not a species of special defence but merely a particular situation where mens rea is lacking. Accordingly, it is available in all criminal charges where mens rea is in issue.

4.20 The editor of *Archbold News* noted that “the court (and indeed the respondents) seem to have accepted in their entirety [defence counsel’s] submissions for the applicant on the subject of insanity”.¹⁵ That is indeed the impression given, but the court in *ex parte K* did not actually discuss whether the defence was restricted to cases where mens rea is in issue. The case before it concerned a charge of assault, so one can understand why the magistrates in *Harper*, who relied on *ex parte K*, did not take the Divisional Court to be stating the law in respect of cases where there is no mental element.

4.21 Sir John Smith’s criticism of the court in *ex parte K* on this point is worth citing in full:

The court quotes *Archbold*, para 17–109, not entirely accurately, for the proposition that “insanity at the time of the alleged offence is merely a particular situation where *mens rea* is lacking,” and the applicant’s submission that “insanity is available as a defence to all criminal charges where *mens rea* is in issue.” These propositions should be read with caution. (i) The defence of insanity is not limited to a denial of the *mens rea* required by the definition of the crime. A person who had that *mens rea* may nevertheless have a defence on the ground that, because of a defect of reason from disease of the mind, he did not know what he was doing was wrong. (ii) In so far as it may imply that insanity cannot be a defence to a crime of strict liability, the second proposition is surely too narrow. Strict liability is sometimes imposed for offences punishable with imprisonment and a person who did not know the nature and quality of the act or know that it was wrong should surely have a defence.¹⁶

4.22 There is a further problem with the proposition in *Harper* that insanity is not a defence to an offence of strict liability: if a person is pleading insane automatism, is the defence permitted, or precluded, following *Harper*?¹⁷ Ward suggests three possible solutions: that *Harper* is *per incuriam*;¹⁸ that “the ‘insane automatism’ cases are concerned with the criteria for returning a special verdict and so do not

¹⁴ Whether this is in fact correct is open to question: see N Walker, letter, [1996] *Criminal Law Review* 844 and N Walker, *Crime and Insanity in England* (1968) vol 1, p 80.

¹⁵ “Insanity in Horseferry Road” (1996) 5 *Archbold News* 5.

¹⁶ “Criminal Law: Insanity - Available as Defence in Summary Trial” [1997] *Criminal Law Review* 129, 132 to 133.

¹⁷ T Ward, “Magistrates, Insanity and the Common Law” [1997] *Criminal Law Review* 796, 800.

¹⁸ In other words, a judgment which overlooked an important factor.

apply to magistrates' courts", or that insane automatism is a defence to strict liability offences but "other forms of insanity are not".¹⁹ Ward comments that there is no authority on this last point.

- 4.23 The first of these answers seems possible: the court in *Harper* did not benefit from hearing full argument and it was a decision made without awareness of earlier relevant authority. In particular no reference is made to *Hennessy*²⁰ where an accused who had suffered a hyperglycaemic episode had only been permitted to plead insanity, nor to *Isitt*²¹ where the defendant was tried on a charge of dangerous driving and there was no suggestion that a defence of insanity or automatism was not available.
- 4.24 With regard to the second possible answer, there is a difficulty with concluding that the "insane automatism" cases have no bearing on insanity in the magistrates' courts and that, as a result, a defence will succeed in the Crown Court but fail in the magistrates' courts. The difficulty is that while it may be appropriate for different *procedures* to be available in the different courts, it is not logical or just if the same mental state may not be relied on as a defence in one court when it could in another.
- 4.25 Fundamentally, if a defence of insanity is a denial of criminal responsibility, then the availability of the defence should not depend on whether there is a mens rea element to the offence.
- 4.26 This is not merely a technical point. Consider the following example. The accused is charged with the offence of causing a water discharge activity, in other words, polluting surface water²² which is a strict liability offence, punishable in the magistrates' courts by up to £50,000 and/or 12 months' imprisonment, and in the Crown Court by an unlimited fine/up to 5 years' imprisonment. The accused, who suffers from delusions, including that he has been entrusted by a supernatural power with the task of saving the world, pollutes the water because he believes he has been commanded to do so. If the insanity defence is only relevant to mens rea, then he would be held responsible and convicted.
- 4.27 *DPP v Harper* applies to summary proceedings only. If the prosecution were pursued in the Crown Court, the court could follow *DPP v Harper* on the basis that there is no obvious justification for a defence being available in the Crown Court but not in the magistrates' courts. Alternatively, the court could distinguish *DPP v Harper*.

¹⁹ T Ward, "Magistrates, Insanity and the Common Law" [1997] *Criminal Law Review* 796, 800.

²⁰ [1989] 1 WLR 287.

²¹ *Isitt* (1978) 67 Cr App Rep 44, 48, by Lawton LJ:

The position is that, in general, certainly with offences like dangerous driving, the Crown have to prove that the conduct which is alleged to be criminal was voluntary conduct, in the sense that the accused's mind went with the acts alleged to be criminal. If his mind for any reason did not go with the acts alleged to be criminal, then he cannot in law commit an offence.

²² Environmental Permitting (England and Wales) Regulations 2010, SI 2010 No 675, regs 38(1)(a) and 12(1)(b). We thank HHJ Atherton for this example.

- 4.28 The purpose of an environmental offence such as this is to protect public water, and some may argue that it is immaterial whether D is mentally disordered because public protection from the harm is sufficiently important for it to be right to punish a person who contravenes the Act, irrespective of their mental condition.
- 4.29 If, however, one takes the contrary view that it is unjust, and futile, to punish a person whose mental state is such that they could not have avoided doing what they did, then there is clearly a problem if *DPP v Harper* is followed. It is not an adequate answer to this particular example to say that prosecutorial discretion would prevent such a case from being prosecuted. It is irrelevant that a sentencing court would exercise its discretion when the person should not be convicted in the first place.

The relationship between the defence of insanity and automatism

- 4.30 The second problem in the current law lies in the relationship between insanity and automatism. We have described at paragraph 2.66 above how the case law distinguishes between “insane automatism” caused by an “internal” factor arising from a disease of the mind, and “sane automatism” caused by an external factor:

The distinction to be drawn is between a malfunctioning of the mind arising from some cause that is primarily internal to the accused, having its source in his psychological or emotional make-up, or in some organic pathology, as opposed to a malfunctioning of the mind which is the transient effect produced by some external factor such as, for example, concussion.²³

Thus the case law distinguishes, not between physical causes of “diseases of the mind” such as epilepsy, dementia, brain tumours or arteriosclerosis, and “diseases of the mind” due to “functional psychosis”,²⁴ but between external and internal causes.

- 4.31 Mackay and Mitchell argue that the distinction based on external factors was the result of the court wishing to avoid classification of a diabetic in a hypoglycaemic state as insane.²⁵ That may be so but, as they would argue, it is unsound to found a distinction between “sane” and “insane” automatism on a distinction between external and internal causes. It is notable that the courts in other common law jurisdictions have not adhered to the distinction.²⁶ The distinction

²³ *Rabey* (1977) 37 CCC (2d) 461, 477 to 478; [1980] 2 SCR 513, 519 to 520.

²⁴ W Wilson, I Ebrahim, P Fenwick and R Marks, “Violence, Sleepwalking and the Criminal Law: Part 2: The Legal Aspects” [2005] *Criminal Law Review* 614.

²⁵ R D Mackay and B J Mitchell, “Sleepwalking, Automatism and Insanity” [2006] *Criminal Law Review*, 901 with reference to *Quick* [1973] QB 910.

²⁶ The distinction has been called “artificial” by the Australian High Court (see *Falconer* (1990) 65 ALJR 20 at [30] described at paras C.83 to C.84 in Appx C).

makes illogical, hair-splitting distinctions inevitable, allowing some an outright acquittal while condemning others to plead guilty or take the risk of a special verdict.²⁷

- 4.32 As Wilson, Ebrahim, Fenwick and Marks point out, diabetics may suffer excessively high blood sugar or excessively low blood sugar, and both states may be caused by “external factors” (alcohol or insulin) or “internal factors” (lack of food or insufficient insulin). The distinction between external and internal causes of an automatic state makes no sense, and “the line drawn between sane and insane automatism can never make medical sense”.²⁸ As Ashworth has written:

There can be no sense in classifying hypoglycaemic states as automatism and hyperglycaemic states as insanity, when both states are so closely associated with such a common condition as diabetes. The difference in burdens of proof (prosecution must disprove automatism, defence must prove insanity) compounds the anomaly.²⁹

- 4.33 Moreover, with some conditions, *both* internal and external factors may operate simultaneously, as in sleepwalking, or hypnosis cases: some people are more susceptible to sleep disorders or to hypnosis, but then there may be an external trigger (an interruption to sleep, a suggestion from the hypnotist) which also plays a part in loss of capacity.

- 4.34 The unsound distinction between sane and insane automatism, based on whether the cause is internal or external, brings with it a number of difficulties. In summary, the distinction is arbitrary and leads to unfairness and decisions which are hard to reconcile. It amply justifies this statement by Mitchell and Mackay:

Surely, therefore, it is time for the English appellate courts, if given the opportunity, to re-evaluate ... and to adopt a more flexible approach, not only in sleepwalking cases, but in an overall consideration of the intractable problem of distinguishing between insane and sane automatism.³⁰

²⁷ W Wilson, I Ebrahim, P Fenwick and R Marks, “Violence, Sleepwalking and the Criminal Law: Part 2: The Legal Aspects” [2005] *Criminal Law Review* 614. See also Mackay (1995) p 36 and following. Hart described the distinction as “clumsy and complex”: *Punishment and Responsibility* (1968) p 253. See also G Williams, *Textbook of Criminal Law* (2nd ed 1983) p 671. Allen describes the distinction as “fatuous”: *Textbook on Criminal Law* (7th ed 2003) p 126. See also H Phoenix, “Automatism: A Fading Defence” [2010] 56 *Criminal Law Quarterly* 328, 343 and K Campbell, “Psychological Blow Automatism: A Narrow Defence” (1980-81) 233 *Criminal Law Quarterly* 342, 343.

²⁸ P Fenwick, “Automatism, Medicine and the Law” (1990) *Psychological Medicine, Monograph Supplement* 17, 23.

²⁹ *Principles of Criminal Law* p 94. As to the difference in burdens of proof, see para 2.79 above.

³⁰ R D Mackay and B J Mitchell, “Sleepwalking, Automatism and Insanity” [2006] *Criminal Law Review* 901, 905.

The problem of inadequate public protection

- 4.35 There is also a potential problem of public protection following an acquittal on the grounds of automatism which, we suggest, needs to be addressed. In some cases, the court has been influenced in its classification of a condition as caused by an internal factor or an external factor, by the desire to ensure that the court has adequate disposal powers to protect the public from recurrence of the conduct. This has, as we have explained above, led to odd and unjust results. The courts' concern is, however, an important one. It seems to us that the law would do better to take account of it in a different way: if there is a risk of recurrence and a risk that, if the condition does recur, harm will be caused, then perhaps a special verdict is desirable, and some kind of protective order should be possible.

The difficulty of distinguishing between the actus reus and the mens rea

- 4.36 In the Crown Court, for the verdict of not guilty by reason of insanity to be given, the prosecution must prove that the accused "did the act or made the omission".³¹ As we describe above,³² this means that the prosecution have to prove "the ingredients which constitute the actus reus",³³ and are not required to prove any mental element.³⁴
- 4.37 Distinctions between the actus reus and the mens rea cannot always easily be drawn. While in many cases it may be evident what constitutes the actus reus, in others it is not so obvious. For example, the state of mind of the accused may not be easy to disentangle from the actus reus where the actus reus realistically requires some awareness of the action (such as where a person possesses or keeps an item, or permits an activity)³⁵, or in an offence such as voyeurism contrary to section 67(1) of the Sexual Offences Act 2003.³⁶ We discussed this issue in our CP on fitness to plead.³⁷ It is even more relevant in cases of insanity because the defendant's state of mind *at the time of the alleged offence* is bound to be in issue if insanity is pleaded.
- 4.38 The case law acknowledges this difficulty but leaves it unresolved.³⁸ For example, in *R (Young) v Central Criminal Court*,³⁹ where the accused was charged with dishonestly concealing material facts,⁴⁰ Lord Justice Rose held that,

³¹ Trial of Lunatics Act 1883, s 2(1).

³² See para 2.96 above.

³³ *A-G's Reference (No 3 of 1998)* [2000] QB 401, 411.

³⁴ *Antoine* [2001] 1 AC 340, 345, [2000] 2 WLR 703.

³⁵ See the commentary by Sir John Smith at "Fitness to Plead: Offence of Dishonestly Concealing Material Facts" [2002] *Criminal Law Review* 588, 589.

³⁶ See *B* [2012] EWCA Crim 770 in which it was held at para [65] that, for the offence of voyeurism, the act is the "deliberate observation of another doing a private act where the observer does so for the specific purpose of the observer obtaining sexual gratification".

³⁷ CP 197, para 6.24 and following paras.

³⁸ In *R (Young) v Central Criminal Court* the trial judge noted, "this distinction cannot be rigidly adhered to in every case because of the diverse nature of criminal offences and criminal activity": [2002] EWHC 548 (Admin), [2002] 2 Cr App R 12 at [12], by Rose LJ.

³⁹ [2002] EWHC 548 (Admin), [2002] 2 Cr App R 12.

⁴⁰ Contrary to s 47(1) of the Financial Services Act 1986.

when considering whether he did the act or made the omission, the jury should “consider the intentions of the defendant not, of course, in relation to dishonesty, and not in relation to the purpose of making the representations, but his intention as one of the facts represented, according to the particulars of the offence, to those said to be the victims of his activity”.⁴¹ Mr Justice Leveson added that a consideration of whether the accused did the act or made the omission “must ... in the context of this case, go beyond purely physical acts. Indeed, the actus reus of this offence is far wider than that: as Lord Justice Rose has observed, it involves concealing a positive state of affairs, namely the nature of the fixed intention that the defendant had at the time.”⁴²

4.39 There is a risk of inconsistency in the application of the insanity defence across different cases because in some offences the actus reus contains a mental element.

4.40 The practical point at issue here is what the prosecution has to prove for there to be a verdict of not guilty by reason of insanity, and what difference it makes whether the mens rea needs to be proved for such a verdict to be given.

4.41 The problem is still more fundamental, as the following example illustrates. X has been planning a terrorist attack. Her brother, D, lives with her and is aware of her activities. D is seriously mentally unwell and does not tell the police about X’s plans. D is charged with an offence contrary to section 38B of the Terrorism Act 2000. Section 38B reads, so far as is material:

(1) This section applies where a person has information which he knows or believes might be of material assistance -

(a) in preventing the commission by another person of an act of terrorism, or

(b) in securing the apprehension, prosecution or conviction of another person, in the United Kingdom, for an offence involving the commission, preparation or instigation of an act of terrorism.

(2) The person commits an offence if he does not disclose the information as soon as reasonably practicable in accordance with subsection (3).

4.42 D pleads not guilty by reason of insanity, and it is accepted that at the time of the offence he was “insane” within the meaning of the M’Naghten Rules. What, then, is the actus reus? Is it having information and failing to disclose it, or is it having information and failing to disclose it while knowing or believing it might help prevent an act of terrorism? If the former is correct, then the prosecution need only prove that D had the information and did not disclose it, and D will face a hospital order. If it is the latter, then it is quite possible that the prosecution will not be able to prove D had the requisite knowledge or belief, and D will be acquitted. The current state of the law does not provide a clear answer.

⁴¹ [2002] EWHC 548 (Admin), [2002] 2 Cr App R 12 at [35].

⁴² [2002] EWHC 548 (Admin), [2002] 2 Cr App R 12 at [40].

- 4.43 This is not a problem which is confined to only a few offences. In recent years, a large number of offences have been created which blend a mental element into the actus reus and where this question would arise on a plea of not guilty by reason of insanity.⁴³
- 4.44 So far we have shown simply that it is not always possible to disentangle the actus reus from the mens rea, but there are three further complications which may arise: what needs to be proved where an accused person raises a defence; what needs to be proved in cases of secondary participation; and what needs to be proved where the charge is of an inchoate offence.
- 4.45 The difficulty becomes acute in the context of defences, many of which are inextricably linked with the elements of the offence which are in issue. This can result in unfairness where a mentally disordered defendant cannot call any objective evidence as to what happened. A defendant who was not pleading insanity would be entitled to adduce evidence of his own beliefs as to relevant facts;⁴⁴ a mentally disordered defendant could not do so.
- 4.46 The problem is also acute in cases of secondary participation where a person aids, abets, counsels or procures another to a criminal offence. It can be of particular importance in the context of murder cases because a person who is secondarily liable will receive the mandatory life sentence. At the very least, what the prosecution is required to prove to establish that the accused “did the act” varies according to the offence. At worst, the exclusion of evidence as to the accused’s subjective beliefs and thoughts at the time is unfair to the mentally disordered accused.⁴⁵
- 4.47 The same problems arise with inchoate (ie incomplete) offences of attempting to commit a crime, conspiring with another to commit a crime, and assisting or encouraging another to commit a crime. The actus reus of an inchoate offence may include conduct which is not in itself unlawful; the mental element makes it unlawful. For example, the actus reus for a charge of conspiracy is simply the agreement that a course of conduct is carried out. A defendant charged with conspiracy who pleads insanity faces difficulties. If all the prosecution need prove is the actus reus, there is a risk that an accused will be subject to a special verdict and the subject of a hospital order without a full offence having been proved against him or her.

⁴³ See CP 197, paras 6.28 and 6.29 for examples of such offences. See also *JB v DPP* [2012] EWHC 72 (Admin), (2012) 176 JP 97 in which the accused was charged with breach of an antisocial behaviour order contrary to s 1(10) of the Crime and Disorder Act 1998. The offence does not require proof of mens rea but there is a statutory defence of reasonable excuse. The court held that the offence did not require the prosecution to prove any mental element but that, if the accused raised the defence of reasonable excuse then his or her state of mind may be relevant to that issue.

⁴⁴ See *A-G’s Reference (No 3 of 1998)* [2000] QB 401 and *Antoine* [2001] 1 AC 340, 334 to 335, [2000] 2 WLR 703.

⁴⁵ *R v M (Witness Statement)* [2003] EWCA Crim 357, [2003] 2 Cr App R 21.

THE LAW IS OUT OF STEP WITH MODERN PSYCHIATRIC UNDERSTANDING

- 4.48 It is clear that the law is lagging behind psychiatric understanding. McAuley puts it as follows:

The psychiatric conception of serious mental illness cuts across the distinctions associated with the traditional interpretation of the M’Naghten Rules. Whereas that interpretation turns on a narrow concept of psychosis that is arbitrarily confined to cases of hallucination, on the one hand, and cases of complete moral illiteracy of a kind that precludes any awareness of the difference between right and wrong, on the other, the psychiatric conception is based on a criterion of “reality testing” that includes the inability to make sound judgments, ie to draw reasoned conclusions from the relevant available evidence as a prelude to action.⁴⁶

- 4.49 In fact, complaints that the M’Naghten Rules need to be brought into line with modern medical knowledge have been made for at least 60 years. In evidence to the Royal Commission on Capital Punishment (1949 – 1953) medical witnesses said that limiting the insanity defence to some cases of psychosis and severe and manifest mental and physical disorders was, “judged by modern clinical standards, a purely arbitrary limitation”.⁴⁷

- 4.50 More recently, the Government agreed with our recommendation that the law on diminished responsibility be updated and clarified to reflect developments in medical knowledge. It seems to us strongly arguable that the law on insanity ought also to be modern, clear, and in line with medical understanding. Experts would then be able to testify more clearly and confidently as to the existence or non-existence of a particular condition and its effects. There should also be a greater likelihood of agreement between experts if they are not having to translate a psychiatric condition into an outmoded legal concept.⁴⁸

“Defect of reason” is the wrong concept

- 4.51 A frequent criticism of the M’Naghten test is that it is based on an obsolete belief in the pre-eminent role of reason in controlling social behaviour. Critics have long argued that contemporary psychiatry and psychology stress that social behaviour is determined more by how a person has learned to behave than by what he or she knows or understands.⁴⁹ Insanity does not only, or even primarily, affect the cognitive or intellectual faculties, but the whole personality, including the will and the emotions. The M’Naghten Rules have never permitted the defendant’s emotional state of mind to be examined.

⁴⁶ McAuley p 38 (footnotes omitted).

⁴⁷ Royal Commission on Capital Punishment report, para 248. This report is discussed at paras D.6 to D.14 in Appx D.

⁴⁸ As Williams put it: “Because automatism is a legal concept, a psychiatrist should be asked to testify to the mental condition as psychiatrically recognised, not to ‘automatism’. It is for the judge to make the translation.” G Williams, *Textbook of Criminal Law* (2nd ed 1983) n 4, p 663.

⁴⁹ See the Butler report, para 18.14. This is discussed below at paras D.23 to D.40 in Appx D.

- 4.52 The legal concept of insanity is limited to cognitive disorders; emotional and volitional disorders are outside its scope.⁵⁰ This omission is odd: “emotions play such a large part in moral decisions that it would be unreasonable to dismiss disorders of the emotions as irrelevant to responsibility”.⁵¹ The omission of disorders which affect the individual’s ability to choose what to do or not do is also problematic.
- 4.53 A result is, as the Royal Commission on Capital Punishment commented, that “an insane person may therefore often know the nature and quality of his act and that it is wrong and forbidden by law, but yet commit it as a result of the mental disease”.⁵²

The test does not include a “volitional” element

- 4.54 The “volitional element” means the capacity to choose whether to do or not do something. It is sometimes referred to as “irresistible impulse” but we are not using that term because the crucial feature is the inability to prevent oneself controlling one’s physical actions, not whether the actions were impulsive or not.
- 4.55 An inability to control oneself as a result of a “disease of the mind” is not recognised in English law as a defence of insanity (though lack of self-control may be evidence that the M’Naghten test is satisfied).⁵³
- 4.56 This narrow construction of the defence has met with telling criticism from leading academics. As Ashworth notes, “some forms of mental disorder impair practical reasoning and the power of control over actions”. He argues from that premise that volitional failing “should clearly be recognized as part of a reformed mental disorder defence”.⁵⁴

“Disease of the mind” is not a psychiatric concept

- 4.57 The M’Naghten test requires the accused to be suffering from a “disease of the mind”. The kind of disorder that is relevant to criminal liability is not necessarily a disease. Judges give the phrase a more modern interpretation in practice: in the guidance given to judges on how to direct the jury “disease of the mind” is described as “an impairment of mental functioning caused by a medical condition”.⁵⁵

⁵⁰ This criticism was made at least as long ago as 1924 by Lord Darling: *Hansard* (HL), 15 May 1924, vol 57, col 447.

⁵¹ C Elliott, *The Rules of Insanity* (1996) p 115.

⁵² Royal Commission on Capital Punishment report, p 80.

⁵³ *A-G of South Australia v Brown* [1960] AC 432.

⁵⁴ *Principles of Criminal Law* p 145.

⁵⁵ Judicial Studies Board, *Crown Court Bench Book* (March 2010) p 327.

4.58 Interpretation of the phrase in the case law has resulted, as we have noted,⁵⁶ in conditions such as diabetes and epilepsy being treated in law as “diseases of the mind”. As Mackay has noted, “the manner in which the judiciary have interpreted ‘disease of the mind’ is largely governed by policy considerations, and has little or nothing to do with the practice of psychiatry”.⁵⁷ The fear of harm from a repetition of the “automatic” action also explains the references in the case law to a disease of the mind which “had manifested itself in violence”.⁵⁸ It seems odd to judge whether a particular mental state is caused by a disease of the mind with reference to whether it shows itself in violent actions, and this approach is perhaps therefore best explained by the courts’ desire to protect society from further risk.⁵⁹

The knowledge limb of the M’Naghten Rules

4.59 The M’Naghten Rules do not provide a defence for a person who understands what they are doing, but whose purpose in carrying out the act is wholly distorted by irrational thinking. For example, a person suffering from depression who kills “in unrealistic despair at the hopelessness of his situation”⁶⁰ would be denied the defence under the M’Naghten Rules. He or she would either be convicted of murder or, more likely, of manslaughter by reason of diminished responsibility. Similarly, a person whose delusion is based on real facts,⁶¹ or a person who kills in the belief he is carrying out divine instructions, will be denied the defence of insanity because he still knows the nature and quality of his act and that it is against the law; the fact that he believes the act is justified because of his delusions does not help him.⁶²

4.60 On one interpretation, “knowing the nature and quality of the act” should mean “the accused’s ability to evaluate his actions, including his reasons or motives for committing them and the consequences normally associated with them”.⁶³ In *Codère* the court took the contrary view.⁶⁴

4.61 In other jurisdictions the cognitive limb has been expanded to refer to an inability to *appreciate* the nature and quality of the act. See for example the Canadian Criminal Code at paragraph C.27 in Appendix C.

⁵⁶ See para 2.32 above.

⁵⁷ Mackay (1995) p 98. Compare Lord Denning’s remark that “any mental disorder that manifests itself in violence and is prone to recur is a disease of the mind”: *Bratty* [1963] AC 386, 412.

⁵⁸ *Burgess* [1991] 2 QB 92, 101, by Lord Lane CJ. See para 2.33 above. As Ashworth has written, the policy of protecting the public has driven the law’s understanding of what constitutes “insanity”: *Principles of Criminal Law* p 143.

⁵⁹ See para 2.33 above.

⁶⁰ McAuley, p 24.

⁶¹ McAuley, p 24.

⁶² If, however, the accused believed – mistakenly – that he was fending off an attack then, because the facts are to be taken as he believed them to be, he may rely on the defence.

⁶³ McAuley, p 30. In the civil context, a person is taken to be unable to make a decision for him or herself if he or she cannot make use of information relevant to that decision, which includes information about the reasonably foreseeable consequences of the decision or failing to make any decision: the 2005 Act, s 3.

⁶⁴ (1917) 12 Cr App Rep 21, 27.

The wrongfulness limb of the M’Naghten Rules

4.62 In *Windle*,⁶⁵ Lord Goddard interpreted the wrongfulness limb as meaning that if the accused knew that what he or she is doing was against the law, then the insanity defence is not available to the accused.⁶⁶ The effect has been “to close off the possibility of expanding the interpretation of the word ‘wrong’ ... to include situations where the accused’s mental disorder prevented him from realizing that his actions could not be rationally justified”.⁶⁷

4.63 The Butler Committee observed that:

Knowledge of the law is hardly an appropriate test on which to base ascription of responsibility to the mentally disordered. It is a very narrow ground of exemption since even persons who are grossly disturbed generally know that murder and arson are crimes.⁶⁸

4.64 More recently, in *Johnson* Lord Justice Latham said:

This area, however, is a notorious area for debate and quite rightly so. There is room for reconsideration of rules and, in particular, rules which have their genesis in the early years of the 19th century. But it does not seem to us that that debate is a debate which can properly take place before us at this level in this case.⁶⁹

We are in a position to debate this issue.

4.65 The interpretation of the wrongfulness limb in English law has been frequently criticised, and it is notable that other jurisdictions have developed in another direction.

The interpretation of the “wrongfulness” limb in other jurisdictions

4.66 In *Stapleton*⁷⁰ the High Court of Australia rejected the *Windle* approach and incorporated the notion of “morally wrong” into the M’Naghten test. The special verdict depends on whether the accused understood the nature of his or her act or knew his or her act was wrong “according to the ordinary standards adopted by reasonable men” even if he or she knew it was legally prohibited.⁷¹ The English Court of Appeal commented on the judgment in *Stapleton*:

⁶⁵ [1952] 2 QB 826.

⁶⁶ Mackay has criticised *Windle* because in it Lord Goddard relied on s 2(1) of the Trial of Lunatics Act 1883 to assist his interpretation, but as that provision is procedural, and about verdict and disposal, “why should it have any impact on how the M’Naghten Rules are interpreted?” R D Mackay, “Righting the Wrong? Some Observations on the Second Limb of the M’Naghten Rules” [2009] *Criminal Law Review* 80, 82.

⁶⁷ McAuley p 31.

⁶⁸ The Butler report, para 18.8.

⁶⁹ *Johnson* [2007] EWCA Crim 1978 at [24], [2008] *Criminal Law Review* 132.

⁷⁰ [1952] HCA 56, (1952) 86 CLR 358 at [29].

⁷¹ This formula was originally advanced much earlier by Dixon J in *Porter* (1933) 55 CLR 182.

The decision of the High Court in Australia is, undoubtedly, a highly persuasive judgment as one would expect. It contains illuminating passages indicating the difficulties and internal inconsistencies which can arise from the application of the M'Naghten Rules, particularly if the decision in *Windle* is correct.⁷²

4.67 The decision in *Stapleton* is, however, subject to criticism. It is not obvious why an inability to engage in moral reasoning should exculpate an individual from criminal responsibility when he or she is still capable of knowing and understanding that his or her conduct is contrary to law.⁷³

4.68 A similar evolution to that in Australia took place in Canada. In the Supreme Court case of *Chaulk*, on the *Windle* point, the majority held:

In considering the capacity of a person to know whether an act is one that he ought or ought not to do, the inquiry cannot terminate with the discovery that the accused knew that the act was contrary to the formal law. A person may well be aware that an act is contrary to law but, by reason of “natural imbecility” or disease of the mind, is at the same time incapable of knowing that the act is morally wrong in the circumstances according to the moral standards of society.⁷⁴

4.69 Justice McLachlin and Justice L’Heureux-Dubé⁷⁵ accepted that Lord Goddard had probably gone too far when he said that knowing that an act is legally wrong is the only relevant aspect of wrongness, but they concluded, contrary to the view of the majority:

That it does not matter whether the capacity relates to legal wrongness or moral wrongness – all that is required is that the accused be capable of knowing that the act was in some sense “wrong”. If the accused has this capacity, then it is neither unfair nor unjust to submit the accused to criminal responsibility and penal sanction.

4.70 The interpretation of “wrong” arose again in the Supreme Court of Canada a few years later, in *Oommen*.⁷⁶ The defendant was charged with murder. There was no dispute that he had killed the victim and that he done so as a result of his insane delusions. He had the general capacity to tell right from wrong, but argued that his actions were justified, due to his paranoid beliefs. The legal test to be applied, for the defence of insanity to succeed, was contained in section 16(1) of the Canadian Criminal Code:

⁷² *Johnson* [2007] EWCA Crim 1978 at [21], [2008] *Criminal Law Review* 132.

⁷³ See the comments of the New Zealand Law Commission in *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 5.6.

⁷⁴ Lamer CJ giving judgment on behalf also of Dickson CJ, LaForest and Cory JJ in *Chaulk* [1990] 3 SCR 1303. Wilson J agreed on this point.

⁷⁵ With whom Sopinka J agreed on this point.

⁷⁶ [1994] 2 SCR 507.

No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

4.71 The Supreme Court asked itself:

What is meant by the phrase “knowing that [the act] was wrong” in s 16(1)? Does it refer only to abstract knowledge that the act of killing would be viewed as wrong by society? Or does it extend to the inability to rationally apply knowledge of right and wrong and hence to conclude that the act in question is one which one ought not to do?⁷⁷

4.72 The court concluded that the defendant’s awareness of “wrongfulness” must be considered in relation to the specific act alleged, and that being aware that it is wrong means being aware that it is something he or she ought not to do.⁷⁸

4.73 The court was seeking to avoid making the defence available to a person who, because of a psychopathic inability to feel empathy in a way that most people do, is unable to appreciate that his actions cannot be justified. The court was confident that the psychopath who sees his act as justified because he has a “deviant moral code” is not one who has lost the ability to decide rationally whether an act is right or wrong: “such a person is capable of knowing that his or her acts are wrong in the eyes of society and, despite such knowledge, chooses to commit them”.⁷⁹ As Mackay has commented:

This is an important judgment as it reflects much more accurately the true nature of the distorted thought processes of those whose psychiatric disorders impact on their capacity to know right from wrong.⁸⁰

⁷⁷ *Oommen* [1994] 2 SCR 507.

⁷⁸ *Oommen* [1994] 2 SCR 507. As it happens, it is also possible to derive this interpretation from the judgment of Tindal CJ in *M’Naghten*.

⁷⁹ *Oommen* [1994] 2 SCR 507.

⁸⁰ R D Mackay, “Righting the Wrong? Some Observations on the Second Limb of the M’Naghten Rules” [2009] *Criminal Law Review* 80, 85.

Conclusion

- 4.74 English law has adopted an unusually, and unjustifiably, narrow interpretation of the “wrongfulness” limb. McAuley suggests that “there is a compelling case for reformulating the rule in a way that does not depend on the contentious concepts of whether the accused ‘knew’ the ‘nature and quality’ of his act or that it was ‘wrong’”.⁸¹ The NZLC has questioned why this limb is needed or justified at all. It commented, in its recent report, “it is still not clear why incapacity to reason *morally* is necessarily the right test for determining when it is not proper to hold the person responsible”.⁸² This is a question to address when considering what capacities ought to form part of a reformed defence.

THE GAP BETWEEN LAW AND PRACTICE

- 4.75 It appears that the legal tests which medical professionals are required to apply are at odds with their professional understanding of psychiatry. It is therefore unsurprising that in practice, those professionals apply variants of the M’Naghten Rules.

- 4.76 In 1995 Mackay observed that:

The “wrongness” limb is not only more frequently used than the “nature and quality” limb but also seems to be applied in cases where the accused believed that what they were doing was morally right. Why is this? Could it be that judges and juries simply consider such mentally ill persons to be “crazy”?⁸³

- 4.77 His empirical research indicates that in practice the law as stated in *Windle* is ignored and “the wrongness issue [is] being interpreted widely/liberally”.⁸⁴ Specifically, he has summarised the research as showing that:

In many of the reports the “wrongness” limb was interpreted to cover whether the defendant thought his/her actions were legally/morally justified, and/or whether the actions were in perceived self defence of themselves or others, in the sense of protecting their physical or spiritual well-being. This once more supports the fact that the question many psychiatrists are addressing is “if the delusion that the defendant was experiencing at the time of the offence was in fact reality, then would the defendant’s actions be justified?” – rather than the narrow cognitive test favoured by the law.⁸⁵

⁸¹ McAuley p 39.

⁸² NZLC, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 5.8 (emphasis in original).

⁸³ Mackay (1995) p 90.

⁸⁴ R D Mackay, “Righting the Wrong? Some Observations on the Second Limb of the M’Naghten Rules” [2009] *Criminal Law Review* 80, 83, citing studies referred to in Part 3 above.

⁸⁵ R D Mackay and others, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 406 to 407.

THE LABEL OF INSANITY

- 4.78 The verdict of “not guilty by reason of insanity” is an inaccurate, unfair and stigmatising label. Some leading academic lawyers have gone as far as to say that the effect of the current law is that “a schizophrenic may not be insane, but a diabetic is. It is a conclusion only a lawyer could reach”.⁸⁶
- 4.79 It is not merely a matter of the law seeming out of date: it is not accurate to apply a term denoting madness to a person who has epilepsy, or diabetes, nor is it fair. Ashworth has referred to “the gross unfairness of labelling these people [those whose behaviour stems from epilepsy, somnambulism and hyperglycaemia] as insane in order to ensure that the court has the power to take measures of social defence against them”.⁸⁷
- 4.80 It has long been recognised that the verdict of not guilty by reason of insanity carries a significant stigma. Respondents to our consultation paper on partial defences to murder confirmed the widely held view that, “the stigma which attaches to being labelled ‘insane’ makes defendants reluctant to plead insanity”.⁸⁸
- 4.81 In *Sullivan* Lord Diplock was uncomfortable labelling an epileptic “insane”. He said:
- It is natural to feel reluctant to attach the label of insanity to a sufferer from psychomotor epilepsy of the kind to which Mr Sullivan was subject, even though the expression in the context of a special verdict of “not guilty by reason of insanity” is a technical one which includes a purely temporary and intermittent suspension of the mental faculties of reason, memory and understanding resulting from the occurrence of an epileptic fit.⁸⁹
- 4.82 More than one writer has made comments to the effect that “it might be preferable to be criminalized and maintain one’s free will than to be psychiatrized and lose it”.⁹⁰

⁸⁶ *Simester and Sullivan’s Criminal Law* p 712.

⁸⁷ *Principles of Criminal Law* p 143. About 400,000 people in England and Wales have been diagnosed as having epilepsy (source: Epilepsy Action). Around 2.5 million people in England and Wales have diabetes: <http://www.diabetes.org.uk/Professionals/Publications-reports-and-resources/Reports-statistics-and-case-studies/Reports/Diabetes-prevalence-2010/> (last visited 15 Mar 2012).

⁸⁸ Judge Advocate Camp; Assistant Judge Advocate General; Silber J; R D Mackay, respondents to Partial Defences to Murder (2003) Law Commission Consultation Paper 173.

⁸⁹ *Sullivan* [1984] AC 156, 173. With respect, it was the application of the test in the M’Naghten Rules which was the source of the difficulty, not the inclusion of the label in the various statutes which gave the courts power to deal with someone who had been found not guilty by reason of insanity.

⁹⁰ J Peay, “Mentally Disordered Offenders, Mental Health, and Crime” in M Maguire, R Morgan and R Reine, *The Oxford Handbook of Criminology* (eds) (4th ed 2007) p 502, referring to R Porter, “Is Mental Illness Inevitably Stigmatizing?” p 6 in A Crisp (ed) *Every Family in the Land* (2004).

Conclusion

- 4.83 There may be some merit in the view that any label connoting irrationality is going to be stigmatising, and that this is, therefore, an inevitable consequence of an insanity defence with a special verdict. However, this does not seem to us to be a justification for retaining the current label of “insane”. We have already noted that it is particularly inappropriate for people with conditions such as epilepsy or diabetes.

THE DEFENCE IS UNDERUSED

To avoid stigma

- 4.84 We have noted in Part 3 above how little the defence is used. We suggest that the significant stigma involved deters insanity pleas. There is an important practical consequence of the inappropriate label of the insanity defence: people who ought to be able to rely on the defence do not try to rely on it but prefer to plead guilty, in order to avoid the stigma.⁹¹
- 4.85 When those who successfully pleaded insanity were automatically subject to a hospital order, defendants who might have pleaded insanity were deterred from entering that plea. Faced with the prospect of indefinite detention in a psychiatric facility,⁹² they tended to prefer the risk of a standard criminal penalty. Although the range of disposals on a special verdict is now more flexible, “the label ‘insane’ remains profoundly unattractive to persons afflicted with mental illness and others within the scope of the defence, as is any prospect of an indefinite stay in a special hospital. Accordingly, many defendants whose condition may as a matter of law provide a good defence of insanity choose instead to plead guilty or defend themselves on other grounds.”⁹³

For other reasons

- 4.86 We are aware of cases where it is hard to understand why the defence of insanity was not relied on. One example is *England*⁹⁴ where the accused was charged with doing an act tending and intended to pervert the course of justice (she had made a false complaint of rape) even though “the appellant’s mind may not fully have accompanied her acts because of the dissociative state from which she was suffering”.⁹⁵

⁹¹ As occurred in *Hennessy* [1989] 1 WLR 287; *DPP v Desmond* [2006] IESC 25; and *Sullivan* [1984] AC 156. In *Sullivan* the accused had kicked a man while suffering an epileptic fit. His plea of non-insane automatism was removed from the jury, following which the defendant preferred to plead guilty. See the NHS Information Centre’s 2011 report *Attitudes to Mental Illness*: http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20act/Mental_illness_report.pdf (last visited 15 Mar 2012).

⁹² Prior to the introduction of a wider range of disposals by the 1991 Act. See para 4.4 above.

⁹³ *Simester and Sullivan’s Criminal Law* p 701.

⁹⁴ See also *Makinson* [2010] EWCA Crim 889.

⁹⁵ *England* [2010] EWCA Crim 1408 at [17], [2011] 1 Cr App (S) 51.

- 4.87 We are also aware of a case⁹⁶ where the defendant had pleaded insanity, and the prosecution had accepted expert evidence, but the prosecution sought to proceed as if the defendant were fully culpable. This suggests a lack of full understanding of the foundation of a plea of not guilty by reason of insanity.
- 4.88 It seems wrong also that a court might collude in accepting a guilty plea when aware from medical reports that the plea should perhaps be one of not guilty by reason of insanity.

SHOULD THE DEFENDANT BEAR THE BURDEN OF PROVING INSANITY?

- 4.89 The general principle in English criminal law is that the prosecution bears the burden of proving the defendant's guilt beyond reasonable doubt. This entails proving each element of the offence charged and rebutting defences raised. The defence of insanity contains an exception to this fundamental tenet: sanity is presumed, and the burden of proving insanity lies on the defendant. The relevant standard of proof is the civil standard of proof, meaning that the defendant must prove on the balance of probabilities that he or she is insane.
- 4.90 The placing of the burden on the defendant has been the subject of critical comment. Sir John Smith put it succinctly:

The general rule requires the prosecution in an offence requiring *mens rea* to prove that the defendant did know the nature and quality of his act, the insanity rule requires him to prove (on the balance of probabilities) that he did not know it. Both rules cannot be right, but the English courts have never faced up to this problem.⁹⁷

- 4.91 At the very least, there is a tension:

As things stand, no English court has addressed the tension between the burden of proof in insanity and the usual requirement for the prosecution to prove a voluntary act and *mens rea* attributable to D.⁹⁸

- 4.92 Placing the burden of proof on the defendant may also be criticised because doing so contradicts the presumption of innocence. In brief, this means that placing the burden of proof on the defendant allows for the possibility that a jury will convict even though it is not sure that the accused was sane at the time.
- 4.93 If placing the burden of proof on the defendant does infringe the presumption of innocence, then it is also possible that the law is in breach of article 6(2) of the ECHR. We discuss this issue in Part 5 below.⁹⁹

⁹⁶ This case is from CPS files on cases which were not proceeded with. We are grateful to the CPS for allowing us access to those files.

⁹⁷ J C Smith, case comment on *Thomas*: "Defence of Insanity - Whether Appropriate for Judge to Leave Defence of Insanity to Jury Against the Wishes of the Defendant" [1995] *Criminal Law Review* 314, 316. Jones notes that this point has been made many times: T Jones, "The Burden of Proof on the Accused" (1995) 111 *Law Quarterly Review* 475, 484.

⁹⁸ *Simester and Sullivan's Criminal Law* p 706.

⁹⁹ See paras 5.42 to 5.59 below.

Additional difficulties with the burden of proof and sane automatism

- 4.94 If automatism is in issue, then the burden of disproving automatism lies on the prosecution. If insanity is in issue, then the burden of proving insanity lies on the defendant (on the balance of probabilities). If both automatism and insanity are in issue – which might be quite rare – the directions to the jury as to who has to prove what, and to what standard, are complicated. As Jones has pointed out, the existence of two different burdens of proof and different standards of proof generates

considerable scope for confusion (and judicial error)... Accepting that there is a “great distinction” between the two burdens, there is no doubt “an easy opportunity for argument on the correctness of the trial judge’s instructions” when both burdens are at issue in the same case.¹⁰⁰

- 4.95 Mr Justice Devlin commented, in *Hill v Baxter*, “As automatism is akin to insanity in law there would be great practical advantage if the burden of proof was the same in both cases”.¹⁰¹ Indeed, but this is not the position in the law as it stands.

THE LAW MAY LEAD TO BREACHES OF THE ECHR

- 4.96 We explore this issue in detail in Part 5 below. In summary, it appears that in practice there is a risk that the rights of an offender with mental illness and/or learning disabilities arising under articles 2, 3 and 8 may be breached as a result of imprisonment. Equally the rights of victims under articles 2 and 8 may be breached if the system of law does not make it possible to deal appropriately with dangerous offenders. We also provisionally conclude that the imposition of the burden of proof of the defence on the defendant breaches article 6 of the Convention, though we acknowledge that there is some weak European Commission of Human Rights case law against this view.

THE LAW HAS A POTENTIALLY UNFAIR IMPACT ON PEOPLE WITH MENTAL DISORDER

- 4.97 At this point we ask whether the defence of insanity, in its current form, leads to an unfair impact on people with mental disorder.¹⁰² We consider this question in relation to adults and children, starting with adults.

¹⁰⁰ T Jones, “The Burden of Proof on the Accused” (1995) 111 *Law Quarterly Review* 475, 482 (footnotes omitted).

¹⁰¹ *Hill v Baxter* [1958] 1 QB 277, 285.

¹⁰² See McAuley, p 23. See also this comment by Mackay: The courts “adopted an extremely narrow cognitive approach towards the rules, ensuring that their application would be restricted to fundamental or extreme intellectual defects”: that a consequence of the unwillingness to plead insanity may be inadequate protection of mentally disordered offenders: Mackay (1995) p 97 relying on *Codère* and *Windle*. See paras 2.36 to 2.42 above.

Adults

- 4.98 On the face of it, a defence of criminal insanity which seeks to exculpate those who suffer from a mental disorder protects those people from the rigours of the criminal law. If, however, that defence is so narrowly or defectively drawn that some of those people cannot avail themselves of it and if the mental disorders suffered by those people amount to a disability, then there is an unfair impact on them. That could amount to unfair indirect discrimination against people with a mental disorder. We now examine this claim.
- 4.99 The right of a person with a disability not to be discriminated against can be found in domestic legislation¹⁰³ and in international instruments.¹⁰⁴ There are also statements of the right not to be discriminated against which are specifically applicable to people with mental disorder.¹⁰⁵ We focus particularly on the prohibition on indirect discrimination in the Equality Act 2010.

Indirect discrimination against people with disabilities

- 4.100 Section 19 prohibits indirect discrimination:

(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.

(2) For the purposes of subsection (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if—

(a) A applies, or would apply, it to persons with whom B does not share the characteristic,

(b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,

(c) it puts, or would put, B at that disadvantage, and

(d) A cannot show it to be a proportionate means of achieving a legitimate aim.

¹⁰³ Direct discrimination because of a protected characteristic (or a combination of protected characteristics) is prohibited by s 13 of the Equality Act 2010 and indirect discrimination by s 19, and discrimination on grounds of disability is specifically prohibited by s 15. "Protected characteristics" include disability and age.

¹⁰⁴ A free-standing right not to be discriminated against is also found in the EU Charter of Fundamental Rights at art 20 – "Everyone is equal before the law" – and art 21. The Charter is part of EU law and is therefore applicable when member states act within the scope of EU law. The UK has both signed and ratified the UN Convention on the Rights of Persons with Disabilities and a right for people with disabilities not to be discriminated against is clearly stated in art 5 of that Convention. There is a positive duty on states to make this right effective in art 4. See also art 14 of the Convention. On the relationship between the UN Convention and the ECHR, see *R (NM) v London Borough of Islington* [2012] EWHC 414 (Admin), [2012] 2 All ER 1245.

¹⁰⁵ Council of Europe Recommendation Rec (2004) 10, concerning the protection of the rights and dignity of persons with mental disorder, art 3. It is not directly enforceable.

The relevant characteristics for the purposes of section 19 are age; disability; gender reassignment; marriage and civil partnership; race; religion or belief; sex; and sexual orientation.

4.101 Disability is defined at section 6:

(1) A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect¹⁰⁶ on P's ability to carry out normal day-to-day activities.

(2) A reference to a disabled person is a reference to a person who has a disability.

(3) In relation to the protected characteristic of disability—

(a) a reference to a person who has a particular protected characteristic is a reference to a person who has a particular disability;

(b) a reference to persons who share a protected characteristic is a reference to persons who have the same disability.

4.102 The wording at section (6)(1) is very close to the equivalent provision in the Disability Discrimination Act 1995, which preceded the Equality Act 2010. Of that provision, Jacobson and Talbot wrote:

This definition is sufficiently broad to encompass learning, developmental or behavioural disorders that tend not to be classed as disabilities, such as autism, attention deficit hyperactive disorder (ADHD), speech and language difficulties, and dyslexia.¹⁰⁷

4.103 Some people with learning disabilities and/or learning difficulties will fall within section 6. Some kinds of mental disorder, such as diagnosed depression, will also fall within this definition of disability.¹⁰⁸ By virtue of regulations made under the Equality Act 2010, addiction to any substance does not count as an impairment within section 6,¹⁰⁹ and nor do tendencies to do particular acts (such as to steal or to physically or sexually abuse other people).¹¹⁰

¹⁰⁶ On the meaning of “long-term effect”, see para 2 of Sch 1 to the Equality Act 2010.

¹⁰⁷ J Jacobson and J Talbot, *Vulnerable Defendants in the Criminal Courts* (Prison Reform Trust, 2009) p 10.

¹⁰⁸ Paragraph 675 of the Explanatory Notes to the Equality Act 2010.

¹⁰⁹ Equality Act 2010 (Disability) Regulations 2010, reg 3. SI 2010 No 2128.

¹¹⁰ Equality Act 2010 (Disability) Regulations 2010, reg 4. SI 2010 No 2128.

4.104 The next question to ask is whether, because of the current interpretation of M’Naghten, a person with a disability within the meaning of section 6 is put at a disadvantage, as compared with a person without a disability. It seems to us that in some cases, this is indeed the result. We believe that a person with a disability who is not able to plead insanity is at a particular disadvantage compared to the person without a disability who is unable to plead insanity. The disabled person who cannot plead insanity will face additional hardships in securing parole (and may therefore end up serving a longer sentence). We note the view of the Joint Committee on Human Rights in its report “A Life Like Any Other”:

The evidence which we have received on the treatment of people with learning disabilities in prison and their inability to secure equal access to parole, raises one of the most serious issues in our inquiry. We are deeply concerned that this evidence indicates that, because of a failure to provide for their needs, people with learning disabilities may serve longer custodial sentences than others convicted of comparable crimes. This clearly engages Article 5 ECHR (right to liberty) and Article 14 (enjoyment of ECHR rights without discrimination). It is also an area that falls within the Prison Service’s responsibilities under the Disability Equality Duty.¹¹¹

4.105 The Government responded that its policy is not to discriminate against disabled prisoners in any aspect of prison life, and it described steps taken to try and make this policy effective.¹¹²

4.106 A different example is that of someone who receives an Indeterminate Sentence for Public Protection (“IPP”)¹¹³ but who is too disordered to engage in the reform programmes required before they can be released, as described by an Independent Monitoring Board:

[An older] man is withdrawn and unable to look after himself. He almost certainly has an organic dementia. He is an IPP prisoner who is quite unable to cooperate in any courses even if they were available and this means that he will remain in prison indefinitely unless somebody intervenes. Before sentencing he was known to social services because he was neglecting himself. The board is so concerned about him that we have written to the minister.¹¹⁴

¹¹¹ Joint Committee on Human Rights *A Life Like Any Other* (2008) HL 40-1 HC 73-1 para 215.

¹¹² See pp 19 to 20 of the Government response to the Joint Committee report, Department of Health (2008) Cm 7378.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_084613.pdf (last visited 2 Feb 2011).

¹¹³ This is a sentence which can be imposed for some violent or sexual offences. The prisoner can be detained after the tariff period (set by the sentencing judge) has expired. Attendance on offending behaviour courses is likely to have an effect on the risk assessment of the prisoner, and thus an effect on recommendations for release.

¹¹⁴ View of an Independent Monitoring Board, cited in K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009) p 6.

- 4.107 We doubt that any pilot or policy would make it possible for the man in the above excerpt to take part in courses which he needs before he can be released, because of his mental condition. The same Independent Monitoring Board also described this case:

The other example is an 80-year-old confused man who also is unable to look after himself. We do not yet know whether he was known to social services but it seems likely. He has a five-year sentence for indecent exposure which is not surprising since he continually takes his clothes off.

- 4.108 The Board concluded, “Neither of these men should be in prison”. We agree, and moreover, it seems to us that the criminal law does not adequately provide for a defence of non-responsibility for people with these kinds of conditions.

Double impact: on children with disabilities

- 4.109 We now ask the same question of children with mental illness and/or learning disabilities: does the way in which the insanity defence is framed have the result that a child with a mental illness and/or learning disabilities is put at an unfair disadvantage?
- 4.110 The first point to make is that the insanity defence is rarely relied on by a child or young person, and this may be in part because mental illness is not often diagnosed before late adolescence. Learning disabilities are, however, identified in many young offenders.¹¹⁵
- 4.111 The fundamental justification for an insanity defence is, as we have seen, the individual’s incapacity to appreciate what he or she is doing or that he or she ought not to do it. There is no recognition in the law that a person might not understand the nature and quality of the act or its wrongfulness due to developmental immaturity, rather than to any disease of the mind. It follows that a child may be convicted though he or she did not understand what he or she was doing.
- 4.112 We question whether the insanity defence caters adequately for children who, *due to mental illness and/or learning disabilities*, do not understand what they are doing and/or that what they are doing is wrong. It is possible that the M’Naghten test, being devised for adults, is simply inappropriate for children and young people. Alternatively, it could be that the failure lies in practice rather than in the legal definition.

¹¹⁵ See Part 3, n 37 above.

4.113 As far as we are aware, the insanity defence is rarely raised in the magistrates' courts, and even less frequently in the youth courts. The range of possible outcomes following a verdict of not guilty by reason of insanity may be part of the reason that it is not raised.¹¹⁶ It seems that the M'Naghten test simply does not cater for children and young people with a reduced ability to understand or appreciate or control their actions, or is simply not thought to be applicable.

4.114 Turning to the *impact* on mentally disordered children, the way the insanity defence is currently framed means that children with learning difficulties and learning disabilities will be unable (and/or unlikely) to plead insanity successfully, as will a child without these disabilities. However, as a recent report of research into the views of 208 Youth Offending Team staff indicates, the child with these difficulties/disabilities may be more likely to receive a custodial sentence and so is at a particular disadvantage compared to the child without this disability:

Participants said that children with mental health problems and ADHD were five times more likely to receive a custodial sentence than children without such impairments; that children with learning disabilities were around two and a half times more likely to receive a custodial sentence; and that children on the autistic spectrum were around twice as likely to receive a custodial sentence.¹¹⁷

4.115 It does therefore seem that the M'Naghten test may in practice result in indirect discrimination against children with disabilities, contrary to the Equality Act 2010. A child with learning difficulties and/or learning disabilities may not plead the insanity defence, and the combination of his or her immaturity and mental disorder might lead to an outcome which is detrimental to his or her wellbeing in a way that would not happen to an adult without a mental disorder.

¹¹⁶ In the magistrates' courts, and in the youth courts (a branch of the magistrates' courts), if a person is not guilty by reason of insanity then there is a straightforward acquittal. There is no "special verdict" as there would be in the Crown Court, and so the special powers of disposal which the Crown Court has are inapplicable in the youth court.

¹¹⁷ J Talbot, *Seen and Heard* (Prison Reform Trust, 2010) p 52. The research was a questionnaire of youth offending team staff and the results are their opinions as to how likely it is that these children will get custodial sentences.

CONCLUSION

There are serious defects in the current law

- 4.116 The rationale of the defence is not reflected in the M’Naghten Rules, and the case law generates anomalies. There is the risk of breaches of the ECHR. The mismatch between the legal test and modern psychiatry is striking and the law is not applied in practice. The defence is little used, in part no doubt because of its inaccurate, unfair and stigmatising label. Some defendants may refuse to plead “not guilty by reason of insanity” because of the stigmatising effect. Because of the narrowness of the legal definition of insanity, some people are not able to plead not guilty by reason of insanity even though, in principle, they ought not to be held criminally responsible. Some of these people also may well be convicted when they should not be. The net result is that the test does not fairly identify those who ought not to be held criminally responsible as a result of their mental condition, and so some of those vulnerable people remain in the penal system, to their detriment.

Why these defects matter

- 4.117 In the first place, it is clearly undesirable for the law to contain contradictions, to be unclear and out of date, and potentially to lead to breaches of the ECHR.
- 4.118 Secondly, for those who are convicted when they ought to be exempted from criminal responsibility, the mere fact of being unfairly convicted matters irrespective of the penalty, for reasons we have set out in Part 1.¹¹⁸
- 4.119 When it comes to the issue of punishment, there is particular reason for being concerned about the effect of a custodial sentence on a person who is mentally disordered because “penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners”.¹¹⁹ Prison or a Young Offenders Institute is not necessarily an appropriate place for people who are mentally ill.¹²⁰ There is a legal principle of equivalence of care, which means that a person who is in custody is entitled to the same health treatment as a person who is not in custody,¹²¹ but this is not necessarily what happens in practice. At worst, if a mentally disordered person is imprisoned without appropriate treatment for the disorder, a breach of article 2 or article 3 is a possible outcome.¹²²

¹¹⁸ See paras 1.20 onwards above.

¹¹⁹ World Health Organisation, *Statement of Trenčín of 2007*: http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf (last visited 23 Nov 2011). See also para 5.70 below.

¹²⁰ For a case where being placed in prison at least contributed to a deterioration in the offender’s mental health, and the Court of Appeal advised caution if it was planned to transfer the offender back to prison from hospital, see *Makinson* [2010] EWCA Crim 889 at [21]. Some prisoners may be transferred from hospital to prison: see paras A.62 to A.67 in Appx A.

¹²¹ See para 5.70 below.

¹²² These are the rights to life and not to be subject to torture or to inhuman or degrading treatment respectively. See paras 5.64 to 5.71 and 5.72 to 5.79 below respectively.

- 4.120 It therefore seems to us that it is highly likely that the insanity defence is defective both as a matter of theory and in the way it works in practice. The result is that people with serious mental health problems are sometimes inappropriately incarcerated in prison (as opposed to in a suitable mental health facility). As respected legal commentators have written:

The position is hardly satisfactory. The high incidence of mentally disordered persons in the prison population who should be receiving treatment for their condition demonstrates that, for mentally disordered offenders, the criminal justice system is failing both in terms of the justice to individual defendants and in terms of health and social policy.¹²³

But is change better than no change?

- 4.121 The NZLC recently concluded that in their jurisdiction the insanity defence “is workable, in spite of its flaws”,¹²⁴ and they preferred not to recommend any change. (The insanity defence in New Zealand is not identical to the English defence.) The NZLC relied quite heavily on a 1994 account of the impact of change in various US jurisdictions, and on targeted informal consultation (no consultation paper or working paper was published prior to the report).
- 4.122 We have also noted US research which tends to indicate that, whatever form the insanity defence takes, the jury will interpret it to mean what they think it ought to mean (rather like the psychiatrists in Mackay’s research) and reach their own judgments. This is, however, irrelevant if the test is so narrowly and inaccurately drawn that defendants do not try to rely on it at all.

Calls for reform

- 4.123 We were reminded of the failings of the insanity defence by comments made in response to our consultation paper on partial defences to murder which referred to “the out-dated nature of the insanity defence”.¹²⁵
- 4.124 There has long been academic criticism of this area of the law. We have cited some of it in this Part.
- 4.125 We are far from the first body to reach this conclusion. Various bodies before us have examined the legal defence of insanity and concluded that it should be reformed. Many of their criticisms and recommendations are still pertinent. Over fifty years ago the Royal Commission on Capital Punishment stated:

¹²³ *Simester and Sullivan’s Criminal Law* pp 701 to 702 (footnote omitted).

¹²⁴ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 6.5.

¹²⁵ *Partial Defences to Murder* (2004) Law Com No 290(2) para 5.22.

When the gap between the natural meaning of the law and the sense in which it is commonly applied has for so long been so wide, it is impossible to escape the conclusion that an amendment of the law, to bring it into closer conformity with the current practice, is long over due.¹²⁶

The case for reform is even more compelling now.

¹²⁶ Royal Commission on Capital Punishment report, para 295.

PART 5

COMPATIBILITY OF THE INSANITY DEFENCE WITH THE EUROPEAN CONVENTION ON HUMAN RIGHTS

- 5.1 In this Part we assess the compatibility of the criminal law of England and Wales governing insanity with the European Convention on Human Rights and Fundamental Freedoms (“the ECHR”). Several articles of the ECHR require examination. There is the question of whether detention of an “insane” person might be in breach of article 5, which governs the lawfulness of detention. We do not think English law is in breach of article 5. Article 6 contains the right to a fair trial, a constituent part of which is the presumption of innocence (article 6(2)), and we consider whether the requirement for the defendant to prove his or her defence of insanity violates article 6(2); in our view it does.
- 5.2 We then note the positive duties on the state to preserve life and to ensure respect for a person’s private life, contained in articles 2 and 8 respectively, and how they bear on the state’s duty to protect the public.
- 5.3 We consider how the imprisonment of mentally ill offenders in normal prison facilities may raise issues of compatibility under articles 2, 3 and 8. This position may be exacerbated by inadequate mechanisms for diversion from the criminal justice system at an early stage.
- 5.4 With regard to the state’s duty under articles 2, 3 and 8 to potential victims and to prisoners we conclude that there is the risk of a breach due, in part, to the state of the insanity defence. The risk of breach would decrease if the defence was reformed to allow a special verdict for those whose medical condition meant that they should not be held criminally responsible, thus opening the way for non-penal disposal powers.

ARTICLE 5

- 5.5 Article 5 of the ECHR contains an exhaustive list of the circumstances in which a person may lawfully be deprived of his or her liberty. Article 5(1)(e) is pertinent to people suffering from mental disorder. It provides for the lawful detention of a person of “unsound mind” even though he or she has not been convicted of an offence:

Article 5

Everyone has the right to liberty and security of the person. No one may be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law

(1)(e) the lawful detention ... of persons of unsound mind

- 5.6 Article 5(1)(e) is engaged when the state detains an individual who has been found not guilty by reason of insanity. Article 5(1)(a) deals with lawful detention of a person after conviction by a competent court. That is not relevant where a

person has been found not guilty by reason of insanity, because he or she has not been convicted of any offence.¹

- 5.7 The purpose of lawful detention under article 5(1)(e) has been stated by the European Court of Human Rights (“ECtHR”) to be in part for public safety, and in some cases, in the interests of the person detained.²

“Persons of unsound mind”

- 5.8 The phrase “unsound mind” is not defined in the Convention. The ECtHR has said that the term:

is not one that can be given a definitive interpretation: ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society’s attitudes to mental illness change, in particular so that a greater understanding of the problems of mental patients is becoming more widespread.³

- 5.9 The court has, however, stated that article 5(1)(e) “obviously cannot be taken as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society”.⁴

Lawful detention under 5(1)(e)

- 5.10 Lawful detention is detention that is in accordance with domestic law and which conforms to the purpose of the restrictions on liberty permitted by article 5(1)(e).⁵ Compliance with national law is not sufficient: the domestic law must itself comply with the ECHR such that any deprivation of liberty is “in keeping with the purpose of protecting the individual from arbitrariness”.⁶

- 5.11 The ECtHR established significant principles of interpretation of article 5(1)(e) in *Winterwerp v The Netherlands*. It said:

There must be no element of arbitrariness; ... no one can be confined as “a person of unsound mind” in the absence of medical evidence establishing that his mental state is such as to justify his compulsory hospitalisation

¹ Where a person has been convicted but is also found to be suffering from mental disorder justifying a hospital order, both arts 5(1)(a) and 5(1)(e) may be relevant. See, eg, *Johnson v UK* (1999) 27 EHRR 296 (App No 22520/93) at [58].

² *Guzzardi v Italy* (1980) 3 EHRR 333 (App No 7367/76) at [98].

³ *Winterwerp v The Netherlands* (1979) 2 EHRR 387 (App No 6301/73) at [37].

⁴ *Winterwerp v The Netherlands* (1979) 2 EHRR 387 (App No 6301/73) at [37].

⁵ *Grant* [2001] EWCA Crim 2611, [2002] QB 1030 at [22] to [23].

⁶ *Haidn v Germany* App No 6587/04 at [80]. See also *Johnson v UK* (1997) 27 EHRR 296 (App No 22520/93) at [60] and *Litwa v Poland* (2000) 33 EHRR 1267 (App No 26629/95) at [73] and [78].

In the court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind". The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder⁷

- 5.12 Lawfulness of detention under article 5 depends also on appropriateness of the place where the person is detained having regard to the grounds for his or her detention.⁸ Under article 5(1)(e) it is the fact that the person is "of unsound mind" which justifies detention, and it therefore follows that the place where he or she is held should be suitable, namely a "hospital, clinic or other appropriate institution".⁹

The three essential features of lawful detention¹⁰

OBJECTIVE MEDICAL EXPERTISE

- 5.13 The first of the features of lawful detention set out in *Winterwerp* – that the individual must reliably be shown to be of unsound mind – requires "objective medical expertise".
- 5.14 In English law, until 2004, if the defendant was found not guilty by reason of insanity for an offence with a sentence fixed by law,¹¹ the court was obliged to make a hospital order irrespective of the defendant's medical opinion. This led to

⁷ *Winterwerp v The Netherlands* A 33 (1979) 2 EHRR 387 (App No 6301/73) at [39]. See also *Shtukurov v Russia* (2012) 54 EHRR 27 (App No 44009/05) at [115].

⁸ In *Aerts v Belgium*, the applicant had been charged with an offence but found to be severely mentally disturbed. He was held on a psychiatric wing of a prison, but not transferred to a suitable psychiatric institution as he should have been according to a decision by the domestic court. The Government argued that his detention was nevertheless compliant with art 5(1)(e) because the psychiatric wing of the prison was appropriate. The ECtHR concluded, referring to *Ashingdane v UK* (1985) 7 EHRR 528 (App No 8225/78) at [44], that in the particular case "the proper relationship between the aim of the detention and the conditions in which it took place was ... deficient": *Aerts v Belgium* (1998) 29 EHRR 50 (App Nos 61/1997/845/1051) at [49]. See also *OH v Germany* App No 4646/08 at [87] to [91], though note the dissenting judgment of Judge Zupančič in which he questions the assumption that all those of "unsound mind" "belong in psychiatric hospitals".

⁹ *Aerts v Belgium* (1998) 29 EHRR 50 (App Nos 61/1997/845/1051) at [46]; *Ashingdane v UK* (1985) 7 EHRR 528 (App No 8225/78) at [44].

¹⁰ *Winterwerp v Netherlands* (1979) 2 EHRR 387 (App No 6301/73) at [39].

¹¹ This includes murder, but it is not certain what other offences are caught by the expression "fixed by law". Para 92 of the explanatory notes and para 12 of the Government circular to the 2004 Act (Home Office, "The Domestic Violence, Crime and Victims Act 2004: Provisions for Unfitness to Plead and Insanity" (2005) Circular 24/2005) refer to murder as an offence for which the sentence is fixed by law, but to no other offence. Although custodial sentences for certain drugs and firearms offences with a minimum fixed term could, arguably, also fall within the definition of "sentences fixed by law", s 174(3) of the Criminal Justice Act 2003 refers to an offence with such a sentence in a way which suggests that it does not fall within the category of an offence the sentence for which is fixed by law.

a possible incompatibility with article 5(1)(e), but this problem has been remedied by the 2004 Act amendment of the 1964 Act.

- 5.15 The present position is that if the accused was found not guilty by reason of insanity, a hospital order can only be made if that defendant could have been made subject to a hospital order under section 37 of the 1983 Act even without the special verdict. The effect of section 37 is that a hospital order cannot be made without evidence from two registered medical practitioners that the offender is suffering from a mental disorder of a nature and degree that makes detention in hospital appropriate. At least one of the medical practitioners must be duly approved under section 12 as having special experience in the diagnosis or treatment of mental disorder.
- 5.16 Therefore, any detention in hospital following a special verdict under section 5 of the 1964 Act (as substituted) must be on the basis of “objective medical expertise” as required under article 5(1)(e).
- 5.17 While it is clear that objective medical expertise is needed to protect against arbitrary detention, arguments arise on the question of what kind of expert evidence is required, and the degree to which the court must follow the expert view.

Who must provide expert evidence to support a hospital order?

- 5.18 A wider range of practitioners are now able to carry out many of the functions under the 1983 Act that used to be reserved to responsible medical officers.¹² The Joint Committee on Human Rights raised concerns about this, particularly over the Government’s view that objective medical expertise “means relevant medical expertise, and not necessarily that of a registered medical practitioner”. On the Government’s view this could extend, for example, to evidence from a psychologist with the relevant skills and ability to identify the presence of a mental disorder.¹³ The Joint Committee disagreed with this broad interpretation, emphasising that the ECtHR had given “every indication ... that objective medical expertise involved reports from psychiatrists who are doctors” and that “the opinion of a medical expert who is a psychiatrist is necessary for a lawful detention on grounds of unsoundness of mind”.¹⁴ The Committee was, of course, taking account of a broad range of functions in the Act, while we are focusing on one function.

¹² The 2007 Act replaced the role of “responsible medical officer” with that of “responsible clinician”. Responsible medical officers were in practice usually consultant psychiatrists, whereas the responsible clinician, who has overall responsibility for a patient’s case, can be any practitioner who has been approved for that purpose. See Joint Committee on Human Rights, *Legislative Scrutiny: Mental Health Bill*, Fourth Report of Session 2006-07, HL Paper 40, HC 288.

¹³ Above, para 23. See also para 6 of the “Further Statement” by the UK <https://wcd.coe.int/com.instranet.InstraServlet?Command=com.instranet.CmdBlobGet&DocId=763898&SecMode=1&Admin=0&Usage=2&InstranetImage=1025689> (last visited 15 Mar 2012) in relation to arts 20 and 24 of Recommendation Rec 2004(10) of the Council of Europe.

¹⁴ Above, para 26: see [48].

- 5.19 The Joint Committee relied on the case of *Varbanov v Bulgaria*¹⁵ where the ECtHR said that “no deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with article 5(1)(e) of the Convention if it has been ordered without seeking the opinion of a medical expert”. The court went on to say that “in the absence of an assessment by a psychiatrist” there was no justification for the applicant’s detention. In the circumstances of the case, the applicant’s detention had been ordered by a prosecutor without even seeking a medical opinion in a situation where there was no emergency.¹⁶ It was alleged that the applicant was suffering from mental illness so the appropriate expertise in that case would have been that of a psychiatrist. The court did not discuss whether a different kind of expertise would be acceptable in relation to a different kind of mental disorder.
- 5.20 Jones argues that it is likely that the courts would support the Government’s view that “it is for national authorities to decide which professionals possess the required expertise to perform the functions under the Act as this is a matter which is likely to come within the ‘margin of appreciation’ that the court allows national authorities to have when applying the Convention”.¹⁷
- 5.21 A decision of the Court of Appeal (Civil Division) also points in the same direction. In *G v E*,¹⁸ E appealed against a decision of the Court of Protection in relation to care arrangements to move him from his foster care home to a residential unit under the provisions of the 2005 Act. E suffered from severe learning disabilities arising from a rare genetic physical condition (tuberous sclerosis) and lacked capacity within the meaning of the 2005 Act. The Court of Appeal considered that “credible expert evidence upon which the court [could] be satisfied that the individual concerned lacks capacity” was required, but the relevant expert did not have to be a psychiatrist.¹⁹ The appeal was dismissed.

Conclusion

- 5.22 In light of *Varbanov v Bulgaria* and *G v E*, we agree with Richard Jones. For a hospital order to be made under section 37 of the 1983 Act in conformity with article 5(1)(e) expert evidence is needed, but not necessarily that of a psychiatrist.

Is the court required to follow the expert evidence?

- 5.23 Some commentators question whether the court should be required to follow the advice given by the experts rather than merely receive it.²⁰ Sutherland and Gearty, for example, suggest that although objective medical expertise is

¹⁵ App No 31365/96 at [47].

¹⁶ The court acknowledged, at para [47] that it “may be acceptable, in urgent cases or where a person is arrested because of his violent behaviour, that such an opinion be obtained immediately after the arrest”.

¹⁷ R Jones, *Mental Health Act Manual* (13th ed 2010) para 1–280.

¹⁸ [2010] EWCA Civ 822, [2010] 4 All ER 579.

¹⁹ [2010] EWCA Civ 822 [2010] 4 All ER 579 at [60] and [61].

²⁰ See B Emmerson, A Ashworth and A Macdonald, *Human Rights and Criminal Justice* (2nd ed 2007) para 11–26.

required in English courts, it is not conclusive as to the verdict, and this in itself leads to a potential incompatibility with article 5(1)(e).²¹ Ashworth's view is that the medical evidence could be accorded more weight than under the restrictive M'Naghten test.²²

5.24 We have considered whether there is a prospect of a criminal court making decisions on disposal going against the weight of the expert evidence about a person found not guilty by reason of insanity. In order to make a hospital order under section 37 of the 1983 Act, the court must be "satisfied on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder, ... that the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him". In addition, the court must be of the opinion "having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section". A court could not therefore lawfully make a hospital order without expert evidence to this effect.

5.25 We have also considered the situation where the medical opinion is in favour of a hospital order but the court exercises its discretion and makes a different order instead. The court could not, in these circumstances, impose a prison sentence because the person found not guilty by reason of insanity has not been convicted of any offence. The only way in which he or she might be detained is by the making of a hospital order, and if the court declines to make one, there is no breach of article 5(1)(e). It may be that there is a difficulty in relation to compatibility with article 5(1)(e) where the accused has been convicted of an offence, but this is not a question we consider in the context of this project.

OF A KIND OR DEGREE WARRANTING COMPULSORY CONFINEMENT

5.26 The second essential feature of lawful detention identified in *Winterwerp* is that the mental disorder must be of a kind or degree warranting compulsory confinement. The ECtHR held, in *Reid v United Kingdom*, that article 5(1)(e) does not require detention in hospital to be conditional on the mental disorder being of a nature or degree amenable to medical treatment.²³ Instead, the court emphasised that its case law refers to a person "being properly established as

²¹ P Sutherland and C Gearty, "Insanity and the European Court of Human Rights" [1992] *Criminal Law Review* 418, 423.

²² *Principles of Criminal Law* p 144, citing E Baker, "Human Rights, M'Naghten and the 1991 Act" [1991] *Criminal Law Review* 84.

²³ *Reid v UK* (2003) 37 EHRR 9 (App No 50272/99) at [51]. Section 17 of the Mental Health (Scotland) Act 1984 provided that where the mental disorder is one which is manifested only by abnormally aggressive or seriously irresponsible conduct (ie a psychopathic or anti-social personality disorder), a person could only be detained where "medical treatment was likely to alleviate or prevent a deterioration of his condition". On the facts, the applicant, who was suffering from a form of psychopathic personality disorder, had benefited from a hospital environment, even though his condition was not perceived as being curable or susceptible to treatment. His detention was therefore justified.

suffering from a mental disorder of a degree warranting compulsory confinement”.²⁴

5.27 Moreover, the court went on to state that confinement may be necessary not only where a person needs treatment to cure or alleviate his or her condition, “but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons”.²⁵

5.28 It is also worth noting the comment of the ECtHR that:

The detention of an individual is such a serious measure that it is only justified where other, less severe measures, have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained.²⁶

THE VALIDITY OF CONTINUED CONFINEMENT DEPENDS UPON THE PERSISTENCE OF SUCH A DISORDER: RELEASE AND REVIEW

5.29 The third essential feature of lawful detention identified in *Winterwerp* is the persistence of the disorder which warranted the original detention. Article 5(4) of the Convention provides that:

Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.²⁷

5.30 The combined effect of articles 5(1) and 5(4) is that, in the words of Lord Bingham:

A person of unsound mind compulsorily detained in hospital should have access to a court with power to decide whether the detention is lawful and, if not, to order his release.²⁸

5.31 A person who after a special verdict is detained in hospital pursuant to a hospital order without a restriction order may be discharged by his or her responsible clinician. He or she may also apply to a tribunal for discharge. If a restriction order is attached to the hospital order then he or she may still apply to the tribunal but may only be discharged by the responsible clinician with the consent of the Secretary of State.²⁹

5.32 Where the patient in detention continues to suffer from the mental disorder, this third criterion under article 5 will be met, even if he or she could be released with

²⁴ *Reid v UK* (2003) 37 EHRR 9 (App No 50272/99) at [51].

²⁵ *Reid v UK* (2003) 37 EHRR 9 (App No 50272/99) at [51].

²⁶ *Varbanov v Bulgaria* App No 31365/96 at [46].

²⁷ The United Kingdom has also accepted art 25 of Recommendation Rec (2004) 10 of the Council of Europe which is to similar effect.

²⁸ *R v Secretary of State, ex p IH* [2003] UKHL 59, [2004] 2 AC 253 at [26].

²⁹ See para A.82 in Appx A.

conditions to manage the disorder.³⁰ By contrast in *Johnson v United Kingdom*³¹ the patient's disorder did not persist, and he argued that from the point when he ceased to suffer from the mental illness which led to his committal to psychiatric hospital, he should have been unconditionally released. The ECtHR did not entirely adopt that view. It said, rather, that:

It does not automatically follow from a finding by an expert authority that the mental disorder which justified a patient's compulsory confinement no longer persists, that the latter must be immediately and unconditionally released.

Such a rigid approach to the interpretation of that condition would place an unacceptable degree of constraint on the responsible authority's exercise of judgement to determine in particular cases and on the basis of all the relevant circumstances whether the interests of the patient and the community into which he is to be released would in fact be best served by this course of action.³²

5.33 The court accepted that the state should be able to exercise some degree of supervision over a person on release. In addition, in some circumstances the condition which the state would wish to impose on the person if released, justifies delaying the person's release. However, the court went on:

It is however of paramount importance that appropriate safeguards are in place so as to ensure that any deferral of discharge is consonant with the purpose of article 5(1) and with the aim of the restriction in sub-paragraph (e) and, in particular, that discharge is not unreasonably delayed.³³

³⁰ *Kolanis v UK* (2006) 42 EHRR 12 (App No 517/02). The applicant contended that, because release on particular conditions was contemplated by the Mental Health Review Tribunal, the fact that the conditions could not be met was not relevant and her detention was unlawful.

³¹ *Johnson v UK* (1999) 27 EHRR 296 (App No 22520/93).

³² *Johnson v UK* (1999) 27 EHRR 296 (App No 22520/93) at [61].

³³ *Johnson v UK* (1999) 27 EHRR 296 (App No 22520/93) at [63]. If it is delayed, there may be a breach of arts 5(1) and (4), as in *R (RA) v Secretary of State* [2002] EWHC 1618 (Admin), [2003] 1 WLR 330.

Compatibility with article 5(1)(e)

The M’Naghten test and article 5

- 5.34 The issue of the compatibility of the insanity test itself with article 5(1)(e) was canvassed in the Royal Court in Jersey.³⁴ It was argued that the M’Naghten Rules were incompatible with article 5(1)(e) and the Bailiff thought it “strongly arguable” that adopting the M’Naghten Rules would involve a breach of article 5.³⁵ It was held that the M’Naghten Rules do not apply in that jurisdiction. This authority is, however, of limited weight in considering the compatibility of English law for several reasons: first, because it is not an authority on the application of the M’Naghten Rules; secondly, because of the legislative changes which have been made in English law since it was decided,³⁶ thirdly because the Bailiff of Guernsey reached the opposite conclusion,³⁷ and lastly because on appeal the position adopted by the Bailiff of Jersey was doubted by the Court of Appeal in Jersey.³⁸
- 5.35 There is clearly a difficulty with the fact that English law classifies people as “insane” who would not be regarded as “insane” by psychiatrists. As Sutherland and Gearty have written, “sleep-walkers, along with epileptics, diabetics (when in a state of ‘hyperglycaemia’) and other defendants on the fringes of the M’Naghten Rules, remain eligible for the inappropriate label, ‘legally insane’”.³⁹ This inappropriate classification is a difficulty for the defence itself, but article 5 of the ECHR is concerned not with classification or labelling but with grounds for detention. The domestic law permits detention in a hospital following a verdict of not guilty by reason of insanity in accordance with section 37 of the 1983 Act,⁴⁰ and so we now consider whether there is a problem of compatibility of the power of detention with article 5.

Detention and article 5(1)(e)

- 5.36 Lawful detention under article 5(1)(e) requires, as we have noted, objective evidence of mental disorder of a kind or degree warranting compulsory

³⁴ *A-G v Prior* [2001] Jersey Law Reports 146. Mackay and Gearty noted in 2001 that English law permitted detention of a person where he or she was of “unsound mind” at the time of the offence, even though the mental disorder may not persist, whereas for detention to be justified under art 5(1)(e) the person must be of unsound mind at the time of detention. *Varbanov v Bulgaria* App No 31365/96 cited at p 561 of R D Mackay and C Gearty, “On Being Insane in Jersey: Part 1 – the Case of *Attorney-General v Jason Prior*” [2001] *Criminal Law Review* 560. Following subsequent statutory amendments by the 2004 Act, the making of a hospital order is now tied, by statute, to circumstances where s 37 of the 1983 Act are satisfied, and s 37 requires the court to be satisfied that the offender *is* suffering from mental disorder, so this potential incompatibility no longer exists.

³⁵ *A-G v Prior* [2001] Jersey Law Reports 146, 158.

³⁶ The 2004 Act amended the 1964 Act so that a hospital order can only be made following a verdict of not guilty by reason of insanity (namely, under s 5 of the 1964 Act) where a hospital order could be made under s 37 of the 1983 Act.

³⁷ See paras C.70 to C.73 in Appx C.

³⁸ [2002] Jersey Law Reports 11, 21. *A-G v Prior* remains the test for insanity in Jersey: *Simao v A-G* [2005] Jersey Law Reports 374 at [23].

³⁹ P Sutherland and C Gearty, “Insanity and the European Court of Human Rights” [1992] *Criminal Law Review* 418, 419 (footnotes omitted).

⁴⁰ Applied to people found not guilty by reason of insanity by virtue of s 5 of the 1964 Act.

confinement. We have also noted that a special verdict of not guilty by reason of insanity does not automatically lead to detention in a hospital, and detention is governed by sections 37 and 41 of the 1983 Act rather than by the M’Naghten test itself. However, a special verdict does act as a gateway to detention under the 1983 Act and the fact that such a verdict may be given in respect of a person who is not “insane” in a psychiatric sense means that the issue of compatibility needs close examination.

- 5.37 Some academics have expressed concern that for the insanity defence to include individuals whose defect of reason was caused by a physical condition is in breach of article 5.⁴¹
- 5.38 If a person is found not guilty by reason of insanity, it is true that he or she may be suffering from a medical condition but not be of unsound mind. The risk is said to be, therefore, that a person who is not of unsound mind, but who is nevertheless treated as such by falling within the M’Naghten Rules, might be detained in a secure hospital, which would be in breach of article 5(1)(e).
- 5.39 There are two factors which need to be taken into account in assessing how likely such an outcome would be. First, the courts must not act in contravention of article 5.⁴² Secondly, section 37 of the 1983 Act must be satisfied before the court can make a hospital order because a “hospital order” made after a verdict of not guilty by reason of insanity has the meaning given by that provision.⁴³ Section 37(1) specifies that the conditions in section 37(2) must be met in order for a hospital order to be made.⁴⁴ If, therefore, the condition is not one which falls within the defined meaning of “mental disorder”, the court has no power to order detention in a hospital. The issue of compatibility therefore depends on the interpretation of “mental disorder”.
- 5.40 Mental disorder is defined as “any disorder or disability of the mind”.⁴⁵ At first glance, a learning disability, which is defined as a “state of arrested or incomplete development of the brain which includes significant impairment of intelligence and social functioning”,⁴⁶ is a “mental disorder” within section 1 of the 1983 Act. However, a person with a learning disability is not to be treated as mentally disordered for the purposes of certain provisions of the 1983 Act, including

⁴¹ *Principles of Criminal Law* pp 144 to 145; R D Mackay and C Gearty, “On Being Insane in Jersey: Part 1 – The Case of *Attorney General v Jason Prior*” [2001] *Criminal Law Review* 560, 561. See also B Emmerson, A Ashworth and A Macdonald, *Human Rights and Criminal Justice* (2nd ed 2007) para 11–24.

⁴² Human Rights Act 1998, s 6.

⁴³ Section 5(4) of the 1964 Act as inserted by s 24(1) of the 2004 Act.

⁴⁴ Section 37 is set out at para 2.85 above.

⁴⁵ Section 1(2) of the 1983 Act. “Dependence on alcohol or drugs” is not a disorder or disability of the mind for the purpose of the 1983 Act. The exclusion does not prevent a person being categorised as mentally disordered if, in addition to their dependency on alcohol or drugs, he or she is suffering from an unrelated mental disorder, or a mental disorder which arises from dependency on alcohol or drugs or withdrawal from alcohol or drugs. See the Department of Health, *Code of Practice: Mental Health Act 1983* (2008) at para 3.10; explanatory notes to the 2007 Act at paras 26 to 27.

⁴⁶ See s 1(4) of the 1983 Act, as inserted by s 2(3) of the 2007 Act.

section 37,⁴⁷ “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct”.⁴⁸ Therefore, if a person is found not guilty by reason of insanity based on his learning disability, there will not be power to make a hospital order unless the disability is associated with abnormally aggressive or seriously irresponsible conduct.

CONCLUSION

- 5.41 It is true that a person found not guilty by reason of insanity is liable to be detained if the court is satisfied following expert medical evidence that the conditions of section 37(2) are met. If the disorder is not a disorder of the mind, then the detention would be unlawful. The possibility arises because of the defective concept of “insanity” in the common law. It seems to us, however, that there is little risk in practice of a detention which is incompatible with article 5(1)(e) because of the factors outlined at paragraph 5.39 above. There is nevertheless force in Ashworth’s point that “it would be best if the defence of insanity itself were reformed sensibly before piecemeal challenges are mounted under the Human Rights Act”.⁴⁹

ARTICLE 6

- 5.42 Article 6 establishes an accused’s right to a fair trial. One of the constituent elements of fairness is the presumption of innocence, as stated in article 6(2): “everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law”.⁵⁰ Article 6(2) is concerned with procedural matters and the way in which an offence may be proved.⁵¹
- 5.43 At common law a defendant is presumed sane.⁵² If the defence raises insanity, the accused bears the burden of rebutting the presumption of sanity and proving on the balance of probabilities that he or she was “insane” within the meaning of the M’Naghten test at the time of his or her relevant conduct.⁵³ The insanity defence therefore entails the common law exception to the general principle that the prosecution is required to prove all elements of the offence and disprove all defences.⁵⁴

⁴⁷ Section 1(2A) of the 1983 Act applies in relation to civil admission under ss 2 and 3. It also applies in relation to provisions concerning mentally disordered offenders: remand for reports or treatment (ss 35 and 36); hospital orders and interim hospital orders (ss 37 and 38); hospital and limitation directions (s 45A); and transfer directions (ss 47 and 48).

⁴⁸ By virtue of s 1(2A) of the 1983 Act, inserted by s 2(2) of the 2007 Act.

⁴⁹ *Principles of Criminal Law* p 145.

⁵⁰ The same presumption is stated at art 14(2) of the International Covenant on Civil and Political Rights (1977) Cmnd 6702.

⁵¹ As opposed to substantive elements of an offence: *R v G* [2008] UKHL 37, [2009] AC 92 at [27]. This was also the view of the ECtHR: *G v UK* App No 37334/08. See also P Roberts, “The Presumption of Innocence Brought Home? *Kebilene* Deconstructed” [2002] 118 *Law Quarterly Review* 41, 48.

⁵² See para 2.20 above.

⁵³ *Smith* (1910) 6 Cr App R 19; *Woolmington v DPP* [1935] AC 462.

⁵⁴ Following *Woolmington v DPP* [1935] AC 462.

- 5.44 The argument that placing the burden of proof on the defendant breaches the presumption of innocence runs like this (as put by Jones):

Insanity precludes a finding of guilt. The current law functions in such a way as to allow the sanity of the accused to be presumed rather than his or her insanity disproved beyond a reasonable doubt by the prosecution, and ... since there is a persuasive onus on the accused to prove insanity (that is, “in effect to require him to establish his innocence”)⁵⁵ on the balance of probabilities, it is possible for there to be a conviction despite the presence of a reasonable doubt as to the guilt of the accused.⁵⁶

- 5.45 In this section we concentrate solely on the question of whether English law is incompatible with article 6(2) of the ECHR.⁵⁷

Is Article 6(2) engaged?

- 5.46 The first question is whether this common law reversal of the burden of proof engages article 6(2) at all. On one view the defence of insanity is concerned with the presumption of sanity rather than the presumption of innocence. This was the position taken by the European Commission of Human Rights in *H v United Kingdom*.⁵⁸ The Commission dismissed as manifestly ill-founded the applicant’s submission that the insanity exception contravened article 6(2). The Commission concluded that the rule did “not concern the presumption of innocence, as such, but the presumption of sanity”. With respect, it seems to us relatively clear that the need for the defendant to prove that he or she is insane engages the presumption of innocence – as set out in the words of Jones above – and so we do not find the reasons of the Commission persuasive.

If it is engaged, is it infringed?

- 5.47 The second question which arises is whether, if article 6(2) is engaged, a court would hold that the obligation on the defendant to prove insanity breaches article 6(2). The approach to be taken in deciding whether a reverse presumption is justified in a particular case is as described by Lord Carswell:

Where the question arises, it has to be determined, first, whether it is fair and reasonable in the achievement of a proper statutory objective for the state to deprive the defendant of the protection normally guaranteed by the presumption of innocence whereby the burden of proof is placed upon the prosecution to prove beyond reasonable doubt all the matters in issue. Secondly, one must determine whether the exception is proportionate, that is to say, whether it goes no further than is reasonably necessary to achieve that objective.⁵⁹

⁵⁵ *Davies v United States* (1895) 160 US 469, 487, by Harlan J.

⁵⁶ T Jones, “Insanity, Automatism, and the Burden of Proof on the Accused” [1995] 111 *Law Quarterly Review* 475, 488 (footnote in original).

⁵⁷ Discussed in S Trechsel, *Human Rights in Criminal Proceedings* (2005) pp 167 to 168.

⁵⁸ *H v UK* App No 15023/89 (Commission decision) (unreported).

⁵⁹ *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 264, 323.

5.48 The leading ECtHR authority on the presumption of innocence and the reverse burden of proof is *Salabiaku v France* where the court stated:

Presumptions of fact or of law operate in every legal system. Clearly, the Convention does not prohibit such presumptions in principle. It does, however, require the contracting states to remain within certain limits in this respect as regards criminal law. ... Article 6(2) does not therefore regard presumptions of fact or of law provided for in the criminal law with indifference. It requires states to confine them within reasonable limits which take into account the importance of what is at stake and maintain the rights of the defence.⁶⁰

5.49 Thus “the derogation from the presumption of innocence requires justification”.⁶¹ Lord Hope held in *Kebilene* that the case law of the European Commission and the ECtHR show that “although article 6(2) is in absolute terms, it is not regarded as imposing an absolute prohibition on reverse onus clauses, whether they be evidential (presumptions of fact) or persuasive (presumptions of law). In each case the question will be whether the presumption is within reasonable limits.”⁶²

5.50 In *H v United Kingdom*, above, the European Commission of Human Rights went on to say that it did not consider that requiring the defence to present evidence concerning the accused’s mental health at the time of the alleged offence, constituted an infringement of the presumption of innocence. As the requirement was not unreasonable or arbitrary there was no violation of article 6(2).

5.51 Jones comments that the decision in *H v United Kingdom* “is both superficial and unconvincing”.⁶³ With respect, we agree. First, the Commission seemed to confuse an evidential burden with a requirement to prove a fact.⁶⁴ Secondly, it extrapolated too much from *Salabiaku*: in that case the ECtHR considered a particular provision in the French Customs Code and, most importantly, the way in which it had been applied in a particular case. Hence its conclusion that “in this instance the French courts did not apply article 392(1) of the Customs Code in a

⁶⁰ *Salabiaku v France* (1988) 13 EHRR 379 (App No 10589/83) at [28]. The decision has been criticised academically and judicially. See, eg, P Roberts, “The Presumption of Innocence Brought Home? *Kebilene* Deconstructed” [2002] 118 *Law Quarterly Review* 41, 59; and *Barnfather v London Borough of Islington* [2003] EWHC 418 (Admin), [2003] 1 WLR 2318.

⁶¹ *Johnstone* [2003] UKHL 28, [2003] 1 WLR 1736 at [48].

⁶² *DPP ex p Kebilene* [2000] 2 AC 326, 385. See also Lord Nicholls of Birkenhead in *Johnstone* [2003] UKHL 28, [2003] 1 WLR 1736 at [48]: “a reasonable balance has to be held between the public interest and the interests of the individual”, and *Janosevic v Sweden* in which the ECtHR said that “in employing presumptions in criminal law, Contracting States are required to strike a balance between the importance of what is at stake and the rights of the defence; in other words, the means employed have to be reasonably proportionate to the legitimate aim to be achieved”. (2004) 38 EHRR 22 (App No 34619/97) at [101].

⁶³ T Jones, “Insanity, Automatism, and the Burden of Proof on the Accused” [1995] 111 *Law Quarterly Review* 475, 491.

⁶⁴ See B Emmerson, A Ashworth, and A Macdonald, *Human Rights and Criminal Justice* (2nd ed 2007) para 11–30, where the authors argue that the reasoning in *H* is flawed and confuses the obligation to present evidence of D’s insanity with the obligation to prove insanity on the balance of probabilities.

way which conflicted with the presumption of innocence”.⁶⁵ Thirdly, the Commission did not explain how it thought the rights of the defence are adequately preserved. Fourthly, the fact that the prosecution is required to prove the actus reus does not address the question of whether the presumption works against the accused on the issue of mens rea.

- 5.52 *H v United Kingdom* also failed to provide an answer to the fundamental point that, with the burden of proof on the defendant, there remains the possibility that a defendant will be convicted even though there is a reasonable doubt about his or her sanity at the time of the offence.
- 5.53 Guidance from other Commonwealth jurisdictions on comparable provisions is of limited use because, as Lord Bingham and Lord Rodger have said “British courts must take their lead from the decisions of the European Court in Strasbourg”.⁶⁶ Nevertheless, we should acknowledge the decision of the Supreme Court of Canada, rejecting a claim that the presumption of innocence had been unjustifiably breached by the reverse burden in the insanity defence.
- 5.54 The Canadian Charter of Rights and Freedoms contains a provision in very similar terms to article 6(2).⁶⁷ The Supreme Court of Canada considered whether the reverse onus in relation to the defence of insanity violated that presumption of innocence in *Chaulk*.⁶⁸ The accused had been charged with murder, and their defence was insanity. The issue came before a 9-judge Supreme Court. The judges held differing opinions, but the majority held that, although the reverse onus provision did violate the presumption of innocence, it was justified because it was a reasonable and proportionate limitation.
- 5.55 Returning to whether, in English law, placing of the burden of proving insanity on the defendant “unjustifiably infringes the presumption of innocence”,⁶⁹ we ask whether it is a necessary and proportionate response. There are a number of arguments as to why it might be fair to put the burden on the defendant but it seems to us that it is clearly not necessary to do so: placing a heavy *evidential* burden on the defendant will suffice.
- 5.56 Thus, although the ECtHR might be inclined to follow the decision of the Commission in *H v United Kingdom*, there are strong grounds for arguing that it should not. Moreover, the ECtHR might yet find, in a particular case, that a person had been convicted in breach of the presumption of innocence where he or she had not been able to put sufficient medical evidence before the court.

⁶⁵ *Salabiaku v France* (1988) 13 EHRR 379 (App No 10589/83) at [30].

⁶⁶ *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 264, 315.

⁶⁷ Section 11(d): “any person charged with an offence has the right ... to be presumed innocent until proven guilty according to law in a fair and public hearing by an independent and impartial tribunal”.

⁶⁸ [1990] 3 SCR 1303.

⁶⁹ See Lord Bingham in *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 264, 305.

- 5.57 Following *Lambert, Jordan and Ali*, Ashworth thinks it unlikely that a challenge to the compatibility of the reverse burden would succeed.⁷⁰ However, he describes it as a “paradox when one reflects that the consequence of a successful defence may be a court order favouring social welfare rather than the defendant’s own interests”.⁷¹ With regard to the ECtHR’s general approach to article 6(2), he comments that “the Strasbourg court has not developed the presumption of innocence with any vigour”,⁷² whereas he considers that domestic courts “are feeling their way towards a more robust promotion of the presumption”.⁷³
- 5.58 The English courts have yet to address directly the compatibility of the reverse burden in the insanity defence with article 6(2). Because of the decision in *H v United Kingdom* English courts might be inclined to dismiss an argument that a person’s right to be presumed innocent had been violated. It is true also that in recent cases English courts have been content for the accused to have to prove a defence in relation to statutory offences,⁷⁴ but we are not certain that this would necessarily be the outcome with insanity. It is unlawful for domestic courts to act in a manner which is incompatible with a Convention right,⁷⁵ and so, we would argue, it is far from inevitable that a court required to consider the placing of the burden of proof of the insanity defence on the defendant would simply rely on M’Naghten and Viscount Sankey’s words in *Woolmington v DPP* to decide the issue. While the court would be obliged to take into account the decision of *H v United Kingdom*, close examination of the issue should lead to the conclusion that the reverse burden of proof is not necessary.

Conclusion

- 5.59 It is inescapable that, because the burden of proof of the defence of insanity rests on the accused, it is possible for there to be a conviction despite the presence of a reasonable doubt as to the guilt of the accused, and this cannot be right.

ARTICLE 2

- 5.60 It is established law that article 2 imposes on the state negative and positive duties to its citizens. Article 2 “enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to

⁷⁰ Note also J Chalmers, “Reforming the Pleas of Insanity and Diminished Responsibility: Some Aspects of the Scottish Law Commission’s Discussion Paper” (2003) 8(2) *Scottish Law and Practice Quarterly* 79, in which he argues that the Scottish Law Commission was mistaken to conclude that the reverse burden of proof breaches art 6(2).

⁷¹ *Principles of Criminal Law* p 142, citing *Lambert* [2001] 1 Cr App R 205.

⁷² *Principles of Criminal Law* p 72.

⁷³ *Principles of Criminal Law* p 72, citing *Woolmington*; *Lambert* [2002] QB 1112, [2001] 1 Cr App R 14; and *Attorney General’s Reference No 4 of 2002* [2004] UKHL 43, [2005] 1 AC 264.

⁷⁴ See *Lambert* [2002] QB 1112, [2001] 1 Cr App R 205; *Sheldrake v DPP* [2004] UKHL 43, [2005] 1 AC 264; and *Keogh* [2007] EWCA Crim 528, [2007] 1 WLR 1500. But see also *Johnstone* [2003] UKHL 28, [2003] 1 WLR 1736.

⁷⁵ Human Rights Act 1998, s 6(1).

safeguard the lives of those within its jurisdiction”.⁷⁶ As Lord Rodger of Earlsferry has put it, “article 2 requires a state to have in place a structure of laws which will help to protect life”.⁷⁷

The state’s duty to potential victims under article 2

5.61 The state’s duty to take steps to safeguard lives:

involves a primary duty on the state to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by a law-enforcement machinery for the prevention, suppression and punishment of breaches of such provisions.⁷⁸

5.62 This duty therefore requires the state to protect its citizens from those people who, because of their mental (or physical) condition, represent a risk of life-threatening harm to others.⁷⁹ The law regulating pleas of insanity and the disposal powers of courts must ensure that such dangerous individuals are managed in such a way as to address the risk, including detention in prison or hospital.

5.63 Detention in hospital could in some cases contribute to the fulfilment of the state’s duty under article 2 (and 3 and 8, in this context) because reoffending rates are lower for those released from secure hospital than from prison.⁸⁰ We cannot be categorical about this because the reoffending rates produced by the Ministry of Justice are only of those who were reconvicted, and do not distinguish between the different reasons that a person might have been in hospital. In other words, not all the people represented by the data were hospitalised following commission of a crime. In addition, there is no distinction drawn in the data between those who committed a crime due to their mental disorder and those who committed a crime and had a mental disorder.

⁷⁶ This is stated in numerous judgments of the ECtHR. See, eg, *Storck v Germany* (2005) 43 EHRR 96 (App No 38033/02) at [101] and *Renolde v France* (2008) 48 EHRR 969 (App No 5608/05) at [80].

⁷⁷ *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74, [2009] 1 AC 681 at [19].

⁷⁸ *Edwards v UK* (2002) 35 EHRR 19 (App No 46477/99) at [54].

⁷⁹ Although there are limits to the steps that can be taken: “while the Convention, and in particular its articles 2 and 3, obliges State authorities to take reasonable steps within the scope of their powers to prevent offences of which they had or ought to have had knowledge, it does not permit a State to protect individuals from criminal acts of a person by measures which are in breach of that person’s Convention rights, in particular the right to liberty ...”: *OH v Germany* App No 4646/08 at [94].

⁸⁰ A rate of 2%, according to MoJ figures from 2008: see tables 7 and 7a in <http://www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/mentally-disordered-offenders-2008.pdf> (last visited 14 Mar 2012). The MoJ no longer publishes separate statistics about mentally disordered offenders.

The state's duty to prisoners under article 2

- 5.64 The state's duty to safeguard the lives of all people within the jurisdiction extends to those held in custody. This entails protection from the risk of death at the hands of another,⁸¹ and also in some cases from suicide.
- 5.65 The ECtHR case law identifies a duty arising out of the nature of the confinement: that in itself it raises the risk of suicide.⁸² Prisoners who are suffering from mental illness have been recognised by the courts to be doubly vulnerable: first because of their detention, and secondly because of their mental condition.⁸³
- 5.66 It should also be noted that the impact of prison on a person with mental disorder may be compounded by the effect of the illness on their behaviour in custody. Sometimes a person's mental illness leads to, or plays a part in, behaviour in prison with the ultimate result of further punishment for breach of prison rules.⁸⁴
- 5.67 The state's obligations to prisoners suffering from mental illness lie at two levels, as described by Lord Rodger of Earlsferry in *Savage v South Essex Partnership NHS Foundation Trust*.⁸⁵ He identifies first a general duty on the state to prevent suicides in custody which requires steps to be taken even though no specific individual is in mind. He then identifies a specific duty in relation to a particular individual where the state knows or ought to know of a real and immediate risk to an inmate's life.⁸⁶ The duty then is on the institution to do all that could reasonably be expected of it to prevent the harm. The duty derives from the prison authorities' "wider duty to protect prisoners who are in a vulnerable

⁸¹ As occurred in *Edwards v UK* (2002) 35 EHRR 19 (App No 46477/99). See Lester, *Pannick and Herberg: Human Rights Law and Practice* (2009) at para 4.2.27 where it is noted that the state's obligations under art 2 are engaged where a prisoner is killed by a mentally ill cellmate.

⁸² *Tanribilir v Turkey* App No 21422/93 at [74]. As noted in *Savage*: "The cases on prisoners and conscripts suggest that the court sees article 2 as imposing an obligation on the State to take appropriate practical measures to prevent them committing suicide because they are under the control of the state and placed in situations where, as experience shows, there is a heightened risk of suicide ...". *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74, [2009] 1 AC 681 at [39].

⁸³ This has been stated by the ECtHR in several cases. See, eg, *Renolde v France* (2008) 48 EHRR 969 (App No 5608/05) at [83] and [84] where the court refers to statements in *Keenan v UK* (2001) 33 EHRR 38 (App No 27229/95) at [91] and [111]; *Younger v UK* (2003) 36 EHRR CD 252; *Trubnikov v Russia* App No 49790/99 at [68]; *Aerts v Belgium* App Nos 61/1997/845/1051 at [66]; and *Rivière v France* App No 33834/03 at [63]. See also R Clayton and H Tomlinson, *The Law of Human Rights* (2009) at para 7.72.

⁸⁴ As in *Keenan v UK* (2001) 33 EHRR 38 (App No 27229/95). In a recent Prison Reform Trust report, several Independent Monitoring Boards reported that it was still common practice to use segregation as a means of dealing with mentally ill prisoners because prison staff did not have the resources or training to deal with them appropriately: K Edgar and D Rickford, *Too Little Too Late* (Prison Reform Trust, 2009) pp 3 to 6.

⁸⁵ [2008] UKHL 74, [2009] 1 AC 681 at [26] and [27].

⁸⁶ As to the extent of the state's duty where it had no knowledge of the prisoner's mental vulnerability, see *Younger v UK* (2003) 36 EHRR CD 252.

position and for whom they are responsible”,⁸⁷ and from the “assumption of responsibility by the state for the individual’s welfare and safety”.⁸⁸

- 5.68 While prison authorities are not obliged to regard all prisoners as potential suicide risks,⁸⁹ the risk of suicide is known to be higher among prisoners than among the equivalent population at large,⁹⁰ and the ECtHR has stated that the authorities should take general measures to prevent suicide.⁹¹ The ECtHR has stated that the central question is:

whether the authorities knew or ought to have known that [the prisoner] posed a real and immediate risk of suicide and, if so, whether they did all that reasonably could have been expected of them to prevent that risk.⁹²

The insanity defence and the state’s duty to prisoners under article 2

- 5.69 There is potential for breach of article 2 if the insanity plea results in defendants being imprisoned when they should not be subject to penal disposals at all because they lacked responsibility for what they did because of their physical or mental condition. This could and should be avoided by a reformed insanity defence.
- 5.70 It might be argued that this is not a concern because, as we have seen, the state is required to take steps to reduce the risk of harm. In addition, the state is expected to provide medical treatment to prisoners as it would to other citizens (a principle known as “equivalence of care”), and to care appropriately for those

⁸⁷ *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74, [2009] 1 AC 681 at [29].

⁸⁸ *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] 2 WLR 381 at [22]. The court described the case where an individual is detained by the state, in a prison or a psychiatric hospital, as “the paradigm example of assumption of responsibility”.

⁸⁹ *Younger v UK* (2003) 36 EHRR CD 252. The ECtHR said that, “Bearing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities” at CD 266.

⁹⁰ “The suicide rate for men in prison is five times greater than that for men in the community. Boys aged 15-17 are 18 times more likely to take their own lives in prison than in the community.” *Care not Custody* <http://www.thewi.org.uk/documents/download.aspx?nodeid=56607> (last visited 8 Dec 2011), p 10, citing S Fazel, R Benning and J Danesh, *Suicides in Male Prisoners in England and Wales 1978-2003* (2005) *The Lancet* 366. As regards female prisoners, although there are low numbers of self-inflicted deaths of female inmates, in 2003 it was found that women accounted for over half of the 211 prisoners who were successfully resuscitated by staff: Deaths in Custody, Joint Committee on Human Rights Third Report (2004-05), para 58. The Ministry of Justice publishes statistics on deaths in custody at <http://www.justice.gov.uk/statistics/prisons-and-probation/safety-in-custody>.

⁹¹ *Tanribilir v Turkey* App No 21422/93 at [74].

⁹² *Renolde v France* App No 5608/05 at [85] and *Keenan* (2001) 33 EHRR 38 (App No 27229/95) at [92]. The state’s duty “must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources”: *Renolde v France* App No 5608/05 at [82].

suffering from serious mental illness.⁹³ This argument overlooks the fact that in practice, the standard of care may fall short.⁹⁴ We note the Joint Committee's observations:

We found broad agreement that there were very severe limitations on treatment of people with mental health problems in a prison environment. Anne Owers, the Chief Inspector of Prisons, told the Committee that it was "verging on the impossible to provide the right kind of environment" in prisons for people who are seriously mentally ill because: "Prisons are not by their nature therapeutic environments. They are not places where prisoners can compulsorily be treated ...".⁹⁵

- 5.71 A reformed defence of insanity would not remove all risk of breaches of article 2 in respect of prisoners. However, by distinguishing more fairly between those who may be held responsible for their crimes and those who may not, it would take some of those suffering from mental disorder out of penal institutions.

ARTICLE 3

- 5.72 Article 3 of the ECHR states that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". It is an unqualified right, meaning that, unlike, for example, article 8, if there is a violation then there can be no justification on the grounds of some other socially beneficial objective.
- 5.73 To fall within the scope of article 3 the ill-treatment must attain a minimum level of severity.⁹⁶ The ECtHR has noted that "The assessment of this minimum is relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age

⁹³ These expectations are contained in Council of Europe Recommendations which, although not binding on member states, are taken into account by the ECtHR, as stated in *Rivière* App No 33834/03 at [72]. See, eg, Recommendation No R (98) 7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational aspects of Health Care in Prison, Appendix, Recommendations I A 5, III D, I B; art 35 of Recommendation Rec 2004(10) of the Council of Europe concerning the protection of the human rights and dignity of persons with mental disorder, which the UK has accepted; and United Nations Basic Principles for the Treatment of Prisoners, Principle 9.

See also Rules 12.1, 12.2, 39, 40.4 and 40.5 of Recommendation Rec (2006) 2 on the European Prison Rules, adopted 11 Jan 2006. The Secretary of State has accepted that they apply to prisons in the UK: *Qazi* [2010] EWCA Crim 2579, [2011] 2 Cr App R (S) 8 at [23].

⁹⁴ In the Bradley report, it was said that "the prison environment ... can be seriously detrimental to mental health": The Bradley Report, p 99, and research by the Centre for Mental Health found that while "mental health inreach teams are making a difference to the prisoners they support", "prison health care departments offer very limited support for prisoners' mental health". G Durcan, *From the Inside* (Centre for Mental Health, 2008) p 7.

⁹⁵ Deaths in Custody, Joint Committee on Human Rights Third Report (2004-05) para 92.

⁹⁶ When assessing the level of severity regard must be had to a vulnerability caused by a prisoner's mental illness: *Lester, Pannick and Herberg: Human Rights Law and Practice* (2009) at para 4.3.31.

and state of health of the victim".⁹⁷ Children who are detained in custody are, of course, doubly vulnerable.⁹⁸

- 5.74 The state is obliged to secure citizens' rights under article 3.⁹⁹ The primary duty to avoid breach of article 3 lies on the custodial institution, and so there are implications for prisons as to the systems and practices they operate. There is also a duty on the sentencing court as a public authority¹⁰⁰ not to send a person to prison where to do so will in itself lead to a breach of article 3.¹⁰¹
- 5.75 When a person is detained, whether following conviction and sentence, a special verdict, or on remand, article 3 remains a relevant consideration. Article 3 is consistent with English common law¹⁰² in setting a minimum standard of treatment for those who are detained by the state.
- 5.76 Detention without the appropriate medical attention required by a person's psychiatric state may amount to inhuman treatment in violation of article 3.¹⁰³ The ECtHR has stated that "when assessing conditions of detention, account has to be taken of the cumulative effects of those conditions, as well as the specific allegations made by the applicant".¹⁰⁴ It is clear that the prison authorities must take notice of the features of the individual prisoner, such as mental illness, which

⁹⁷ *Keenan v UK* (2001) 33 EHRR 38 (App No 27229/95) at [108] footnotes omitted. See also *Kudla v Poland* App No 30210/96 at [91].

⁹⁸ On obligations to children in custody arising under other Conventions see the United Nations Convention on the Rights of the Child and the European Rules for Juveniles subject to Sanctions or Measures adopted by the Council of Europe in 2008.

⁹⁹ *Z v UK* (2001) 34 EHRR 97 (App No 29392/95) at [73]. See *R (Howard League for Penal Reform) v Secretary of State* [2002] EWHC 2497 (Admin), [2003] 1 FLR 484.

¹⁰⁰ *Qazi* [2010] EWCA Crim 2579, [2011] 2 Cr App R (S) 8 at [21]. Although in *Qazi* neither *Drew* [2003] 2 Cr App R 371, [2003] 1 WLR 1213 nor *X v UK* App No 5299/71 were cited to the court.

¹⁰¹ The sentencing court is bound to have regard to Convention rights: *R (P and Q) v Home Secretary* [2001] EWCA Civ 1151, [2001] 1 WLR 2002. The extent of this duty was examined in *Qazi* where the Court of Appeal concluded that "It is only in circumstances where the very fact of imprisonment itself might expose the individual to a real risk of an article 3 breach that the court will be called upon to enquire whether sentencing a person to custody will mean a breach of article 3": *Qazi* [2010] EWCA Crim 2579, [2011] 2 Cr App R (S) 8 at [35].

¹⁰² See *Qazi* [2010] EWCA Crim 2579, [2011] 2 Cr App R (S) 8 at [20].

¹⁰³ *Rivière v France* App No 33834/03 at [74]. See also *Musial v Poland* App No 28300/06. Detention in inappropriate conditions for a physical condition or disability may also amount to breach of art 3: *Price v UK* (2001) 34 EHRR 1285 (App No 33394/96), *Vincent v France* App No 6253/03, *Modarca v Moldova* (2009) 48 EHRR 39 (App No 14437/05). See also R Clayton and H Tomlinson, *The Law of Human Rights* (2009) at para 8.143.

¹⁰⁴ *A and others v UK* (2009) 49 EHRR 625 (App No 3455/05) at [128] referring to *Ramirez Sanchez v France* (2006) 45 EHRR 1099 (App No 59450/00) at [119].

they are aware of,¹⁰⁵ and that “increased vigilance” is required where the prisoner has particular vulnerability or weakness.¹⁰⁶

5.77 In *Dybeku v Albania*¹⁰⁷ it was the cumulative effect of the inappropriate conditions of detention – having regard to the mental state of the prisoner – which amounted to inhuman and degrading treatment.

5.78 In order for there not to be a breach of article 3¹⁰⁸ steps that the prison authorities might take, such as segregation or use of handcuffs, need to be proportionate and reasonably necessary for some legitimate purpose, taking account of the vulnerability of the individual.¹⁰⁹

5.79 In *Keenan v United Kingdom*,¹¹⁰ the ECtHR found that a lack of psychiatric advice about K’s confinement in segregation, and ineffective monitoring of his condition, amounted to a breach of article 3. This may be contrasted with a case where the ECtHR found that although the failures of the authorities led to a deterioration in the prisoner’s mental condition, the case did not meet the threshold of article 3.¹¹¹

ARTICLE 8

5.80 Article 8 states that:

1. Everyone has the right to respect for his private ... life ...

¹⁰⁵ *Keenan v UK* (2001) 33 EHRR 38 (App No 27229/95). See also R Clayton and H Tomlinson, *The Law of Human Rights* (2009) at para 8.143 where it is noted that regard must be had to the vulnerability of mentally ill prisoners and the extra difficulties they may experience in complaining about ill treatment.

¹⁰⁶ *Herczegfalvy v Austria* (1992) 15 EHRR 437 (App No 10533/83).

¹⁰⁷ App No 41153/06. See also *Romanov v Russia* (2007) 44 EHRR 23 (App No 63993/00), a case where conditions of detention were so bad that they amounted to a breach of art 3.

¹⁰⁸ See *Kucheruk v Ukraine* (2011) 52 EHRR 28 (App No 2570/04) where the detained person, who suffered from schizophrenia, was placed in a disciplinary cell for nine days and was handcuffed for seven of those days. The state’s argument that the handcuffing was to prevent the accused harming himself was rejected. The state had failed to obtain psychiatric advice at that point as to treatment or the accused’s fitness for such measures.

¹⁰⁹ *R (N) v Secretary of State* [2009] EWHC 1921 (Admin) at [102], relying on *Mouiel v France* (2004) 38 EHRR 34 (App No 67263/01).

¹¹⁰ (2001) 33 EHRR 38 (App No 27229/95). Mark Keenan suffered from serious mental illness, probably schizophrenia. He had acute psychotic episodes with paranoia. He was charged with assault and remanded into custody. He was subsequently released on bail, convicted, and sentenced to four months’ imprisonment. He was known to be potentially suicidal. He assaulted prison staff. Nine days before the end of his sentence he was ordered to serve seven days’ segregation and a further 28 days’ extra sentence for a breach of prison discipline. Whilst serving the additional term he committed suicide.

¹¹¹ *Drew v UK* (2006) 43 EHRR SE2 (App No 35679/03). The prisoner was held on remand in a psychiatric hospital, but on sentence was sent to prison. He was not able to receive the appropriate medical treatment in prison during the eight days he spent there before he was returned to hospital. The lack of appropriate medication led to a deterioration in his condition, which took months to remedy once he had been transferred to hospital.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of ... the economic well-being of the country, for the prevention of disorder or crime,

- 5.81 As with article 3, there is a minimum level of interference which must be reached before it can be said that there has been a breach of the article.¹¹² And as with articles 2 and 3, there is a positive obligation on the state to avoid breach.
- 5.82 Unlike article 3, article 8 is qualified, meaning that interference with it is permissible within the limits specified within article 8(2).

The state's duty to protect potential victims

- 5.83 The ECtHR has confirmed that states "have a duty to protect the physical and moral integrity of an individual from other persons. To that end, they are to maintain and apply in practice an adequate legal framework affording protection against acts of violence by private individuals."¹¹³ Thus, for example, in one case a man had been convicted of violent acts and threats towards his estranged wife. The court took the view that, due to his personality disorder he ought to be treated in hospital rather than sent to prison, but failed to order the hospital to detain him and treat him. The result was that he was released and made further threats against the woman and others, the state had failed in its duty to the victim under article 8.¹¹⁴
- 5.84 This duty on the state argues for adequate powers to be available in respect of offences which are summary only – meaning that they can only be tried in the magistrates' courts – as in respect of offences which can be tried in the Crown Court. For example, a stalker might commit an offence contrary to section 2 of the Protection from Harassment Act 1997 (a summary only offence). If a special verdict or a power to make a hospital order were not available in the magistrates' courts, the potential victim could be left without adequate protection against violation of his or her article 8 right.

The state's duty to prisoners under article 8

- 5.85 The ECtHR has given the following interpretation of article 8:

¹¹² *Raninen v Finland* (1997) 26 EHRR 563 (App No 20972/92).

¹¹³ *Hajduová v Slovakia* App No 2660/03 at [46] citing *X and Y v The Netherlands* [1986] 8 EHRR 235 (App No 8978/80) at [22] and [23]; *Costello-Roberts v UK* [1995] 19 EHRR 112 (App No 13134/87) at [36]; *DP v UK* [2003] 36 EHRR 14 (App No 38719/97) at [118]; *MC v Bulgaria* [2005] 40 EHRR 20 (App No 39272/98) at [150] and [152]; and *A v Croatia* (55164/08) 14 Oct 2010 at [60]

¹¹⁴ *Hajduová v Slovakia* App No 2660/03 at [48] to [52].

Private life is a broad term not susceptible to exhaustive definition. ... Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world. The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life.¹¹⁵

- 5.86 It follows that potential infringement of article 8 needs to take account of the mental vulnerability of the individual.¹¹⁶ Where, for example, the prison authorities decide to segregate a person there is potential for breach of article 8.¹¹⁷ It may be justified, of course, by reference to another article of the ECHR, such as article 2 if the prisoner is likely to endanger another's life (as contrasted with, say, article 3 where a breach may not be justified by reference to another article).

Summary: the M’Naghten test and articles 2, 3 and 8

- 5.87 The test which is applied by the courts to distinguish between those who may fairly be held criminally responsible for their actions and those who may not be so held due to their mental condition is arguably defective. If a person is detained in custody and thereby placed in a position where breaches of articles 2 3 or 8 are more likely than if he or she been subjected to any of the other available appropriate disposal powers, then we would say that the fault lies in part with the test itself.
- 5.88 For example, if the test were framed in such a way that people who were not responsible due to their mental condition may only be detained in a hospital (where treatment is available) and not in a penal institution, then it seems reasonable to assume that the risk of a preventable death, and violation of article 2, would decrease. The same can be said of the risk of treatment which amounts to a violation of article 3, or of article 8.
- 5.89 As the law stands, individuals suffering from a serious mental condition who ought to be excused criminal liability and punishment, may fall outside the scope of the defence of insanity. This is in part because the present defence is governed by an outdated legal test. In addition, the very label “insanity” may deter some mentally ill individuals from seeking to rely on the defence, resulting in their eventual conviction, imprisonment and possibly inappropriate treatment.

¹¹⁵ *Bensaid v UK* (2001) 33 EHRR 10 (App No 44599/98) at [47].

¹¹⁶ See, eg, *X (a woman formerly known as Mary Bell) v O’Brien* [2003] 2 FCR 686.

¹¹⁷ *McFeeley v UK* (1980) 3 EHRR 161 (App No 8317/78).

APPENDIX A

THE PATH OF A MENTALLY DISORDERED OFFENDER THROUGH THE CRIMINAL JUSTICE SYSTEM

INTRODUCTION

- A.1 This Appendix follows a chronological view of the progress of an accused person with a mental disorder through the criminal justice system, from possible outcomes before the case reaches court, through powers available to the court while the case is progressing, to final disposal of the case. The purpose of tracing this route, in the context of this project, is to show how the defence of “not guilty by reason of insanity” fits into the criminal justice system.
- A.2 By “person with mental disorder” we mean a person with a mental illness and/or learning disability or learning difficulty. For a full description of the various meanings of “mental disorder”, “learning disabilities”, “learning difficulty” and “mentally disordered offenders”, see the glossary.

PRE-COURT DIVERSION

- A.3 Not all offences are prosecuted, and this is true in relation to all suspected offenders, not just those who appear to suffer from a mental disorder. Some cases are the subject of “diversion” instead.¹ The term “diversion” can be used to mean different things. It can be used to describe out-of-court disposals administered by the police,² or it can mean “the process of diverting individuals away from prison but not out of the criminal justice system altogether”. The police may decide to take no further action, to pursue a restorative justice process, to issue a Penalty Notice for Disorder, or to caution the person who is alleged to have committed an offence. The caution may be a “simple caution”, or a “conditional caution”. In these circumstances, the case never reaches the court, and may not even be referred to the Crown Prosecution Service (“the CPS”).
- A.4 If the case proceeds, there will be a review by the CPS, and again there may be a decision to discontinue the case or to caution the person. The accused could be sent to hospital, following steps taken by the police or mental health professionals, under the civil powers in the 1983 Act pending the decision of the CPS.³

¹ “In 2009, 38% of the 1.29 million offences ‘solved’ by police were dealt with by a disposal outside the court system”. “Solved” in this context means a crime was detected and a person identified as responsible for the offence and dealt with. Criminal Justice Joint Inspection, *Exercising Discretion: The Gateway to Justice* (June 2011) p 9.

² Guidance on such disposals was issued by the Office for Criminal Justice Reform in 2007: *Out-of-Court Disposals for Adults: A Guide to Alternatives to Prosecution* (July 2007).

³ See para A.74 below.

- A.5 The CPS applies the Code for Crown Prosecutors to each case. This entails an evidential test – whether there is sufficient evidence to provide a realistic prospect of conviction on each charge – and a public interest test. A prosecution will only be pursued by the CPS if both the evidential test and the public interest test are satisfied. There is also specific CPS Legal Guidance which is applied: Guidance on Cautioning and Diversion, Guidance on Adult Conditional Cautions, Guidance on Diversion of Offenders with mental health problems and/or learning disabilities, and Guidance on Mentally Disordered Offenders, as well as Home Office Guidelines.⁴ Following consideration of a case in the light of this guidance, the prosecution might decide that it is not in the public interest to proceed against a person suffering from a mental disorder:

A prosecution is less likely to be required if the suspect is, or was at the time of the offence, suffering from significant mental or physical ill health, unless the offence is serious or there is a real possibility that it may be repeated. Prosecutors apply Home Office guidelines about how to deal with mentally disordered offenders and must balance a suspect's mental or physical ill health with the need to safeguard the public or those providing care services to such persons.⁵

- A.6 If both tests are satisfied, then the person is charged with the offence, but the Code for Prosecutors applies throughout the case and the prosecution is kept under review. For example, there may be enough evidence to proceed against a defendant and it may be in the public interest to proceed at one stage in a case, but if the defendant's mental health deteriorates it may cease to be in the public interest to pursue the prosecution, such as where the accused is admitted to hospital for treatment.
- A.7 Diversion may be particularly relevant to an accused person who appears to suffer from a mental disorder. In a review in October 2009 the Office for Criminal Justice Reform (the "OCJR") described diversion of people with mental disorder in the following way:

NACRO (2004) describes diversion as a process of decision making, which results in MDOs [mentally disordered offenders]⁶ being diverted away from the criminal justice system towards health and social care. Diversion may occur at any stage of the criminal justice process: before arrest; after proceedings have been instigated; in place of prosecution; or when a case is being considered by the courts. If a

⁴ Home Office, "Provision for Mentally Disordered Offenders" (1990) Circular 66/90.

⁵ CPS, *Code for Crown Prosecutors* (2010) para 4.17(j). The guidelines referred to is the Home Office, "Provision for Mentally Disordered Offenders" (1990) Circular 66/90.

⁶ Defined in OCJR's report at p 1 as "those who come into contact with the Criminal Justice System because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically mentally ill ... It also includes those in whom a degree of mental disturbance is recognised, even though that may not be severe enough to bring it within the criteria laid down by the Mental Health Act 1983". They are using a definition by NACRO in *Liaison and Diversion for Mentally Disordered Offenders: A Mental Health Good Practice Guide* (2006).

prosecution is initiated, the Crown Prosecution Service (CPS) might decide to discontinue or, if the offender is prosecuted because prosecution is appropriate, the court might opt for a relevant disposal under the Mental Health Act 1983/2007, such as a hospital order, in place of a criminal justice disposal, such as imprisonment.⁷

- A.8 The Government plans to roll out a national court liaison and diversion service by 2014 which is intended to increase the number of people diverted out of the criminal justice system due to their mental health.⁸

AT COURT, PRE-TRIAL

- A.9 Once the case reaches court,⁹ the court's powers to deal with a person who appears to suffer from mental disorder become relevant. The court has the power to send a person to hospital, for a report, or for treatment. The Department of Health has issued a Code of Practice to accompany the 1983 Act (revised in 2008). Chapter 33 of the Code "offers guidance on the use of the Act to arrange treatment for mentally disordered people who come into contact with the criminal justice system".¹⁰ The Code of Practice for the 1983 Act states that:

People who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as anyone else ... Wherever possible, people who appear to the court to be mentally disordered should have their treatment needs considered at the earliest possible opportunity by the court mental health assessment scheme where there is one.¹¹

- A.10 We now describe the powers available to the court to deal with a mentally disordered defendant before a trial begins.

⁷ OCJR, *Provision of Mental Health Services to Individuals Passing Through the Criminal Justice System: A Qualitative Literature Review* (Oct 2009) p 13. The reference to "NACRO (2004)" is to NACRO, *Findings of the 2004 Survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for Mentally Disordered Offenders in England and Wales* (2004).

⁸ <http://www.guardian.co.uk/society/2011/mar/28/divert-mentally-ill-offenders-prison> (last visited 16 Jan 2012).

⁹ An adult defendant will always make his or her first appearance before a magistrates' court regardless of where he or she will be tried (the Crown Court or magistrates' courts). A defendant who is under the age of 18 will normally make his or her first appearance before a youth court.

¹⁰ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 33.1.

¹¹ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) paras 33.2 to 33.3.

Remand to hospital for a report, pre-trial¹²

- A.11 The Crown Court has the power to remand an accused person to hospital for a report on his or her mental condition under section 35 of the 1983 Act.¹³ The magistrates' courts have the same power but may only exercise it pre-trial if the accused consents.¹⁴
- A.12 Subsection (3) provides that the magistrates and Crown Court may exercise this power if:
- (a) the court is satisfied, on the written or oral evidence of a registered medical practitioner, that there is reason to suspect that an accused person is suffering from mental disorder; and
 - (b) the court is of the opinion that it would be impracticable for a report on his mental condition to be made if he were remanded on bail.¹⁵
- A.13 Thus an accused can be remanded if an assessment of his or her mental condition is required but this would be impossible to complete if the individual were at liberty. Although the remand may be renewed,¹⁶ it may not exceed 12 weeks in total.¹⁷

Remand to hospital for treatment

- A.14 Under section 36, the Crown Court has the power to remand an accused¹⁸ to hospital for treatment. This power is only available to the Crown Court, and not to magistrates' courts. Following the changes made in the Mental Health Act 2007 to the definition of mental disorder and the new statutory appropriate treatment test, in order to exercise its powers under section 36, the court must now be satisfied on the written or oral evidence of two medical practitioners that:

the accused is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and

appropriate medical treatment is available for him.

¹² Judges and magistrates were advised in Home Office, "Mentally Disordered Offenders: Inter-Agency Working" (1995) Circular 12/95 that "custody is inefficient as a means solely to obtain medical reports or meet treatment needs": para 19.

¹³ For the purposes of s 35, in the Crown Court, "an accused" includes a person awaiting trial for an offence punishable with imprisonment and does not extend to defendants charged with non-imprisonable offences.

¹⁴ Section 35(2)(b) of the 1983 Act.

¹⁵ The registered medical practitioner must be on the list of those approved by the Secretary of State under s 12(2) of the 1983 Act "as having special experience in the diagnosis or treatment of mental disorder": s 35(3)(a) of the 1983 Act.

¹⁶ Section 35(5) of the 1983 Act.

¹⁷ Section 35(7) of the 1983 Act.

¹⁸ Defined in subsection (2) as "any person who is in custody awaiting trial before the Crown Court for an offence punishable with imprisonment (other than an offence the sentence for which is fixed by law) or who at any time before sentence is in custody in the course of a trial before that court for such an offence".

- A.15 For the purposes of mental disorder, “medical treatment” refers to “medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.”¹⁹ Treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.²⁰
- A.16 Before the amendments to the definition of mental disorder introduced by the 2007 Act, the Crown Court was only able to remand an accused to hospital for treatment if he or she was suffering from “mental illness” or “severe mental impairment”. There is now a single definition of mental disorder, and so the court may be able to use its powers under section 36 in relation to a wider range of accused people than before.
- A.17 A person may only be remanded under this power for a maximum of 28 days at a time and for 12 weeks in total.²¹ It is not a final disposal.
- A.18 Section 36 is an alternative to remand in custody. It can be used where a person may otherwise be found unfit to plead, enabling the accused to receive treatment prior to the trial. The trial may proceed at a later date when his or her condition has improved but will not necessarily do so. Section 36 also provides an alternative to the power of the Secretary of State under section 48 to transfer remand prisoners.²²

Transfer to hospital from custody

- A.19 If, while awaiting trial, a defendant has been remanded into custody by the Crown Court or by a magistrates’ court, the Secretary of State may order that he or she be transferred to hospital if satisfied²³ that:
- (a) the person is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment;
 - (b) he is in urgent need of such treatment; and
 - (c) appropriate medical treatment is available for him.
- A.20 The Secretary of State may attach restrictions to the transfer direction.²⁴
- A.21 In 2010, 499 defendants were transferred from remand to hospital without being tried or sentenced.²⁵ It has been estimated that on average, they were transferred within three weeks of the remand.²⁶

¹⁹ Section 145(4) of the 1983 Act.

²⁰ Section 145(1) of the 1983 Act.

²¹ Section 36(6) of the 1983 Act.

²² Although the preferred route is the one provided by s 48 where there is an urgent need for treatment: R Jones, *Mental Health Act Manual* (14th ed 2011) para 1-461.

²³ By reports from at least two registered medical practitioners: s 48(1) of the 1983 Act.

²⁴ Section 49 of the 1983 Act. The restrictions are the same as those that may be imposed by a court under s 41 of the 1983 Act.

A.22 After an accused person has been transferred to hospital following such a direction, if, in the opinion of the “responsible clinician”,²⁷ the accused no longer requires treatment or no effective treatment can be given at the place to which he or she has been transferred, then the court may remand him or her in custody or on bail,²⁸ or the Secretary of State may direct that the accused be removed to any place where he or she would otherwise have been detained.²⁹ In any event, the transfer direction ceases to have effect when the case is disposed of at the end of the case. (The disposal may be by way of hospital order.)³⁰

A.23 If a defendant is the subject of a transfer direction under section 48 as just described, and the defendant remains too ill to be brought before the court, the court may nevertheless make a hospital order in respect of the defendant under section 51(5) of the 1983 Act, which provides as follows:

(5) If ... it appears to the court having jurisdiction to try or otherwise deal with the detainee—

(a) that it is impracticable or inappropriate to bring the detainee before the court; and

(b) that the conditions set out in subsection (6) below are satisfied,

the court may make a hospital order (with or without a restriction order) in his case in his absence and, in the case of a person awaiting trial, without convicting him.

A.24 The conditions in subsection (6) are that the court:

(a) is satisfied, on the written or oral evidence of at least two registered medical practitioners,³¹ that

(i) the detainee is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to be detained in a hospital for medical treatment; and

(ii) appropriate medical treatment is available for him; and

²⁵ Ministry of Justice, *Offender Management Caseload Statistics 2010 Tables* (2010), table A6.5. See also <http://www.ic.nhs.uk/pubs/inpatientdetmha1011> (last visited 22 Mar 2012)

²⁶ Tribal, *Financial Support to the Bradley Review* (December 2008) p 14.

²⁷ This is the term used in the 1983 Act, as amended by the 2007 Act. A responsible clinician does not have to be a doctor – it can be anyone who is approved to undertake the role. Such an approved clinician could be a nurse, psychologist, occupational therapist or social worker: see the explanatory notes to the 2007 Act, para 48.

²⁸ Section 51(4) of the 1983 Act.

²⁹ Section 51(3) of the 1983 Act.

³⁰ Section 51(2) of the 1983 Act.

³¹ At least one medical practitioner must be approved by the Secretary of State.

(b) is of the opinion, after considering any depositions or other documents required to be sent to the proper officer of the court, that it is proper to make such an order.

A hospital order under section 51(5) cannot be made in respect of a person remanded in custody by a magistrates' court,³² unless the magistrates' court commits the case to the Crown Court for trial.³³

A.25 It has been noted that section 48 together with section 51(5) "amounts to indefinite detention without trial."³⁴ Therefore, it has been held by the Divisional Court that the power under section 51(5) should only be exercised by a Crown Court before a conviction in exceptional circumstances.³⁵ If the trial has begun, then a person's mental fitness to stand trial should be determined in accordance with the unfitness to plead procedure as provided by section 4 of the 1964 Act.³⁶

Following a finding that the accused is unfit to plead and to stand trial³⁷

A.26 If a person is found unfit to plead it means that he or she is "under a disability" so that it is inappropriate for him or her to be tried.³⁸ If the court finds that an accused is unfit, the trial must be stopped.³⁹ Instead, a jury will be asked to determine whether the accused "did the act or made the omission charged."⁴⁰ If the jury are not satisfied that the accused did the act or make the omission charged, then the accused is acquitted.⁴¹

A.27 The procedure for determining unfitness to plead under section 4 of the 1964 Act only applies to Crown Court proceedings.⁴² However, section 11(1) of the Powers of Criminal Courts (Sentencing) Act 2000 provides magistrates' courts with a power to adjourn a case for a medical examination and report of a defendant who is being tried for an offence punishable with imprisonment on summary conviction, if the court:

³² Section 51 only applies where a transfer direction is given in respect of a person as described under s 48(2)(a) – namely, a person who is remanded in custody not being a sentenced prisoner, a person remanded in custody by a magistrates' court, a civil prisoner or an immigration detainee: s 51(1) of the 1983 Act.

³³ Section 52(6) of the 1983 Act.

³⁴ B Hale, *Mental Health Law* (5th ed 2010) p 156.

³⁵ *R (on the application of Kenneally) v Snaresbrook Crown Court and Rampton Health Authority* [2001] EWHC 968 (Admin), [2002] QB 1169. Pill LJ said, at [32], that "inappropriate" in s 51(5) should be construed restrictively and that "a high degree of disablement or relevant disorder must be present".

³⁶ *Griffiths* [2002] EWCA Crim 1762, [2002] Mental Health Law Reports 407.

³⁷ Referred to in this appendix as "unfit to plead".

³⁸ Section 4 of the 1964 Act.

³⁹ Section 4A(2) of the 1964 Act, inserted by the 1991 Act.

⁴⁰ Section 4A of the 1964 Act, inserted by the 1991 Act. This is referred to as a "trial of the facts" or a "section 4A hearing." See Part 6 of CP 197.

⁴¹ Section 4A(4) of the 1964 Act, inserted by the 1991 Act.

⁴² There is currently no procedure available to magistrates' courts that reflects the Crown Court procedure: see Part 8 of CP 197.

(a) is satisfied that the accused did the act or made the omission charged, but

(b) is of the opinion that an inquiry ought to be made into his physical or mental condition before the method of dealing with him is determined

Further, the 1983 Act permits a magistrates' court to make a hospital order without convicting the defendant under section 37(3) if it is satisfied that the defendant did the act or made the omission charged and a hospital order would have been available under section 37(1) if the defendant had been convicted.

AT COURT, FOLLOWING CONVICTION, OR A FINDING THAT THE DEFENDANT DID THE ACT OR MADE THE OMISSION, OR A SPECIAL VERDICT, BUT BEFORE DISPOSAL

A.28 The powers of the court, following a determination and before final disposal or sentence, are the same as for a defendant who is awaiting trial: the court may remand the person to hospital for reports or for treatment.

Remand to hospital for report

A.29 In the Crown Court, a defendant who has been arraigned for an imprisonable offence (except one where the sentence is fixed by law)⁴³ but who has not been sentenced or otherwise dealt with for that offence, may be remanded to hospital for a report on his or her mental condition under section 35 of the 1983 Act.⁴⁴ This applies where there have been findings that a person is unfit to plead and that he or she did the act or made the omission, and also where a special verdict has been delivered.⁴⁵

A.30 In the magistrates' courts, the power to remand a defendant to hospital for a report under section 35 of the 1983 Act is available in respect of any person convicted by the court of an imprisonable offence, any person charged with an imprisonable offence if the court is satisfied that he or she did the act or made the omission charged, and any person charged with an imprisonable offence if the person consents to the court making the order.⁴⁶

A.31 As regards the conditions that need to exist for the order to be made, see paragraph A.12 above.

⁴³ It is not clear whether "an offence the sentence for which is fixed by law" refers to murder only. Although in para 92 of the explanatory notes and the Government circular to the 2004 Act (Home Office, "The Domestic Violence, Crime and Victims Act 2004: Provisions for Unfitness to Plead and Insanity" (2005) Circular 24/2005 para 12), it is discussed as if it is limited to murder we do not think the position is clear cut. It might be open to a court to interpret s 5(3) of the 1964 Act as referring to offences with mandatory sentences other than murder, such as certain drugs and firearms offences with minimum fixed term custodial sentences.

⁴⁴ Section 35(2)(a) of the 1983 Act.

⁴⁵ By virtue of s 5A(2)(a) of the 1964 Act, inserted by the 2004 Act.

⁴⁶ Section 35(2)(b) of the 1983 Act.

Remand to hospital for treatment

- A.32 The power to remand a person to hospital for treatment which is available pre-trial⁴⁷ is also available in respect of an accused who has been charged with an imprisonable offence (except for one where the sentence is fixed by law) and “who at any time before sentence is in custody in the course of a trial before that court for such an offence”.⁴⁸

Transfer to hospital from custody

- A.33 As with the person who has not yet been tried, if an accused has been remanded into custody following a conviction and pending sentence, the Secretary of State may direct that he or she be transferred to hospital.⁴⁹

FINAL DISPOSAL BY THE COURT OF A PERSON SUFFERING FROM MENTAL DISORDER

- A.34 The magistrates’ and Crown Court’s powers of sentence in relation to a person who has been *convicted* of an offence and is suffering from mental disorder are the same powers as for any person convicted of an offence,⁵⁰ but with the additional powers to make a hospital order, a guardianship order, or to give hospital and limitation directions. These orders are described below.
- A.35 Where the court is considering the sentence of a person who is or who appears to be mentally disordered, it should order and consider a medical report before imposing a custodial sentence, unless the sentence is fixed by law.⁵¹ Before passing a custodial sentence on such an offender, unless the sentence is fixed by law, the court must take account of information about the person’s mental condition and the likely effect of the sentence on the condition and on any treatment.⁵²

⁴⁷ See para A.14 above.

⁴⁸ Section 36(2) of the 1983 Act.

⁴⁹ Section 48 of the 1983 Act.

⁵⁰ Generally speaking, when it comes to sentencing a convicted offender, a court is required to have regard to specified purposes of sentencing (punishment of offenders, reduction of crime, reform and rehabilitation, protection of the public and the making of reparation), but if a court is considering making a hospital order, an interim hospital order or a hospital direction with a limitation direction, as the final disposal of a case, then the court does not have to have regard to these purposes: s 142(2)(d) of the Criminal Justice Act 2003 and, in relation to offenders under 18, s 142A(4)(c).

⁵¹ Section 157(1) of the Criminal Justice Act 2003. The court does not have to do this if it does not think it is necessary: s 157(2).

⁵² Section 157(3) of the Criminal Justice Act 2003.

A.36 One of the sentencing options which may be available to a court is a “mental health treatment requirement”, which may be part of a community order⁵³ or a suspended sentence order.⁵⁴ Such a requirement is “a requirement that the offender must submit, during a period or periods specified in the order, to treatment by or under the direction of a registered medical practitioner or a registered psychologist (or both, for different periods) with a view to the improvement of the offender's mental condition”.⁵⁵ If the offender’s mental health is “such as to warrant the making of a hospital order or guardianship order”, then a mental health treatment requirement is not appropriate.⁵⁶ We understand that mental health treatment requirements are still used far less frequently than they might be, and there is a lack of awareness of them amongst the judiciary and lawyers.⁵⁷

Interim hospital orders

A.37 Under section 38 of the 1983 Act, the court has the power to make an interim hospital order, prior to making a hospital order under section 37 or dealing with the convicted offender in some other way. The offender must be suffering from mental disorder, and there must be “reason to suppose that the mental disorder ... is such that it may be appropriate for a hospital order to be made”.⁵⁸ An interim hospital order can be made by the Crown Court or a magistrates’ court after conviction, when the court needs more time to decide whether to impose a hospital order or to use an alternative disposal. Similarly, the Crown Court can make an interim hospital order in respect of a person who has been found not guilty by reason of insanity or unfit to plead and to have done the act, where the court has not yet made a disposal under section 5 of the 1964 Act.⁵⁹

A.38 An interim hospital order is not available in respect of a person who is convicted of “an offence the sentence for which is fixed by law”.⁶⁰ The same restriction does not, however, apply where the person is found not guilty by reason of insanity or unfit to plead and to have done the act in respect of an offence the sentence for which is fixed by law.⁶¹

A.39 An interim hospital order may not last longer than twelve months.

⁵³ Section 177(1)(h) of the Criminal Justice Act 2003.

⁵⁴ Section 190(1)(h) of the Criminal Justice Act 2003.

⁵⁵ Section 207(1) of the Criminal Justice Act 2003.

⁵⁶ Section 207(3)(a)(ii) of the Criminal Justice Act 2003.

⁵⁷ See H Khanom, C Samele and M Rutherford, *A Missed Opportunity? Community Sentences and the Mental Health Treatment Requirement* (Centre for Mental Health, 2009); L Seymour and M Rutherford, *The Community Order and the Mental Health Treatment Requirement* (Centre for Mental Health, 2008); E Solomon and A Silvestri, *Community Sentences Digest* (Centre for Criminal Justice Studies, 2008).

⁵⁸ Section 38(1) of the 1983 Act.

⁵⁹ Section 5A(2)(d) of the 1964 Act.

⁶⁰ Section 38(1) of the 1983 Act.

⁶¹ Section 5A(2)(d) of the 1964 Act.

Hospital orders and guardianship orders

- A.40 Where a person has been convicted of an imprisonable offence (other than one where the sentence is fixed by law), the Crown Court or a magistrates' court may make a hospital order under section 37 of the 1983 Act or a guardianship order.⁶² The Crown Court may attach restrictions on the hospital order; the magistrates' courts do not have power to impose restrictions. A hospital order is described further at paragraphs A.43 to A.48 below, and a guardianship order at paragraphs A.49 to A.50 below. If the defendant is a "child or young person"⁶³ then only a youth court may make a hospital order or guardianship order.⁶⁴
- A.41 Thus, a hospital order may be made in respect of a person who has been convicted of an offence without any finding of insanity or unfitness. A significant difference is that, in the case of a person who has been convicted, the court may make an order but the hospital is not required to admit the person, whereas if there has been a finding of unfitness or a special verdict, the court can require the hospital to admit the person.⁶⁵
- A.42 It has been argued that where there is a causal link between the mental illness and the offence, a hospital order should be imposed rather than a penal order, but this suggestion has been doubted by the courts.⁶⁶

Hospital orders under section 37

- A.43 Section 37 provides for an order that an offender suffering from a mental disorder shall be admitted to hospital for treatment. The court may only make a hospital order if the court is satisfied on the written or oral evidence of two registered medical practitioners that the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him or her to be detained in hospital, and appropriate medical treatment is available.⁶⁷ The court must also be of the opinion that, "having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is [by means of a hospital order]".⁶⁸ It is not the case that if the conditions in section 37(2) are satisfied, then a hospital order (rather than a term of imprisonment) should be made.⁶⁹

⁶² Section 37(1) of the 1983 Act.

⁶³ That is, any person under the age of 18: Powers of Criminal Courts (Sentencing) Act 2000, s 8(1).

⁶⁴ Subsections 8(2) and (6) of the Powers of Criminal Courts (Sentencing) Act 2000.

⁶⁵ Explanatory Notes to the 2004 Act, para 93. See s 37(4) of the 1983 Act where an order is made pursuant to s 5 of the 1964 Act, as substituted by s 5A of the 1964 Act.

⁶⁶ *Dass* [2009] EWCA Crim 1208, [2009] Mental Health Law Reports 288 at [44] to [47].

⁶⁷ Section 37(2)(a)(i) of the 1983 Act. At least one medical practitioner must be approved by the Secretary of State.

⁶⁸ Section 37(2)(b) of the 1983 Act.

⁶⁹ "There is no presumption. While the welfare of the offender is an important consideration, the appropriate sentence must be assessed according to the seriousness of the offence": *Khan* [2010] EWCA Crim 2880, [2011] 2 Cr App R (S) 31 at [31].

- A.44 There must be evidence that arrangements have been made for the accused's admission to hospital, and admission must take place within 28 days.⁷⁰
- A.45 A significant feature of a hospital order is its duration: although made for six months in the first instance, it can be renewed.⁷¹ It is, therefore, a disposal without a fixed end date (indeterminate).
- A.46 A hospital order may be unrestricted, in which case the individual will be managed by his or her doctor, subject to the supervision of the First Tier Tribunal (Mental Health) and Upper Tribunal for England and the Mental Health Review Tribunal for Wales ("the tribunal").⁷² Alternatively, it may be restricted, on which see paragraph A.51 below.
- A.47 Where an offender faces a possible life sentence, but could alternatively be the subject of a hospital order with a restriction, or possibly a hospital and limitation direction, the court may be guided on the disposal by principles set down in case law. In *Walton*⁷³ the Court of Appeal reviewed the authorities and said that there is a principle that:
- Where an offender is suffering from a mental disorder which is susceptible to treatment and a place is available in a special hospital the court should not impose a sentence of life imprisonment with the intention of preventing the release of the offender by the Mental Health Tribunal.
- A.48 However, in the more recent case of *Welsh*,⁷⁴ in which the defendant had pleaded guilty to manslaughter by reason of diminished responsibility, the Court of Appeal took account of the possibility that the tribunal would be able to release the offender even though he remained dangerous. The court emphasised the fact that the defendant had a propensity for violence even before he suffered from mental illness, and as he bore "substantial responsibility for the offence" and would remain a danger, a custodial sentence was appropriate.

⁷⁰ Section 37(4) of the 1983 Act.

⁷¹ Section 20 of the 1983 Act.

⁷² This was previously known as the Mental Health Review Tribunal. Although this was retained for Wales, in England it has now been subsumed into the Health, Education and Social Care Chamber under the new tribunal structure following the Tribunals, Courts and Enforcement Act 2007.

⁷³ [2003] EWCA Crim 2254, [2004] 1 Cr App R (S) 35 at [20], by Rix LJ.

⁷⁴ *Welsh* [2011] EWCA Crim 73, [2011] 2 Cr App R (S) 68.

Guardianship order

- A.49 A guardianship order may be made under section 37(1) of the 1983 Act as an alternative to a hospital order. The order may only be made in respect of an offender who is 16 or older, and only if the court is satisfied on the written or oral evidence of two registered medical practitioners that the mental disorder from which the offender is suffering “is of a nature or degree which warrants his reception into guardianship”.⁷⁵
- A.50 Under a guardianship order, the offender is placed under the responsibility of a local authority or a person approved by the local authority. The order may only be made with the consent of the authority or person who is to be the guardian.⁷⁶ Like a hospital order, this can be made by magistrates’ or the Crown Court following conviction, or by a magistrates’ court without conviction if the court is satisfied that the offender did the act or made the omission.⁷⁷

Restriction orders

- A.51 Where the Crown Court makes a hospital order under section 37 of the 1983 Act, it may “further order that the offender shall be subject to special restrictions” set out in section 41. This is known as a restriction order. A restriction order can also be given where a person who has been found to have done the act (in other words, someone who has not been convicted), is given a hospital order. The principal effect of a restriction order is that the patient cannot be given leave of absence or transferred to another hospital without the approval of the Secretary of State, and may not be discharged from hospital except by the Secretary of State or a tribunal. The tribunal has, however, a duty to discharge the individual if it is not satisfied that the criteria for detention are met.
- A.52 In deciding whether to impose a restriction order, the court must consider whether, having regard to the nature of the offence, the antecedents of the offender and the risk of reoffending if “set at large”, it is necessary for the protection of the public from serious harm for the court to restrict the offender’s discharge from hospital.⁷⁸
- A.53 The Secretary of State can direct that the patient should no longer be subject to a restriction order, or discharge the patient during the time a restriction order is in force, either absolutely or subject to conditions.⁷⁹
- A.54 Restriction orders imposed by the court remain in force until they are discharged absolutely by the Secretary of State or a tribunal.⁸⁰

⁷⁵ Section 37(2)(a)(ii) of the 1983 Act. At least one registered medical practitioner must be approved by the Secretary of State.

⁷⁶ Section 37(6) of the 1983 Act.

⁷⁷ A guardianship order gives the guardian the power, for example, to require the person to live in a specific place or to attend specific places for, for example, medical treatment or education. See further s 8 of the 1983 Act.

⁷⁸ Section 41(1) of the 1983 Act.

⁷⁹ Section 42 of the 1983 Act. While the restriction order is in force, the Secretary of State can order the recall of a conditionally discharged patient. Discharge from hospital is discussed at paras A.81 to A.95 below.

A.55 A magistrates' court has no power to make a restriction order. However, if the defendant is 14 or older and has been convicted of an imprisonable offence, the court is satisfied that the conditions exist to make a hospital order, and feels that a restriction order should also be made, it may commit a convicted offender to the Crown Court to be dealt with.⁸¹

Hospital and limitation directions

A.56 If an offender has been convicted at the Crown Court, the court has the power to direct that, instead of being removed to and detained in prison, the offender be removed to and detained in a specified hospital (a "hospital direction"); and that the offender be subject to the special restrictions set out in section 41 (a "limitation direction").⁸²

A.57 This power is not available to a magistrates' court; nor may the Crown Court exercise this power in respect of a person who was convicted in the magistrates' court.⁸³

A.58 These directions can only be given after the court has imposed a sentence of imprisonment and before doing so has considered making a hospital order under section 37. As with hospital orders, the court must be satisfied:

on the written or oral evidence of two registered medical practitioners—

(a) that the offender is suffering from mental disorder;

(b) that the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and

(c) that appropriate medical treatment is available for him.⁸⁴

⁸⁰ Prior to the 2007 Act, the Crown Court could impose time-limited restriction orders. Section 40 of the 2007 Act amended s 41 of the 1983 Act so that the court no longer has the power to make restriction orders for a limited period.

⁸¹ Section 43 of the 1983 Act. If the magistrates do commit a defendant to the Crown Court for sentence under this provision, then they may direct him or her to be detained in hospital until the Crown Court deals with the case, instead of remanding the defendant into custody: s 44.

⁸² Section 45A of the 1983 Act as inserted by s 46 of the Crime (Sentences) Act 1997.

⁸³ Section 45A(1) of the 1983 Act. It may also not be exercised in respect of a person under 21. Hughes LJ has suggested that the reason it is not available in respect of an offender aged 18, 19 or 20 could usefully be reviewed: *A-G's Reference (No 54 of 2011)* [2011] EWCA Crim 2276 at [22].

⁸⁴ Section 45A(2) of the 1983 Act. At least one of the medical practitioners must give oral evidence to the court: s 45A(4). At least one medical practitioner must be approved by the Secretary of State.

A.59 Release is governed by the law relating to prisoners, and thus the offender can only be discharged before the end of the prison sentence by the Secretary of State, who may order a return to prison. (The release of a person who is detained in a secure hospital under a hospital order is, by contrast, a matter for the tribunal).⁸⁵

A.60 As *Blackstone's* puts it:

[Hospital and limitation directions] are designed to apply where the court has heard evidence that the offender is suffering from a mental disorder and the making of a hospital order is appropriate, but the court wishes to ensure that the offender upon completion of his period of treatment will thence be transferred to prison for the remainder of the sentence rather than being released from hospital.⁸⁶

A.61 Peay describes hospital and limitation directions as “a hybrid order which permits the courts to sentence those suffering from psychopathic disorder to a period of imprisonment, but to direct that they be admitted to a psychiatric hospital with the option of return to prison if treatment was either impossible or unexpectedly effective.”⁸⁷ A hospital direction means that “the offender will be managed in hospital in the same way as a prisoner who has been transferred to hospital subject to special restrictions under sections 47 and 49 of the Act”.⁸⁸ Eleven hospital and limitation directions were made in 2010.

Transfer to hospital

A.62 As we note above, a person with a mental disorder may be convicted and sentenced in the same way as a defendant without any mental disorder. Where an offender is convicted and given a custodial sentence, the Secretary of State may direct that he or she is transferred from prison to hospital,⁸⁹ and such a direction has the same effect as a hospital order.

A.63 The Secretary of State may only make such a direction where he or she is satisfied, by reports from at least two registered medical practitioners:⁹⁰

- (1) that the said person is suffering from mental disorder; and
- (2) that the mental disorder is of a nature or degree which makes it appropriate for him or her to be detained in a hospital for medical treatment;

⁸⁵ See paras A.89 to A.91 below.

⁸⁶ *Blackstone's* E22.6.

⁸⁷ J Peay, “Mentally Disordered Offenders, Mental Health, and Crime” 496, 499 in M Maguire, R Morgan and R Reiner (eds) *The Oxford Handbook of Criminology* (4th ed 2007). Since that was written, the 1983 Act has been amended to allow such directions in respect of any “mental disorder”, not just psychopathic disorders.

⁸⁸ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 33.23.

⁸⁹ Section 47 of the 1983 Act. In 2010-2011, 470 people were transferred under s 47: <http://www.ic.nhs.uk/pubs/inpatientdetmha1011> Table 1 (last visited 22 Mar 2012).

⁹⁰ At least one medical practitioner must be approved by the Secretary of State.

- (3) that appropriate medical treatment is available, and that
 - (4) “having regard to the public interest and all the circumstances, that it is expedient so to do”.⁹¹
- A.64 The Secretary of State may add a “restriction direction” to the transfer direction.⁹²
- A.65 If the Secretary of State makes a transfer direction and a restriction direction, he or she can later direct that the person be remitted to any prison or other institution in which he or she might have been detained if the prisoner had not been removed to hospital. Alternatively, the Secretary of State may release the person on licence or discharge him or her with supervision if such a power would have been available if he or she had been remitted to a prison or other institution.⁹³
- A.66 A transfer is appropriate where the mental disorder develops after sentence; if the mental disorder at the time of sentence is such that a hospital order is appropriate, then that should be the order made at disposal.⁹⁴
- A.67 If offenders have been transferred under section 47 but are detained in hospital after the release date, then they “cease to be restricted patients but remain detained as if on a hospital order without restrictions”.⁹⁵

Supervision order

- A.68 A supervision order is an order which requires the person to be under the supervision of a social worker, an officer of a local probation board, or an officer of a provider of probation services for a specified period of not more than two years.⁹⁶ A supervision order may require the person to submit during the whole or part of that period to treatment by or under the direction of a registered medical practitioner, but only if the court is satisfied on the evidence of at least two registered medical practitioners that the defendant’s mental condition is “such as requires and may be susceptible to treatment; but is not such as to warrant the making of a hospital order”.⁹⁷ This can include treatment as a non-resident at an institution specified in the order.

⁹¹ Section 47(1) of the 1983 Act.

⁹² Section 49 of the 1983 Act. See para A.51 above.

⁹³ Section 50(1)(b) of the 1983 Act.

⁹⁴ *Beatty* [2006] EWCA Crim 2359, [2006] Mental Health Law Reports 333.

⁹⁵ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 33.35.

⁹⁶ Made under s 5 of the 1964 Act.

⁹⁷ See generally Part 1 of Sch 1A to the 1964 Act.

Final disposal after a special verdict or a finding of unfitness

- A.69 If a person's mental disorder has resulted in a finding of unfitness and that he or she has done the act or made the omission charged or a verdict of not guilty by reason of insanity, then he or she is treated differently from those who have been convicted of an offence. Where a person has been found to have done the act or made the omission charged,⁹⁸ or found not guilty by reason of insanity,⁹⁹ then the Crown Court may *only* make a hospital order, a supervision order, or an order for the defendant's absolute discharge.¹⁰⁰
- A.70 If the verdict is for an offence where the sentence is fixed by law (such as murder) and the court has power to make a hospital order, then the court is required to make a hospital order with a restriction order.¹⁰¹ Given that the court can only make a hospital order if the conditions for a hospital order are satisfied, even on a charge of murder, there is no obligation to make a hospital order.
- A.71 "Hospital order" has the meaning given by section 37 of the 1983 Act, "restriction order" has the meaning given to it by section 41 of the 1983 Act, and "supervision order" is defined in Part 1 of Schedule 1A to the 1964 Act.¹⁰²

Remittal for trial following a finding of unfitness

- A.72 If a person has been found to be unfit and to have done the act or made the omission and consequently is detained by a hospital order¹⁰³ with a restriction order under section 41 which has not ceased to have effect, then the Secretary of State may remit the person for trial.¹⁰⁴ This must follow a consultation with the person's responsible clinician. The Secretary of State would then consult the CPS who should re-review the case for prosecution.¹⁰⁵

⁹⁸ Section 5 of the 1964 Act, as amended by the 1991 Act and s 24(1) of the 2004 Act, provides that s 37 of the 1983 Act can have effect as if the reference to a person being convicted before the Crown Court included a reference to the case where an unfit accused is found to have done the act. For magistrates' powers, see also s 37(3) of the 1983 Act.

⁹⁹ Section 5(1) of the 1964 Act, as amended by the 1991 Act and s 24(1) of the 2004 Act.

¹⁰⁰ Section 5(2) of the 1964 Act as amended by the 1991 Act and the 2004 Act.

¹⁰¹ Section 5(3) of the 1964 Act as amended.

¹⁰² These definitions are imported by s 5(4) of the 1964 Act. For hospital orders, see para A.43 above; for restriction orders see para A.51 above; and for supervision orders see para A.68 above.

¹⁰³ Under s 5(1)(b) of the 1964 Act.

¹⁰⁴ Section 5A(4) of the 1964 Act.

¹⁰⁵ CPS, *Legal Guidance – Mentally Disordered Offenders* (revised December 2010), http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/index.html (last visited 16 Jan 2012).

A.73 The legislation is silent on the matter of remission in respect of a person who has been made the subject of a hospital order without a restriction order, a supervision order or an absolute discharge under section 5. Whether a prosecution can be resumed in these circumstances is therefore much less clear. The CPS argues that “the statutes [the 1964 Act, the 1991 Act and the 2004 Act] neither restrict nor reserve the trial of an offender who becomes fit to plead after an order is made”. It is unlikely that the CPS will be made aware when a person subject to an unrestricted hospital order or supervision order becomes fit again as the responsible clinician has no duty to advise the CPS if the person’s mental condition improves. However, the CPS takes the view that a prosecution can still be resumed if such information does come to light.¹⁰⁶

CIVIL POWERS UNDER THE 1983 ACT

A.74 A mentally disordered offender would normally be dealt with by way of Part 3 of the 1983 Act – namely, powers under sections 35 to 55 as discussed so far. However he or she might also be dealt with by way of powers under the civil sections of the 1983 Act, which are usually available to either mental health professionals as discussed below or the police (see paragraph A.4 above).

Compulsory admission to hospital

A.75 A person can be detained in hospital through civil admission for assessment under section 2 of the 1983 Act and for treatment under section 3 of the 1983 Act. An application can be made under section 2 on the grounds that:

the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period; and

the person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.¹⁰⁷

A person can only be detained for a period of 28 days under section 2. However, further detention can be obtained if a subsequent application (such as under section 3 of the 1983 Act) or an order or direction through other powers of the 1983 Act is made before the expiry of the section 2 application.

A.76 Section 3 provides a power for compulsory admission of a person to hospital for treatment. The section 37 hospital order discussed at paragraph A.43 above operates in a similar way. The criteria for admission are that:

- (1) the person is suffering from mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment in a hospital; and

¹⁰⁶ CPS, *Legal Guidance – Mentally Disordered Offenders* (revised December 2010), http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/index.html (last visited 16 Jan 2012).

¹⁰⁷ Department of Health, *Code of Practice: Mental Health Act 1983* (2008), para 4.2; s 2(2) of the 1983 Act.

- (2) it is necessary for the health or safety of the patient or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless he or she is detained under this section; and
- (3) appropriate medical treatment is available for him or her.¹⁰⁸
- A.77 Written evidence from two registered medical practitioners is required for admission under both sections 2 and 3.¹⁰⁹ The application for admission is normally made by an approved mental health professional – although it can also be made by the “nearest relative”¹¹⁰ – who must confirm that the criteria are satisfied and that the nearest relative does not object to the detention. Unlike hospital orders made under part 3 of the 1983 Act, if a person is admitted to hospital under the civil sections, a restriction order cannot be attached. However, a community treatment order can be made which has a similar effect to a restriction order (see paragraph A.80 below).
- A.78 There is also an emergency power of admission for assessment under section 4 of the 1983 Act for a period of up to 72 hours. Further, doctors and approved clinicians have “holding powers” under section 5(2) to detain a hospital inpatient who was informally admitted to hospital for up to 72 hours where an application for detention should be made. Nurses of a prescribed class have a similar holding power, but detention can only be permitted for up to 6 hours or until the arrival of a doctor or approved clinician.¹¹¹

Community disposals

- A.79 An application can be made for a person to be placed under the guardianship¹¹² of a local social services authority or another person the authority has approved. The person must be suffering from mental disorder of a nature or degree that warrants guardianship and it must be necessary in the interests of the welfare of the person or for the protection of other persons.¹¹³

¹⁰⁸ Section 3(2) of the 1983 Act.

¹⁰⁹ Sections 2(3) and 3(3) of the 1983 Act. At least one medical practitioner must be approved by the Secretary of State.

¹¹⁰ The “nearest relative” is defined in s 26 of the 1983 Act. He or she has certain rights and powers in relation to the patient for whom he or she is the nearest relative for, including a power to block an admission to hospital under s 3 and rights to request the release of certain patients: see para A.94 below. Patients who have a restriction order attached to the hospital order do not have a “nearest relative” for the purposes of the 1983 Act.

¹¹¹ Section 5(4) of the 1983 Act.

¹¹² Section 7 of the 1983 Act.

¹¹³ Section 7(2) of the 1983 Act.

- A.80 The 1983 Act also makes provision for supervised community treatment, also known as community treatment orders, to allow patients detained under section 3 and section 37 (without a restriction order) back into the community.¹¹⁴ Community treatment orders are used frequently for people subject to orders under Part 3 of the 1983 Act, as well as other patients detained under the 1983 Act. Those who are made subject to a community treatment order can be recalled by the responsible clinician.¹¹⁵

FOLLOWING DISPOSAL: HOW THE INDIVIDUAL MIGHT COME TO BE RELEASED FROM A HOSPITAL ORDER

- A.81 The routes of release available to a person detained in hospital are largely the same whether he or she is detained under the civil or the criminal sections of the 1983 Act. However, as would be expected, these routes are more limited where a restriction order has been imposed.

Discharge by the responsible clinician or the hospital managers

- A.82 If a restriction order is attached to the hospital order, he or she can only be discharged by the responsible clinician or the hospital managers if the Secretary of State consents.¹¹⁶
- A.83 The responsible clinician has a power to discharge most unrestricted patients from detention.¹¹⁷ This decision can be made at any time and not necessarily at the termination of the detention period. This applies to hospital orders made under civil sections and hospital orders made by a court under section 37 or following a transfer under section 47, but it does not extend to patients “remanded to hospital or under an interim hospital order.”¹¹⁸
- A.84 The Code of Practice states that “if, at any time, responsible clinicians conclude that the criteria which would justify renewing a patient’s detention ... are not met, they should exercise their power of discharge.”¹¹⁹ There is no statutory guidance on what the responsible clinician needs to consider in the exercise of this discretion.

¹¹⁴ Section 17A of the 1983 Act, inserted by the 2007 Act.

¹¹⁵ Section 17E of the 1983 Act, inserted by the 2007 Act.

¹¹⁶ Section 41(3)(c)(iii) of the 1983 Act.

¹¹⁷ Section 23(2)(a) of the 1983 Act. See R Jones, *Mental Health Act Manual* (14th ed 2011) para 1-343 and Department of Health, *Code of Practice: Mental Health Act 1983* (2008), para 29.16.

¹¹⁸ B Hale, *Mental Health Law* (5th ed 2010) p 242.

¹¹⁹ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 29.16.

A.85 The hospital managers – that is “the organisation or individual in charge of the hospital”¹²⁰ – have a similar power to discharge unrestricted patients.¹²¹ As with the responsible clinician, no statutory criteria are specified for the exercise of their discretion. However, the Code of Practice states that “the essential yardstick is whether the grounds for continued detention ... under the Act are satisfied.”¹²²

A.86 It has been suggested that it would be appropriate for the considerations to be taken by the responsible clinician or the hospital managers to be the same as those required of the tribunals.¹²³ Therefore, in assessing the continued detention of a patient, the hospital managers and responsible clinician should consider whether:

(1) the patient is still suffering from mental disorder;

(2) the disorder continues to be of a nature or degree which makes assessment or assessment followed by medical treatment (for s 2 patients) or treatment (for s 3 patients [and section 37]) in a hospital appropriate;

(3) for s 3 patients [and section 37], the appropriate medical treatment test continues to be satisfied; and

(4) detention in a hospital is still necessary in the interest of the patient’s own health or safety for the protection of others

The patient should be discharged if any of those questions can be answered in the negative.¹²⁴

A.87 The powers of discharge of the responsible clinician and the hospital managers are exercised independently: the hospital managers are not able to block the discharge of a patient if it is ordered by the responsible clinician, and equally the responsible clinician cannot block the discharge of a patient if ordered by the hospital managers.¹²⁵

A.88 Hospital managers also have a duty to refer cases of unrestricted patients detained under Part 3 of the 1983 Act to the relevant tribunal (see paragraph below) if three years have passed without their case being heard by the tribunal.¹²⁶

¹²⁰ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 31.3.

¹²¹ Section 23(2)(a) of the 1983 Act. The Code of Practice gives guidance on the criteria to be applied at para 31.16.

¹²² Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 31.14.

¹²³ *South West London and St George’s Mental Health NHS Trust v W* [2002] EWHC 1770 (Admin) at [81] by Crane J.

¹²⁴ R Jones, *Mental Health Law Manual* (14th ed 2011) para 1-342.

¹²⁵ B Hale, *Mental Health Law* (5th ed 2010) p 242.

¹²⁶ Section 68 of the 1983 Act; Department of Health, *Code of Practice: Mental Health Act 1983* (2008), para 30.34.

Discharge by the tribunal

- A.89 The tribunal has the power to review a person's continued detention under the 1983 Act. The detained person can apply to the tribunal within the relevant period which differs depending on the power under which the person is detained.
- A.90 A person compulsorily detained under the civil section for treatment (section 3) is entitled to apply within the first six months of detention.¹²⁷ Similarly, persons detained in hospital under section 5(1) of the 1964 Act following a special verdict or finding of unfitness to plead and prisoners transferred to hospital¹²⁸ (with or without a restriction order) can apply within the first six months of detention. However, a person subject to a section 37 hospital order can only apply to the tribunal in the second six months of detention.
- A.91 The role of the tribunal is to determine whether the grounds for continued detention exist. It falls to the party seeking to continue detention to prove that the grounds are made out.¹²⁹ Section 72(1) sets out the criteria to be applied by the tribunal in the consideration for unrestricted patients. In relation to patients detained under section 3 or a hospital order without a restriction, the tribunal should discharge a patient if not satisfied:
- (i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
 - (ii) that it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment; or
 - (iii) that appropriate medical treatment is available for him; ...¹³⁰
- A.92 The tribunal has similar powers in relation to restricted patients.¹³¹ Patients under a restriction order have a right to apply to the tribunal within the second six months of detention and every year thereafter.¹³² The criteria to be applied by the tribunal in the determination of release of a restricted patient are set out in section 73.

¹²⁷ Section 66(2)(b) of the 1983 Act.

¹²⁸ Section 69(2) of the 1983 Act.

¹²⁹ See *R (on the application of H) v Mental Health Review Tribunal For North and East London Region* [2001] EWCA Civ 415, [2002] QB 1.

¹³⁰ Section 72(1)(b) of the 1983 Act. See *Drew* [2003] UKHL 25, [2004] 1 Cr App R (S) 8, 65.

¹³¹ Section 70 of the 1983 Act.

¹³² Sections 70(a) and 79(1) of the 1983 Act.

A.93 The tribunal must order the discharge of a restricted patient if not satisfied that the criteria under section 72(1)(b) (as set out above) are made out and further that “it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.”¹³³ If the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment, they must direct an absolute discharge.¹³⁴ However, if the tribunal considers that it may be appropriate for a patient to be liable to recall they must grant a conditional discharge.¹³⁵ Conditions usually relate to the supervision, residence or medical treatment of the patient.¹³⁶

Discharge by a nearest relative

A.94 A person compulsorily admitted to hospital under the civil section can also be discharged by their nearest relative.¹³⁷ The responsible clinician would then only be able to block the discharge if he or she certifies that, if discharged, the patient “would be likely to act in a manner dangerous to other persons or to himself”.¹³⁸ If a person is detained in a hospital under a court order, such as section 37, the nearest relative can only request the release of the detained person in an application to the relevant tribunal (see paragraph above) to consider the detained person’s case.¹³⁹ The nearest relative provisions do not apply to restricted patients.

Powers of the Secretary of State to discharge a restricted patient

A.95 The Secretary of State has the power to order the discharge (absolute or conditional) of a restricted patient under section 42(2) of the 1983 Act at any time. Unlike the tribunal’s power of discharge, the Secretary of State is not bound by any statutory criteria in the exercise of this discretion. However, if satisfied that the patient is no longer suffering from mental disorder from the evidence on the patient’s mental condition, the Secretary of State should discharge the patient.¹⁴⁰ This power would usually be exercised at the request of a patient’s responsible clinician.

¹³³ Section 73(1)(b) of the 1983 Act.

¹³⁴ Section 73(1)(b) of the 1983 Act.

¹³⁵ Section 73(2) of the 1983 Act.

¹³⁶ R Jones, *Mental Health Act Manual* (14th ed 2011) para 1-874.

¹³⁷ Section 23(2) of the 1983 Act. The nearest relative cannot discharge a person detained following an emergency application for assessment under s 4. See n 110 above on “nearest relative”.

¹³⁸ Section 25(1) of the 1983 Act.

¹³⁹ Section 69(1) of the 1983 Act. This restriction on the nearest relative’s power is understandable, for “it is one thing for the court to abandon control to the medical authorities, another for the nearest relative to be able to override the order of a criminal court.” B Hale, *Mental Health Law* (5th ed 2010) pp 241 to 242.

¹⁴⁰ *Kynaston v Secretary of State for Home Affairs* (1981) 73 Cr App R 281, by Lawton LJ: R Jones, *Mental Health Act Manual* (14th ed 2011) para 1-541.

Diagram 1: Path of mentally disordered offender in the magistrates' court

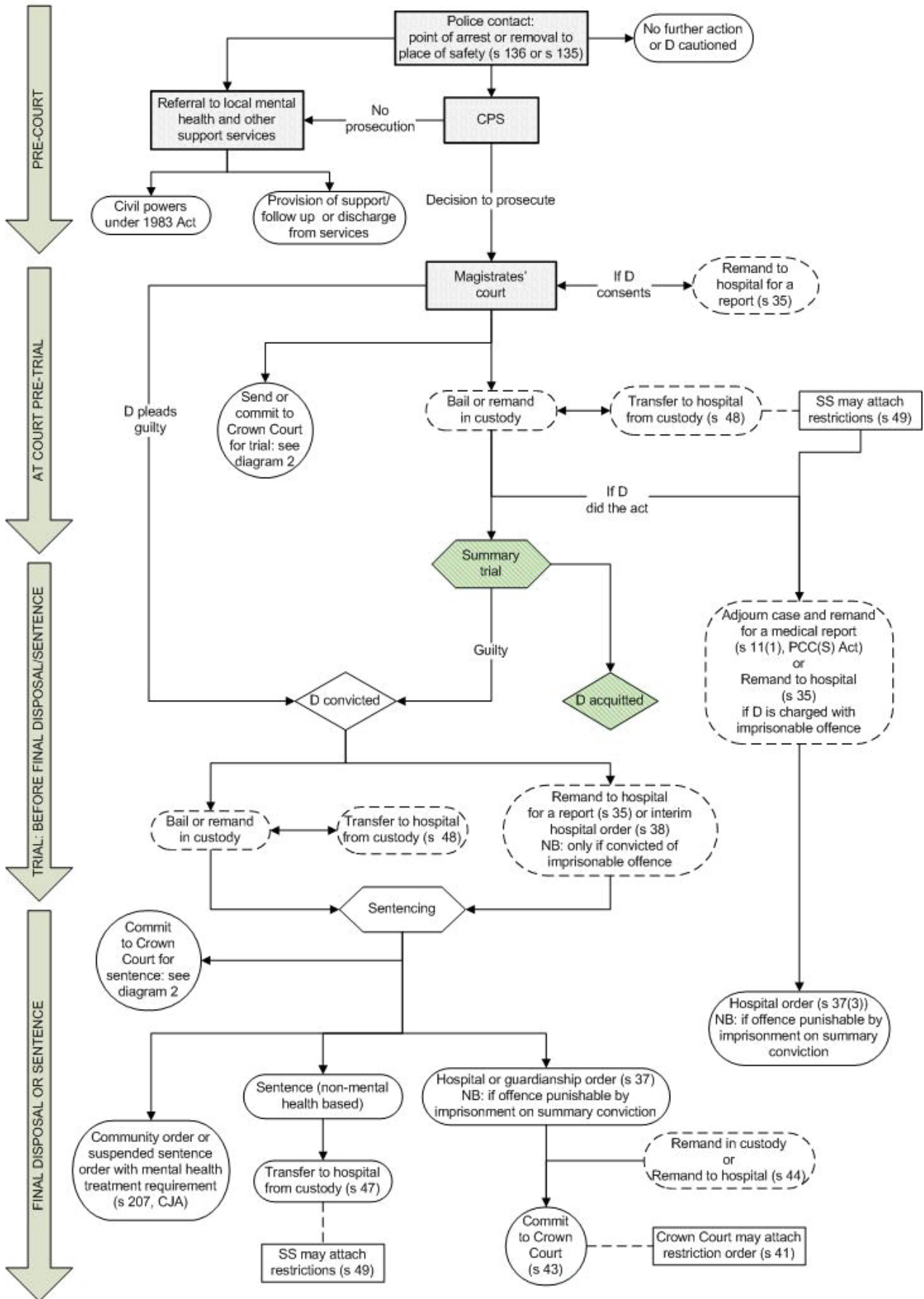
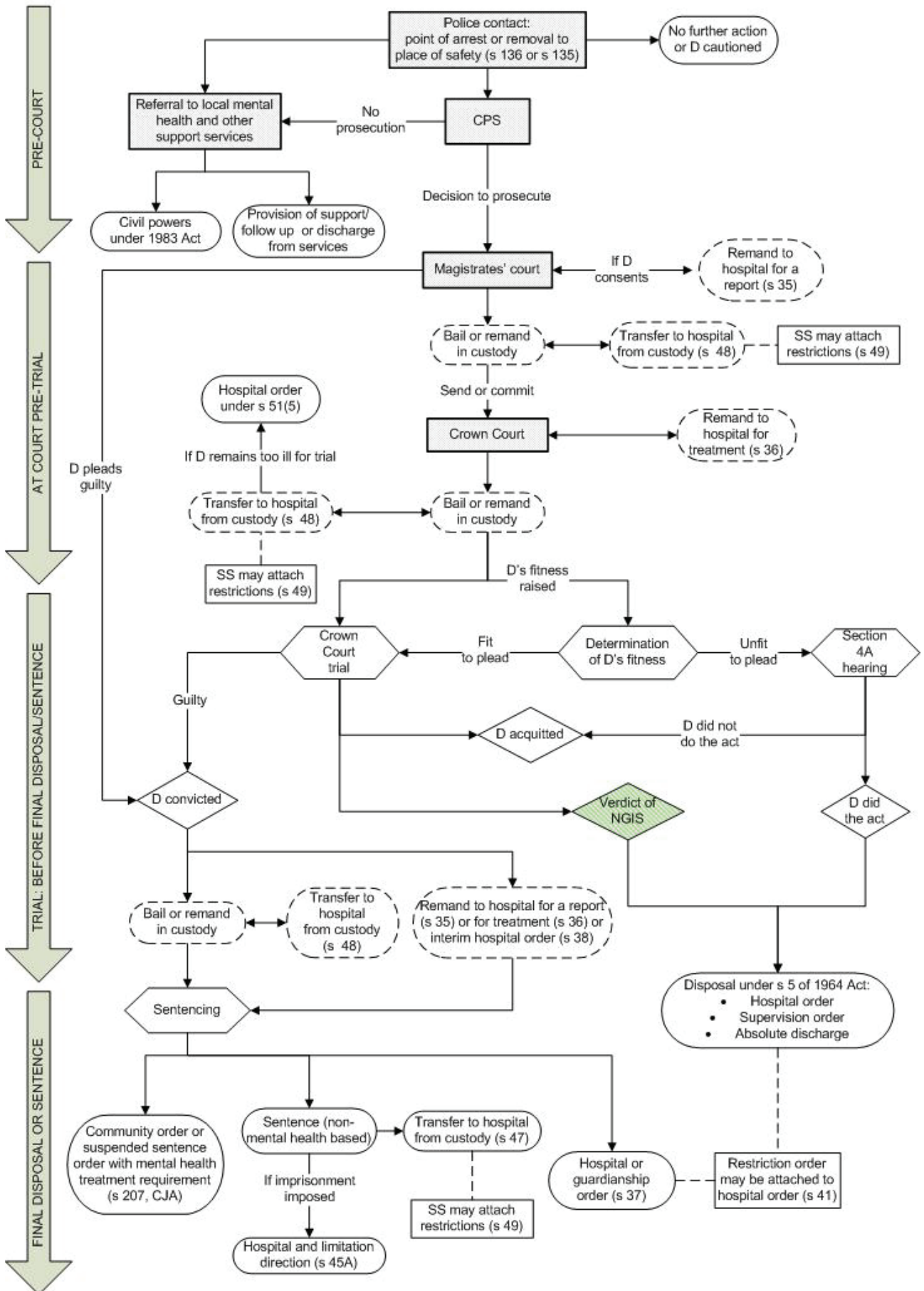


Diagram 2: Path of mentally disordered offender in the Crown Court



Key for diagrams 1 and 2

Stage in the process

Temporary disposal

Final disposal or sentence

Court hearing

Verdict or finding

Possible restrictions to a hospital order

Sent or committed to Crown Court

Group relevant to the new defence

Notes on diagrams:

- D refers to the defendant.
- NGIS refers to not guilty by reason of insanity.
- All sections referred to are from the 1983 Act unless otherwise stated.
- PCC(S) Act refers to the Powers of the Criminal Court (Sentencing) Act 2000.
- CJA refers to the Criminal Justice Act 2003.
- References to "did the act" means "did the act or made the omission charged".
- SS refers to the Secretary of State or Welsh Ministers.

APPENDIX B

NOT GUILTY BY REASON OF INSANITY (NGIS) VERDICTS (2006 – 2009)

Analysis conducted for the Law Commission of England & Wales by Professor Cheryl Thomas, Director, UCL Jury Project (October 2011)

BACKGROUND NOTE TO ANALYSIS

- B.1 The following provides an analysis of all Not Guilty by Reason of Insanity (“NGIS”) verdicts returned in all Crown Courts in England and Wales in the 28-month period of 1 October 2006 to 31 January 2009. The data are drawn from CREST, the HMCTS case management and reporting system for Crown Courts, covering all charges against all defendants in all Crown Courts in England and Wales in this same time period. The results are also placed in the context of all defendants charged in all Crown Courts in England and Wales and all Not Guilty jury verdicts by deliberation returned in all Crown Courts in England and Wales in the same period.
- B.2 This analysis examines all Not Guilty by Reason of Insanity verdicts in relation to verdicts, defendants, cases and offences. This varied approach to analysing the data is important in order to present an accurate picture of Not Guilty by Reason of Insanity verdicts. This is because it enables the analysis to take into account the fact that some cases can involve multiple charges and/or multiple defendants, and therefore a single approach to analysing the data can produce misleading results.
- B.3 The Verdicts-based analysis examines:
- Distribution of NGIS verdicts in relation to all jury verdicts by deliberation and all charges against defendants in all Crown Courts in the same period.
- B.4 The Defendant-based analysis examines:
- Ethnicity
 - Gender
 - Age
- B.5 Case-based analysis examines:
- Court region
 - Number of charges against defendant
- B.6 The Offence-based analysis examines:
- Offence type (general and specific)
 - Types of disposal orders by offence

Length of disposal orders by offence

KEY FINDINGS

- B.7 Instances where a defendant is found Not Guilty by Reason of Insanity are extremely rare: they account for a very small proportion of all Not Guilty jury verdicts (0.3%), all jury verdicts and all defendants in jury trials (0.1%).
- B.8 Defendants found Not Guilty by Reason of Insanity are very similar in terms of their ethnic background and gender to all defendants charged in Crown Court and appearing in jury trials.
- B.9 The age distribution among defendants found Not Guilty by Reason of Insanity is higher than the age distribution of all defendants appearing in jury trials. Among all defendants appearing in jury trials, the single largest group is those 20 to 29 years of age (31%), but among NGIS defendants the largest groups are those 30 and 39 and 40 and 49 (30% both).
- B.10 Cases involving Not Guilty by Reason of Insanity verdicts are distributed across the Crown Court regions in similar proportions to all jury trials.
- B.11 The main difference between cases involving Not Guilty by Reason of Insanity verdicts and other cases in the Crown Courts is the type of offences involved.

PART 1: OVERALL FIGURES

- B.12 In the 28-month time period covered by the CREST data, Not Guilty by Reason of Insanity verdicts (89) account for 0.3% of all Not Guilty jury verdicts reached by deliberation (33,865). Table 1 below provides a more detailed breakdown of how NGIS verdicts relate all jury trials and all charges against all defendants.

Table 1: NGIS verdicts, cases and defendants

| | All NGIS verdicts (Oct 06 – Jan 09) | All outcomes by jury deliberation (Oct 06 – Jan 09) | All charges (Oct 06 – Jan 09) |
|------------|--|--|--|
| Verdicts | 89 | 96,748 (0.1%) | 722,289 (0.01%) |
| Cases | 40 | 19,355 (0.2%) | 110,170 (0.04%) |
| Defendants | 40 | 32,454 (0.1%) | 220,757 (0.02%) |

PART 2: DEFENDANT-BASED ANALYSIS

2.1 Gender and ethnicity

- B.13 As Table 2 shows, there does not appear to be any real difference in the ethnic profile of defendants found Not Guilty by Reason of Insanity compared with the ethnic profile of all defendants in Crown Courts in the same time period or all defendants found Not Guilty by jury deliberation in the same period.

Table 2: Ethnicity of NGIS defendants in relation to all defendants

| Defendant ethnicity | All defendants in Crown Court | All Not Guilty jury verdicts | All NGIS verdicts |
|---------------------|-------------------------------|------------------------------|-------------------|
| White | 62% | 60% | 53% |
| BME | 19% | 23% | 22% |
| Unknown | 19% | 17% | 25% |

B.14 Table 3 below provides a breakdown of all defendants found NGIS by gender and ethnicity.

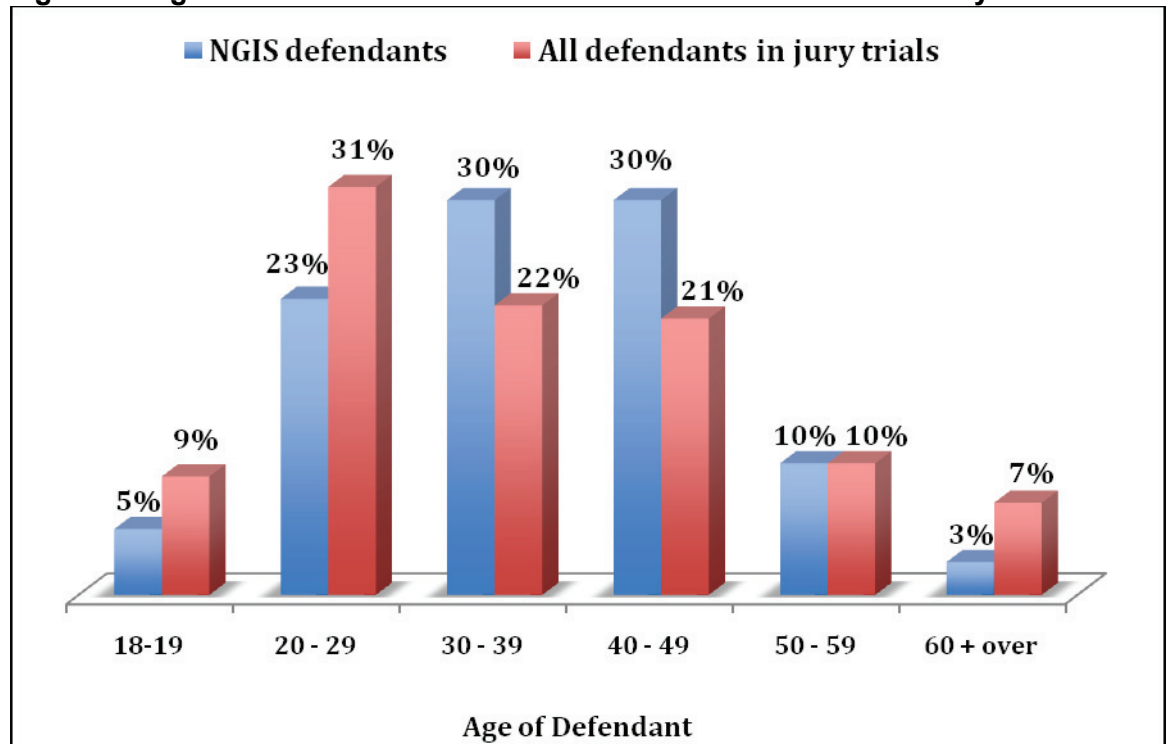
Table 3: NGIS verdicts by defendant gender and ethnicity

| | White | Black | Asian | Mixed | Other | Unknown | Totals | |
|--------|-------|-------|-------|-------|-------|---------|--------|--------|
| Male | 17 | 4 | 0 | 1 | 2 | 7 | 31 | 77.50% |
| Female | 4 | 2 | 0 | 0 | 0 | 3 | 9 | 22.50% |
| Totals | 21 | 6 | 0 | 1 | 2 | 10 | 40 | |
| | 53% | 15% | 0% | 2% | 5% | 25% | | |
| | BME | | | | 22% | | | |

2.2 Age of defendants

B.15 As Figure 1 below shows, most defendants found Not Guilty by Reason of Insanity (60%) are aged 30 to 49. This differs from all defendants in jury trials, where the single largest group (31%) is made up of those aged 20 to 29.

Figure 1: Age of NGIS Defendants in relation to All Defendants in Jury Trials



B.16 There appears to be very little difference in the age profile of male and female defendants found Not Guilty by Reason of Insanity (Table 4), especially considering that the numbers are very small and therefore percentages could potentially have varied more widely.

Table 4: Age and gender of defendants with NGIS verdicts (Oct 2006 – Jan 2009)

| Age group | number | % | Male | | Female | |
|---------------|-----------|-----|-----------|--------------|----------|--------------|
| 18-19 | 2 | 5% | 2 | 6% | 0 | 0% |
| 20 - 29 | 9 | 23% | 7 | 22% | 2 | 22% |
| 30 - 39 | 12 | 30% | 9 | 29% | 3 | 33% |
| 40 - 49 | 12 | 30% | 9 | 29% | 3 | 33% |
| 50 - 59 | 4 | 10% | 3 | 10% | 1 | 11% |
| 60 + over | 1 | 3% | 1 | 3% | 0 | 0% |
| totals | 40 | | 31 | 77.5% | 9 | 22.5% |

PART 3: CASE-BASED ANALYSIS**3.1 Number of charges against defendants**

- B.17 As Table 5 shows, the level of multiple charging in NGIS cases is remarkably consistent with the level of multiple charging for all defendants in all Crown Court cases.

Table 5: Number of charges against NGIS defendants

| Charges per defendant | Number of cases | % of all NGIS | All defendants |
|-----------------------|-----------------|---------------|----------------|
| 1 | 15 | 38% | 37% |
| 2 | 14 | 35% | 26% |
| 3 | 4 | 10% | 13% |
| 4 | 4 | 10% | 8% |
| 5 | 1 | 2% | 4% |
| 6 | 1 | 2% | 3% |
| 7 | 1 | 2% | 2% |
| | 40 | | |

3.2 Court region

- B.18 Table 6 also shows that the distribution of NGIS verdicts across Crown Court regions is very consistent with the distribution of all jury verdicts across Crown Court regions.
- B.19 The London, Midlands and South East regions combined account for almost all (88%) of NGIS verdicts.

Table 6: Number of NGIS cases by court region

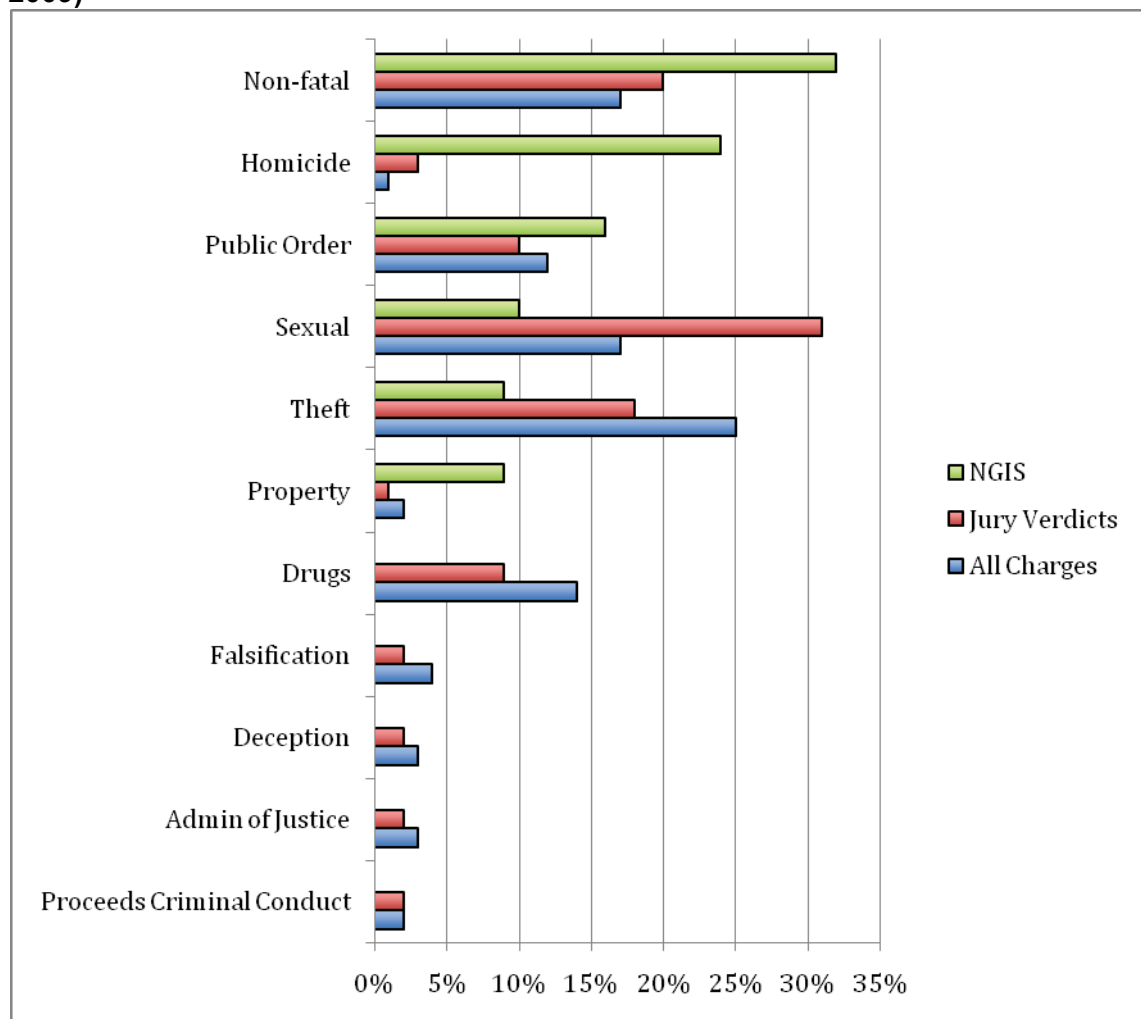
| Court region | Number of cases | % of all NGIS | All jury verdicts |
|--------------|-----------------|---------------|-------------------|
| London | 14 | 35% | 26% |
| Midlands | 11 | 28% | 15% |
| South East | 10 | 25% | 20% |
| North East | 2 | 5% | 11% |
| North West | 2 | 5% | 12% |
| South West | 1 | 2% | 10% |
| Wales | 0 | 0% | 6% |
| Total | 40 | | |

PART 4: OFFENCE-BASED ANALYSIS

4.1 Offence types in NGIS cases

- B.20 As Figure 2 and Table 7 below show, there are some very substantial differences in the general offence types involved in verdicts of Not Guilty by Reason of Insanity in comparison with both all jury verdicts and all charges against defendants in all Crown Courts.
- B.21 Non-fatal offences against the person (32%), homicide (24%) and property (9%) are very substantially over-represented in NGIS verdicts compared with both all jury verdicts and all charges in the Crown Court. Public order offences (16%) are also over-represented but less substantially.
- B.22 Sexual offences (10%) and theft-related offences (9%) are substantially under-represented: sexual offences particularly in relation to all jury verdicts (31%) and theft offences particularly in relation to all charges (25%).
- B.23 There were no instances of NGIS verdicts for drugs, falsification, deception, administration of justice and proceeds of crime offences.

Figure 2: Offence Types: All Charges, Jury Verdicts and NGIS Verdicts (2006-2009)¹



¹ Source of data on all charges and jury verdicts: C Thomas, *Are Juries Fair?* (Ministry of Justice Research Series, 2010).

Table 7: Comparison of Offence Types: All charges, jury verdicts & unfit to plead

| Offence Type | Not Guilty by Reason of Insanity Verdicts | Jury Verdicts | All Charges |
|---------------------------|---|---------------|-------------|
| Non-fatal | 32% | 20% | 17% |
| Homicide | 24% | 3% | 1% |
| Public Order | 16% | 10% | 12% |
| Sexual | 10% | 31% | 17% |
| Theft | 9% | 18% | 25% |
| Property | 9% | 1% | 2% |
| Drugs | 0% | 9% | 14% |
| Falsification | 0% | 2% | 4% |
| Admin of Justice | 0% | 2% | 3% |
| Deception | 0% | 2% | 3% |
| Proceeds Criminal Conduct | 0% | 2% | 2% |

4.2 Specific offences charged in NGIS cases

B.24 Table 8 below shows the specific offences defendants were charged with in all NGIS cases. Offences common to both male and female defendants appear shaded in the table. No women were charged with any sexual, property or theft offences in NGIS cases.

Table 8: General and specific offences for NGIS defendants by gender

| Offence type (Blackstone's) | Defendants | |
|---------------------------------------|---|---|
| | Male | Female |
| Non-fatal offences against the person | Affray | |
| | Assault occasioning actual bodily harm | Assault occasioning actual bodily harm |
| | | Assault with intent to resist apprehension |
| | Attempting to inflict grievous bodily harm | |
| | Causing grievous bodily harm with intent to do grievous bodily harm | |
| | Common assault | |
| | Doing an act of cruelty to a child or young person under 16 years | |
| | False imprisonment | |
| | Inflicting grievous bodily harm | |
| | Unlawful wounding | Unlawful wounding |
| | Wounding with intent to do grievous bodily harm | Wounding with intent to do grievous bodily harm |
| Homicide-related | Attempted murder (victim one year old or over) | Attempted murder (victim one year old or over) |
| | Murder (victim one year old or over) | Murder (victim one year old or over) |

| | | |
|---------------------------|--|--|
| | | Murder (victim under one year old) |
| | | Causing death by dangerous driving |
| | Threatening to kill | |
| Sexual | Attempted rape (of female under 16) | |
| | Engaging in sexual activity in presence of a child aged under 13 - offender 18 or over | |
| | Exposure | |
| | Sexual assault of male child under 13 | |
| | Sexual assault on a female | |
| Public order | Aggravated vehicle taking (taking) driving dangerously on road/place | |
| | Dangerous driving | Dangerous driving |
| | Having article with blade, or which was sharply pointed, in public place | |
| | | Having offensive weapon |
| | Possessing an imitation firearm with intent to cause fear or violence | |
| Damage to property | Arson | |
| | Arson with intent to endanger life | |
| | Committing arson recklessly | |
| | | Damaging property (value of damage £5000 or less - Criminal Damage Act 1971) |
| Theft, handling | | Attempted robbery |
| | Burglary (with intent to steal - in dwelling) | |
| | Burglary (stealing or attempting to steal - in dwelling) | |
| | Robbery | |
| | Theft (from the person of another) | |

4.3 Disposals in NGIS cases

Table 9: Disposals on all verdicts of Not Guilty by Reason of Insanity

| Type of Disposal Order | Number made | % of all NGIS verdicts |
|--|-------------|------------------------|
| Hospital Order | 28 | 32% |
| Restriction Order under s.41 of Mental Health Act 1983 | 11 | 12% |
| Absolute Discharge/Defendant Discharged | 10 | 11% |
| Supervision Order: comply with directions in order | 9 | 10% |

| | | |
|---|-----------|----|
| Interim Hospital Order: Specified period | 7 | 8% |
| Supervision Order: comply with directions of supervisor | 7 | 8% |
| Supervision Requirement | 6 | 7% |
| Mental Health Treatment | 2 | 2% |
| No RDCO order made | 2 | 2% |
| Residence Requirement | 2 | 2% |
| Disqualified | 1 | 1% |
| Forfeiture other than vehicle under s.143 PCC (Sentencing) Act 2000 | 1 | 1% |
| Restriction Order without time limit | 1 | 1% |
| Unknown (Not recorded in CREST) | 2 | 2% |
| Total | 89 | |

Table 10: Length of disposal orders in NGIS verdicts

| DISPOSAL ORDER | LENGTH of ORDER | OFFENCES CHARGED |
|---|-----------------|---|
| Interim Hospital Order: Specified period | 28 days | <ul style="list-style-type: none"> Attempted murder |
| | 12 weeks | <ul style="list-style-type: none"> Causing death by dangerous driving Attempted murder |
| | Not recorded | <ul style="list-style-type: none"> Arson |
| Mental Health Treatment | 2 years | <ul style="list-style-type: none"> Possessing an imitation firearm with intent to cause fear or violence Theft (one case) |
| Residence Requirement | 2 years | <ul style="list-style-type: none"> Possessing an imitation firearm with intent to cause fear or violence Theft (one case – as above with MHT order) |
| Supervision Order: comply with directions in order | 2 years | <ul style="list-style-type: none"> Assault occasioning actual bodily harm Doing an act of cruelty to a child or young person under 16 years. Causing grievous bodily harm with intent to do grievous bodily harm Common assault Sexual assault on a female Attempted murder Arson with intent to endanger life |
| Supervision Order: comply with directions of supervisor | 2 years | <ul style="list-style-type: none"> Unlawful wounding Affray Common assault Burglary Assault occasioning actual bodily harm |
| | 1 year | <ul style="list-style-type: none"> Wounding with intent to do grievous bodily harm Burglary |

24 October 2011. Professor Cheryl Thomas, Professor of Judicial Studies, Director UCL Jury Project, UCL Faculty of Laws, Bentham House, London, WC1H 0EG. Tel. 07771 763216. Email: cheryl.thomas@ucl.ac.uk.

APPENDIX C

THE LAW OF OTHER JURISDICTIONS

INSANITY

JURISDICTIONS WITH A VERSION OF THE M'NAGHTEN RULES

Australia

- C.1 Australian law comprises a mixture of common law and code jurisdictions.¹ Most jurisdictions have reformed their insanity defences, largely by way of revised terminology. In the majority of jurisdictions, the defence continues to be based on the M'Naghten Rules but the exact approach varies. In contrast with England and Wales, some include a volitional element.²
- C.2 The scope of the defence and its relationship with automatism in Australia differs from the relationship between the two defences in England. In *Falconer* a majority of the High Court of Australia rejected the internal defect/external influence distinction established in *Hennessy*, *Quick* and *Sullivan* in England and Wales.³ Chief Justice Mason, Justice Brennan and Justice McHugh (in a joint judgment) held that “there seems to be no reason in principle why psychological trauma which produces a transient non-recurrent malfunction of an otherwise healthy mind should be distinguished from a physical trauma which produces a like effect”.⁴ Justice Toohey provided that “the application of the ‘external factor’ test is artificial and pays insufficient regard to the subtleties surrounding the notion of mental disease.”⁵
- C.3 In *Falconer*, the court focused on the notion of a “diseased mind”, which it held to be the objective standard of an “ordinary person”: “if the mind’s strength is below that standard, the mind is infirm; if it is of or above that standard, the mind is sound or sane”.⁶ A condition that results from the reaction of a healthy mind to extraordinary external stimuli is therefore not within the definition of mental illness, although such a condition may be evidence of mental illness if it involves some abnormality and is prone to recur.

¹ The common law jurisdictions are New South Wales, South Australia and Victoria. The code jurisdictions are the Commonwealth, the Northern Territory, Queensland, Tasmania and Western Australia. The Australian Capital Territory has a partially applied code. In some common law jurisdictions such as South Australia and Victoria, the common law has been replaced by a statutory defence.

² A “volitional element” is the capacity to choose whether to do or not do something.

³ (1990) 65 ALJR 20. On *Hennessy*, *Quick* and *Sullivan* see paras 2.66 and following above.

⁴ (1990) 65 ALJR 20 at [25].

⁵ (1990) 65 ALJR 20 at [30].

⁶ (1990) 65 ALJR 20 at [27].

- C.4 The elements of the defence also differ from those in England. The question of the interpretation of the wrongfulness limb arose in the High Court of Australia in *Porter*.⁷ The accused was charged with murdering his child. The key issue for the jury was whether Porter knew that what he was doing was wrong. Justice Dixon emphasised that this meant that the court was “dealing with one particular thing, the act of killing, the act of killing at a particular time a particular individual. We are not dealing with right or wrong in the abstract.” He continued, “What is meant by ‘wrong’? What is meant by wrong is wrong having regard to the everyday standards of reasonable people.”⁸ Subsequently, in 1952, the High Court of Australia subjected the interpretation of “wrong” to careful analysis in *Stapleton*⁹ where the court chose not to follow *Windle* but instead interpreted the “wrongfulness” limb as a question of whether the accused knew his act was wrong “according to the ordinary standards adopted by reasonable men”.¹⁰ This approach has been criticised.¹¹ Individuals whose moral views result from mental impairment may be thought to lack the capacity to reason properly, but the question remains why inability to reason morally should exculpate an individual from criminal responsibility when that individual is still capable of knowing and understanding that his or her conduct is contrary to law.

Australian jurisdictions which include a volitional element

WESTERN AUSTRALIA

- C.5 The insanity defence is governed by sections 26 and 27 of the Criminal Code Act Compilation Act 1913 (WA), as amended.¹² Section 26 establishes a presumption of sanity. Section 27 is titled “insanity” but the text refers to “unsoundness of mind” and “mental impairment”. It reads:

(1) A person is not criminally responsible for an act or omission on account of unsoundness of mind if at the time of doing the act or making the omission he is in such a state of mental impairment as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission.

(2) A person whose mind, at the time of his doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist.

⁷ *Porter* [1933] HCA 1, (1933) 55 CLR 182.

⁸ *Porter* [1933] HCA 1, (1933) 55 CLR 182 at [10], by Dixon J (in summing up).

⁹ *Stapleton* [1952] HCA 56, (1952) 86 CLR 358.

¹⁰ *Stapleton* [1952] HCA 56, (1952) 86 CLR 358 at [29].

¹¹ By, eg, the New Zealand Law Commission who point out that “in all other respects the criminal law focuses on whether or not the act was contrary to law; the moral beliefs of individuals are irrelevant.” New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 5.6. This is overstating the case in relation to some offences such as where the accused’s dishonesty is in issue.

¹² By the Criminal Law (Mentally Impaired Accused) Act 1996 (WA).

- C.6 Under section 28, the insanity defence in section 27 also applies to “a person whose mind is disordered by intoxication or stupefaction caused without intention on his part by drugs or intoxicating liquor, or by any other means”. It might be thought even more inappropriate to label someone insane who is merely intoxicated than someone who is diabetic or epileptic as is the case in England and Wales, especially when this may lead to indefinite detention under section 22 of the Criminal Law (Mentally Impaired Accused) Act 1996 (though the section also allows for an unqualified release if the court feels this is warranted in the circumstances). The position can be contrasted with other areas (see for example Australian Capital Territory, below) which expressly exclude intoxication from the scope of the defence.
- C.7 The section differs from the M’Naghten Rules in the use of the phrase “capacity to understand” as opposed to “know”. This phrase suggests that there is some similarity to the Model Penal Code formulation (see paragraph C.50 below). However the Western Australian Law Reform Commission report on the subject¹³ tells us that this first limb “has been interpreted as being substantially the same as the M’Naghten formulation which refers to not knowing ‘the nature and quality of the act [the accused] was doing’”.

AUSTRALIAN CAPITAL TERRITORY

- C.8 Division 2.3.2 of the Criminal Code 2002 (ACT) is titled “Lack of capacity – mental impairment”. Sections 28 and 29 read:

28 Mental impairment and criminal responsibility

(1) A person is not criminally responsible for an offence if, when carrying out the conduct required for the offence, the person was suffering from a mental impairment that had the effect that—

(a) the person did not know the nature and quality of the conduct; or

(b) the person did not know that the conduct was wrong; or

(c) the person could not control the conduct.

(2) For subsection (1)(b), a person does not know that conduct is wrong if the person cannot reason with a moderate degree of sense and composure about whether the conduct, as seen by a reasonable person, is wrong.

(3) The question whether a person was suffering from a mental impairment is a question of fact.

(4) A person is presumed not to have been suffering from a mental impairment.

(5) The presumption is displaced only if it is proved on the balance of probabilities (by the prosecution or defence) that the person was suffering from a mental impairment.

¹³ Law Reform Commission of Western Australia, *Review of the Law of Homicide*, Report No 97 (2007) p 231.

(6) The prosecution may rely on this section only if the court gives leave.

(7) If the trier of fact is satisfied that a person is not criminally responsible for an offence only because of mental impairment, it must—

(a) for an offence dealt with before the Supreme Court—return or enter a special verdict that the person is not guilty of the offence because of mental impairment; or

(b) for any other offence—find the person not guilty of the offence because of mental impairment.

29 Mental impairment and other defences

(1) A person cannot rely on a mental impairment to deny voluntariness or the existence of a fault element, but may rely on mental impairment to deny criminal responsibility.

(2) If the trier of fact is satisfied that a person carried out conduct because of a delusion caused by a mental impairment, the delusion itself cannot be relied on as a defence, but the person may rely on the mental impairment to deny criminal responsibility.

C.9 Mental impairment is defined in section 27(1) to include senility, intellectual disability, mental illness, brain damage and severe personality disorder. This can be contrasted with, for example, several US jurisdictions¹⁴ which expressly exclude personality disorders from the scope of the defence. Similarly, in Canada,¹⁵ although there is no blanket exclusion, in practice a psychopath would not be entitled to the defence since he or she would not have lost the ability to decide rationally whether an act was right or wrong. The Supreme Court of Canada has held that “such a person is capable of knowing that his or her acts are wrong in the eyes of society and, despite such knowledge, chooses to commit them”.¹⁶

C.10 Mental illness is defined in section 27(2) as “an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition (a reactive condition) resulting from the reaction of a healthy mind to extraordinary external stimuli”, although this may be evidence of mental illness if it involves some abnormality and is prone to recur, under section 27(3).

SOUTH AUSTRALIA

C.11 The defence is found in section 269C of the Criminal Law Consolidation Act 1935. Section 269C reads:

¹⁴ See further on the US at para C.50 below.

¹⁵ See further on Canada at para C.26 below.

¹⁶ *Oommen* [1994] 2 SCR 507. See below at paras C.36 to C37.

Mental competence

A person is mentally incompetent to commit an offence if, at the time of the conduct alleged to give rise to the offence, the person is suffering from a mental impairment and, in consequence of the mental impairment—

- (a) does not know the nature and quality of the conduct; or
- (b) does not know that the conduct is wrong; or
- (c) is unable to control the conduct.

C.12 “Mental impairment” is defined in section 269A of the Act as including:

- (a) a mental illness (which is defined in the section as “a pathological infirmity of the mind (including a temporary one of short duration”); or
 - (b) an intellectual disability; or
 - (c) a disability or impairment of the mind resulting from senility,
- but does not include intoxication.

NORTHERN TERRITORY

C.13 Section 43C of the Criminal Code Act (NT) is entitled “Defence of mental impairment” and reads:

(1) The defence of mental impairment is established if the court finds that a person charged with an offence was, at the time of carrying out the conduct constituting the offence, suffering from a mental impairment and as a consequence of that impairment:

- (a) he or she did not know the nature and quality of the conduct;
- (b) he or she did not know that the conduct was wrong (that is he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or
- (c) he or she was not able to control his or her actions.

(2) If the defence of mental impairment is established, the person must be found not guilty because of mental impairment.

The definition of mental impairment is set out in section 43A, and includes “senility, intellectual disability, mental illness, brain damage and involuntary intoxication.”¹⁷

¹⁷ Criminal Code Act 1983 (Northern Territory), s 43A.

QUEENSLAND

- C.14 The defence in Queensland is still called “insanity” and is governed by section 27 of the Criminal Code Act 1899 (Qld) which reads:

(1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person’s actions, or of capacity to know that the person ought not to do the act or make the omission.

(2) A person whose mind, at the time of the person’s doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist.

As in Victoria, there is no statutory definition of the terms mental disease or insanity. The use of the term “capacity to understand” brings this form of the defence closer to the Model Penal Code version, which focuses on capacity and appreciation of wrongness rather than mere knowledge.

TASMANIA

- C.15 The defence is governed by section 16 of the Criminal Code Act 1924 (Tas). The section is still titled “insanity” but that term is not used anywhere in the text of the section which reads:

(1) A person is not criminally responsible for an act done or an omission made by him –

(a) when afflicted with mental disease to such an extent as to render him incapable of –

(i) understanding the physical character of such act or omission; or

(ii) knowing that such act or omission was one which he ought not to do or make; or

(b) when such act or omission was done or made under an impulse which, by reason of mental disease, he was in substance deprived of any power to resist.

(2) The fact that a person was, at the time at which he is alleged to have done an act or made an omission, incapable of controlling his conduct generally, is relevant to the question whether he did such act or made such omission under an impulse which by reason of mental disease he was in substance deprived of any power to resist.

(3) A person whose mind at the time of his doing an act or making an omission is affected by a delusion on some specific matter, but who is not otherwise exempted from criminal responsibility under the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the fact which he was induced by such delusion to believe to exist really existed.

(4) For the purpose of this section the term “mental disease” includes natural imbecility.

- C.16 Under section 17, the defence extends to a person suffering from disease of the mind caused by intoxication.

Australian jurisdictions which do not include a volitional element

VICTORIA

- C.17 In Victoria, the common law defence of insanity was replaced by a statutory defence in 1997 with the introduction of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic). Under section 20 of the Act, a person may be found not guilty because of mental impairment if, at the time of engaging in conduct constituting the offence:

The person was suffering from a mental impairment that had the effect that –

(a) he or she did not know the nature and quality of the conduct; or

(b) he or she did not know that the conduct was wrong (that is, he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong).

- C.18 The burden of proof rests on the party raising the issue, and it must be proved on the balance of probabilities.¹⁸ There is no volitional element to the defence.

- C.19 In the absence of a statutory definition of “mental impairment”¹⁹ the M’Naghten Rules apply. The Act does not explicitly specify “defect of reason arising from disease of the mind”, but this has been implied by the courts.²⁰ Ultimately, whether a person was suffering from mental impairment at the time of the act is a matter of fact for the jury to determine.²¹

¹⁸ Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic), s 21.

¹⁹ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 4.35.

²⁰ See further *R v R* [2003] VSC 187; *Gemmill* [2004] VSCA 72; and *Martin* [2005] VSC 518.

²¹ Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic), s 21.

NEW SOUTH WALES

- C.20 The defence of mental illness is set out under the Mental Health (Forensic Provisions) Act 1990 (NSW).²² Under section 38 of the Act a person is entitled to receive a “special verdict”. This section reads as follows:

(1) If, in an indictment or information, an act or omission is charged against a person as an offence and it is given in evidence on the trial of the person for the offence that the person was mentally ill, so as not to be responsible, according to law, for his or her action at the time when the act was done or omission made, then, if it appears to the jury before which the person is tried that the person did the act or made the omission charged, but was mentally ill at the time when the person did or made the same, the jury must return a special verdict that the accused person is not guilty by reason of mental illness.

- C.21 There is no statutory definition of mental illness and the common law still applies in the form of the M’Naghten Rules,²³ though the defence is known as one of mental illness rather than insanity.

New Zealand

- C.22 In New Zealand the defence of insanity is stated in section 23 of the Crimes Act 1961 (NZ). The provision opens with the presumption of sanity in subsection (1), and then continues:

(2) No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable –

(a) Of understanding the nature and quality of the act or omission; or

(b) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

(3) Insanity before or after the time when he did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he did or omitted the act, in such a condition of mind as to render him irresponsible for the act or omission.²⁴

- C.23 There is no volitional element in the New Zealand defence, in contrast to Australia where some jurisdictions have included such an element (see above, paragraphs C.1 to C.21).

²² Formerly the Mental Health (Criminal Procedure) Act 1990, altered by the Mental Health Legislation Amendment (Forensic Provisions) Act 2008.

²³ See *Southon* [2002] NSWSC 255 at [36], by Kirby J; *Simpson* [2004] NSWSC 233 at [80], by Bell J.

²⁴ The terms of s 23(2) of the Crimes Act suggest that in New Zealand the defence is available in relation to any offence.

- C.24 A recent New Zealand Law Commission report²⁵ recommended that no reform of section 23 should take place because none of the reform options that had been identified were viable. Abolition was rejected, as was a “largely cosmetic redrafting” of the qualifying conditions²⁶ (although the report approved of similar redrafting in parts of Australia it noted that this would cause problems in NZ since the preferred terms “intellectual disability” and “mental illness” are already used in other contexts and for other purposes elsewhere on the NZ statute book). The Commission felt that even a limited redrafting might create similar problems to those that exist under the current law, and perhaps even new problems and anomalies.
- C.25 A revision of the cognitive impairment aspect of the defence was also rejected as none of the options were considered to be suitable. A status-based defence would be too inflexible; general causation and open-ended community standard approaches would give psychiatrists and the jury too much discretion and flexibility. Moreover, since the Commission concluded that formulations in other jurisdictions vary only semantically and would not really assist in resolving any of the present difficulties with the New Zealand definition, their adoption was also rejected. The Commission therefore concluded that the defence is workable, despite its flaws, and recommended that it be retained in its present form.²⁷

Canada

- C.26 The Canadian Criminal Code provides that a verdict that the accused is not criminally responsible on account of mental disorder may be returned where the jury/judge:

finds that an accused committed the act or made the omission that formed the basis of the offence charged, but was at the time suffering from mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1) ...²⁸

- C.27 The test for mental disorder in subsection 16(1) is:

No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

There is no volitional element to the test and thus the fact that the accused was affected by an irresistible impulse and could not control his or her actions will not give rise to the defence.

- C.28 It is supplemented by a presumption in subsection 16(2):

²⁵ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010).

²⁶ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) p 33.

²⁷ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) pp 13 to 15.

²⁸ Canadian Criminal Code, s 16.

Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.

- C.29 The burden of proof lies on the party which raises the issue (subsection 16(3)).
- C.30 Mackay describes the Canadian Criminal Code test as “a reformulated M’Naghten test”.²⁹ However, as discussed below (paragraph C.32), the notion of “wrong” is interpreted more widely in Canadian case law than in English case law.³⁰ Furthermore, the use of the term “appreciate” rather than “know” brings the test closer to the Model Penal Code approach (see paragraph C.62 below) and makes the test much less restrictive than the M’Naghten Rules.³¹

The notion of “wrong”

- C.31 As in Australia, a majority of the Supreme Court of Canada rejected the *Windle* approach in the case of *Chaulk*.³² The majority held:

In considering the capacity of a person to know whether an act is one that he ought or ought not to do, the inquiry cannot terminate with the discovery that the accused knew that the act was contrary to the formal law. A person may well be aware that an act is contrary to law but, by reason of “natural imbecility” or disease of the mind, is at the same time incapable of knowing that the act is morally wrong in the circumstances according to the moral standards of society.³³

- C.32 Justice McLachlin, Justice L’Heureux-Dubé and Justice Sopinka accepted that knowing that an act is legally wrong cannot be the only relevant aspect of wrongness, but they did not share the conclusion of the majority and instead held:

That it does not matter whether the capacity relates to legal wrongness or moral wrongness – all that is required is that the accused be capable of knowing that the act was in some sense “wrong”. If the accused has this capacity, then it is neither unfair nor unjust to submit the accused to criminal responsibility and penal sanction.

- C.33 Justice McLachlin adopted this approach as a matter of interpretation of the Canadian Code and relevant case law and in light of her view of the purpose of the criminal law. She also considered the practical difficulty which arises if the moral standards of ordinary people are supposed to be the touchstone. She also made the important point that failure to appreciate that an act is contrary to ordinary standards of morality is not a usual component of the criminal law:

²⁹ Mackay (1995) p 139.

³⁰ Mackay (1995) p 139.

³¹ As emphasised in, eg, Scot Law Com 195 at para 2.47.

³² *Chaulk* [1990] 3 SCR 1303.

³³ Majority by Lamer J, joined by Dickson, La Forrester and Cory JJ with concurrence by Wilson and Gonthier JJ in *Chaulk*.

To hold that absence of moral discernment due to mental illness should exempt a person who knows that legally he or she ought not to do a certain act is, moreover, to introduce a lack of parallelism into the criminal law; generally absence of moral appreciation is no excuse for criminal conduct. When the moral mechanism breaks down in the case of an individual who is sane, we do not treat that as an excuse for disobeying the law; for example, in the case of a psychopath. The rationale is that an individual either knows or is presumed to know the law, and the fact that his or her moral standards are at variance with those of society is not an excuse. Why, if the moral mechanism breaks down because of disease of the mind, should it exempt the accused from criminal responsibility where he or she knows, or was capable of knowing, that the act was illegal and hence one which he or she “ought not to do”. Why should deficiency of moral appreciation due to mental illness have a different consequence than deficiency of moral appreciation due to a morally impoverished upbringing, for example? I see no reason why the policy of the law should differ in the two cases.³⁴

C.34 The final reason that Justice McLachlin gave was that it is hard in some cases to determine what is generally thought of as morally wrong, and so such a test would be unacceptably vague in application in such cases.

C.35 The interpretation of “wrong” was considered further by the Supreme Court a few years after *Chaulk* in *Oommen*.³⁵ There was no dispute that the defendant, who was charged with murder, had killed the victim and that he had done so as a result of his insane delusions. He had the general capacity to tell right from wrong, but felt his actions were justified, due to his paranoid beliefs.

C.36 The Supreme Court held:

The accused must possess the intellectual ability to know right from wrong in an abstract sense. But he or she must also possess the ability to apply that knowledge in a rational way to the alleged criminal act ... The crux of the inquiry is whether the accused lacks the capacity to rationally decide whether the act is right or wrong and hence to make a rational choice about whether to do it or not.³⁶

C.37 The court was confident that the psychopath who sees his act as justified because he has a “deviant moral code” is not one who has lost the ability to decide rationally whether an act is right or wrong and therefore cannot take advantage of the defence: “such a person is capable of knowing that his or her acts are wrong in the eyes of society and, despite such knowledge, chooses to commit them”.³⁷ Other jurisdictions have chosen to avoid the same problem by

³⁴ *Chaulk* [1990] 3 SCR 1303.

³⁵ [1994] 2 SCR 507.

³⁶ *Oommen* [1994] 2 SCR 507.

³⁷ *Oommen* [1994] 2 SCR 507.

simply excluding personality disorders from the scope of the term “disease of the mind” or equivalent: a number of American states take this approach.³⁸

- C.38 The New Zealand Law Commission has questioned why this limb is needed or justified at all. It commented in its recent report, “it is still not clear why incapacity to reason *morally* is necessarily the right test for determining when it is not proper to hold the person responsible”.³⁹ It made the point that “in all other respects the criminal law focuses on whether or not the act was contrary to law; the moral beliefs of individuals are irrelevant”.⁴⁰ McAuley has suggested that “there is a compelling case for reformulating the rule in a way that does not depend on the contentious concepts of whether the accused “knew” the “nature and quality” of his or her act or that it was “wrong”.⁴¹
- C.39 The test seems to cover only those who are deluded about facts that inform the accused about the nature, quality or wrongness of his or her behaviour. It has been criticised for its narrow focus because:

It seems to misconstrue the nature and significance of psychological disturbance in that psychopathology appears to be viewed merely as a source of false beliefs, and only those false beliefs that mislead the defendant about the wrongfulness of his behaviour are treated as exculpatory.⁴²

Ireland

- C.40 Section 5(1) of the Criminal Law (Insanity) Act 2006 provides:

Where an accused person is tried for an offence and, in the case of the District Court or Special Criminal Court, the court or, in any other case, the jury finds that the accused person committed the act alleged against him or her and, having heard evidence relating to the mental condition of the accused given by a consultant psychiatrist, finds that:

- (a) the accused person was suffering at the time from a mental disorder, and
- (b) the mental disorder was such that the accused person ought not to be held responsible for the act alleged by reason of the fact that he or she –
 - (i) did not know the nature and quality of the act, or
 - (ii) did not know that what he or she was doing was wrong, or

³⁸ For more on the US see para C.50.

³⁹ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 5.8 (emphasis in original).

⁴⁰ New Zealand Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, R120 (2010) para 5.6.

⁴¹ McAuley p 39.

⁴² R Schopp, *Automatism, Insanity and the Psychology of Criminal Responsibility* (1991) p 30.

(iii) was unable to refrain from committing the act,

the court or the jury, as the case may be, shall return a special verdict to the effect that the accused person is not guilty by reason of insanity.

C.41 “Mental disorder” is defined widely in section 1 and “includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication”.

C.42 The test includes a volitional element.⁴³ Prior to this statute, the common law in Ireland had recognised an irresistible impulse element to the defence of insanity where the law in England did not. In *Doyle v Wicklow County Council*,⁴⁴ the Supreme Court of Ireland recognised that the M’Naghten Rules did not provide the sole or exclusive test for determining the sanity or insanity of an accused. In this case, Justice Griffin adopted a statement set out by Justice Henchy in *The People (Attorney General) v Hayes*⁴⁵ which provided that:

The [M’Naghten] Rules do not take into account the capacity of a man on the basis of his knowledge to act or to refrain from acting, and I believe it to be correct psychiatric science to accept that certain serious mental diseases, such as paranoia and schizophrenia, in certain cases enable a man to understand the morality or immorality of his act or the legality or illegality of it, or the nature and quality of it, but nevertheless prevent him from exercising a free volition as to whether he should or should not do that act.⁴⁶

C.43 A volitional element to the defence was therefore recognised. On the facts, it was held that the jury was allowed to find the accused not guilty of murder by reason of insanity where, although he understood the nature and quality of the act and its wrongfulness, “he was debarred from refraining from assaulting his wife fatally because of a defect of reason, his mental illness”.⁴⁷ This development may have been driven by the absence of any diminished responsibility defence in Ireland: see *The People (Director of Public Prosecutions) v O’Mahony*⁴⁸ in which the court considered *Byrne*⁴⁹ and held that on the same facts in Ireland the accused could have been acquitted on ground of insanity,⁵⁰ obviating the need for a separate diminished responsibility plea.⁵¹ The plea of diminished responsibility has since been introduced into Irish law by section 6 of the Criminal Law (Insanity) Act 2006.

⁴³ Section 5(1)(b)(iii).

⁴⁴ [1974] IR 55.

⁴⁵ (20 Nov 1967) Central Criminal Court (unreported).

⁴⁶ *Doyle v Wicklow County Council* [1974] IR 55 at [14].

⁴⁷ *Doyle v Wicklow County Council* [1974] IR 55 by Griffin J at [14], with whom the other judges agreed.

⁴⁸ [1985] IR 517.

⁴⁹ [1960] 2 QB 396.

⁵⁰ [1985] IR 517, 522.

⁵¹ [1985] IR 517, 523, per Finlay CJ; compare *Re Ellis* [1990] 2 IR 291.

Hong Kong

- C.44 Provision for the special verdict is laid down by the Criminal Procedure Ordinance (Cap 221), section 74 which states:

Acquittal on grounds of insanity

(1) Where any act or omission is charged against any person as an offence, and it is given in evidence on trial of such person for that offence that he was insane, so as not to be responsible according to law for his actions at the time when the act was done or the omission made, then, if it appears to the jury before whom such person is tried that he did the act or made the omission charged, but was insane as aforesaid at the time when he did or made the same, the jury shall return a special verdict that the accused person is not guilty by reason of insanity.

- C.45 The applicable test is the common law M'Naghten Rules and is identical to the formulation used in England and Wales.⁵²
- C.46 The defence has not been considered by the Law Reform Commission of Hong Kong.

India

- C.47 Section 84 of the Indian Penal Code 1860⁵³ states:

Nothing is an offence, which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.

- C.48 The burden is on the accused, the standard being the balance of probabilities.⁵⁴ A recent Report of the Indian Law Commission concluded that no relaxation in this rule was called for and it did not recommend any change.⁵⁵
- C.49 In the recent case of *Surendera Mishra v State of Jharkhand*⁵⁶ the Supreme Court considered the meaning of "unsoundness of mind". It concluded:

⁵² M Jackson, *Criminal Law of Hong Kong* (2003) p 225.

⁵³ The same provision appears in s 84 of the Singapore Penal Code.

⁵⁴ Indian Evidence Act (1872), s 105.

⁵⁵ *185th Report of the Indian Law Commission* (March 2003) p 463.

⁵⁶ 2011 SCCL.COM 15 at [9].

In our opinion, an accused who seeks exoneration from liability of an act under Section 84 of the Indian Penal Code is to prove legal insanity and not medical insanity. [The] expression “unsoundness of mind” has not been defined in the Indian Penal Code and it has mainly been treated as equivalent to insanity. But the term insanity carries different meaning in different contexts and describes varying degrees of mental disorder. Every person who is suffering from mental disease is not ipso facto⁵⁷ exempted from criminal liability. The mere fact that the accused is conceited, odd, irascible and his brain is not quite all right, or that the physical and mental ailments from which he suffered had rendered his intellect weak and affected his emotions or indulged in certain unusual acts, or had fits of insanity at short intervals or that he was subject to epileptic fits and there was abnormal behaviour or the behaviour is queer are not sufficient to attract the application of Section 84 of the Indian Penal Code.

US Model Penal Code

C.50 In 1962 the US Model Penal Code was developed by the American Law Institute. Section 4.01 reads:

- (1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he (or she) lacks substantial capacity either to appreciate the criminality/wrongfulness of his (or her) conduct or to conform his (or her) conduct to the requirements of the law.
- (1) As used in this Article the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

C.51 This test is similar to the M’Naghten Rules but has significant differences. The approach is based on capacity for knowledge and understanding rather than mere knowledge itself. The phrase “lacks substantial capacity” allows for degrees of incapacity rather than the “all-or-nothing approach” of the Rules which ask only whether the defendant did or did not in fact know the nature, quality or wrongness of the act. The term “appreciated” rather than “know” as in the M’Naghten Rules may also more accurately reflect the state of mind of a mentally ill defendant, who may know in some sense that his or her behaviour is considered to be wrong but without true appreciation or understanding of that wrongfulness.⁵⁸ The test also incorporates a volitional element which does not form part of the M’Naghten Rules.

C.52 However, as we discuss below, each State has authority to define their own substantive criminal law, which may or may not include an affirmative defence of insanity.

⁵⁷ The Latin phrase, directly translated as “by the fact itself”.

⁵⁸ F N Dutile and T H Singer, “What Now for the Insanity Defense?” (1982-1983) 58 *Notre Dame Law Review* 1104, 1107.

Clark v Arizona

- C.53 A debate over the constitutionality of a State's test for insanity arose in *Clark v Arizona*.⁵⁹ The US Supreme Court held that neither Arizona's statutory test, which inquires only into the defendant's moral capacity and not his or her cognitive capacity, nor the *Mott* rule,⁶⁰ which prohibits a defendant from introducing mental disease evidence to negate mens rea, violates the Due Process Clause of the Fourteenth Amendment of the United States Constitution.
- C.54 The Due Process Clause of the Fourteenth Amendment of the United States Constitution aims to protect fundamental principles such as the presumption of innocence and the requirement that a verdict must be supported with sufficient evidence.⁶¹ In *Clark v Arizona*, the constitutional issue was whether or not Arizona's test for insanity violated due process rights. The court reasoned the M'Naghten test has not been treated as a fundamental principle which must exist in order for there to be due process and that by using only a portion of the M'Naghten test, Arizona was not violating due process rights.
- C.55 To this end, the court held that States have the authority to define their own substantive criminal law, which may or may not include an affirmative defence of insanity. This suggests that States could decline to have any mental incapacity defence at all, as well as refusing to allow evidence of mental illness to negate mens rea. This leaves mentally incapacitated defendants fully exposed to criminal responsibility. However, the court then reasoned that "the cognitively incapacitated are a subset of the morally incapacitated" and that a test of moral incapacity therefore necessarily encompasses the notion of cognitive incapacity. Arizona's scheme was thus held in fact to be in conformity with the M'Naghten Rules.
- C.56 It is therefore unclear whether it is open constitutionally to States to abolish the insanity defence *and* have a rule of law prohibiting the introduction of evidence of mental illness to negate mens rea, though it could be argued that this is the effect of the ruling in *Clark*.⁶² The general public's hostility to the defence in the United States,⁶³ and the fact that several States have very restrictive forms of the defence, may mean that total abolition in some areas would receive considerable support.

⁵⁹ (2006) 548 US 735.

⁶⁰ *State v Mott* (1997) 187 Ariz 536, 540.

⁶¹ R Coonen, "United States v Gatewood: Does the Three Strikes Statute Violate Due Process and Undermine the Presumption of Innocence" (2001-2002) 29 *American Journal of Criminal Law* 86.

⁶² T Echard, "Clark v Arizona: Has the Court Painted itself into a Corner?" (2008) 1 *Phoenix Law Review* 213.

⁶³ See eg P C Ellsworth and others, "The Death Qualified Jury and the Defence of Insanity" (1984) 8 *Law and Human Behavior* 81; V P Hans, "An Analysis of Public Attitudes toward the Insanity Defence" (1986) 24 *Criminology* 393.

- C.57 At present, four States (Idaho, Kansas, Utah and Montana) do not have any formal insanity defence but do allow the defendant to introduce evidence of mental incapacity in order to negate mens rea.⁶⁴ Woodman and Gilles have argued that this is inadequate to safeguard the rights of the mentally ill, given that most will be capable of forming the necessary intent to do the act but *without* being able to appreciate the true nature or wrongness of that act.⁶⁵ The converse problem is that dangerous mentally ill people may receive an outright acquittal and could be released without treatment given that this approach leaves no scope for a special verdict or disposal in respect of people from whom the public need to be protected.
- C.58 Alaska is the only state to have a defence stated strictly in terms of cognitive rather than moral incapacity.⁶⁶ The law was amended after the high profile case of Robert Meach, a paranoid schizophrenic who in 1973 killed 4 teenagers while on day release from hospital after an earlier insanity acquittal for another killing.⁶⁷ In response to public incredulity that such a dangerous person could have been released before serving the full, lengthy sentence that would have been imposed on a sane person for the same crime, the State legislature passed the statute that is now in force.
- C.59 The revised statute in Alaska⁶⁸ allows for an intermediate verdict of “guilty but mentally ill” (GBMI) or a variation on that wording. This has been described as “an attempt to paper over the logical chasm separating theoretically unsound punishment of the mentally ill with public exasperation over insanity acquittals.”⁶⁹ Those who would be found insane under the Model Penal Code’s “substantial capacity” test (such as Meach) would be found guilty but mentally ill under Alaska’s current statute. Those found GBMI are not relieved of criminal responsibility. In theory, they are treated and then serve the balance of their sentence in conventional custody, though there is some evidence that this does not always happen in practice.⁷⁰

Scotland

- C.60 A revised test has been introduced by section 168 of the Criminal Justice and Licensing (Scotland) Act 2010, which inserted a new section 51A into the Criminal Procedure (Scotland) Act 1995. It reads:

⁶⁴ See further Idaho Code s 181-207 (1997), Kansas Statute Annotated s 22-3220 (1995), Montana Code Annotated s 46-14-214 (2001) and the Utah Code Annotated s 76-2-305 (1999) as referenced in: C Slobogin, “The Integrationist Alternative to the Insanity Defense” (2003) 30 *American Journal of Criminal Law* 315, 339.

⁶⁵ R E Woodman and J K Gilles, “Insanity of the Mens Rea Model: Due Process and the Abolition of the Insanity Defense” (2008) 28 *Pace Law Review* 455.

⁶⁶ See A P March, “Insanity in Alaska” (2010) 98 *Georgetown Law Journal* 1481.

⁶⁷ A P March, “Insanity in Alaska” (2010) 98 *Georgetown Law Journal* 1481, 1495.

⁶⁸ Along with a number of other states which have abolished the formal insanity defence including Arizona, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Michigan, Montana, New Mexico, Pennsylvania, South Carolina, South Dakota and Utah.

⁶⁹ A P March, “Insanity in Alaska” (2010) 98 *Georgetown Law Journal* 1481, 1497.

⁷⁰ A P March, “Insanity in Alaska” (2010) 98 *Georgetown Law Journal* 1481, 1497.

(1) A person is not criminally responsible for conduct constituting an offence, and is to be acquitted of the offence, if the person was at the time of the conduct unable by reason of mental disorder to appreciate the nature or wrongfulness of the conduct.

(2) But a person does not lack criminal responsibility for such conduct if the mental disorder in question consists only of a personality disorder which is characterised solely or principally by abnormally aggressive or seriously irresponsible conduct.

(3) The defence set out in (1) is a special defence.

(4) The special defence may be stated only by the person charged with the offence and it is for that person to establish it on the balance of probabilities.

(5) In this section, “conduct” includes acts and omissions.

C.61 Psychopathy is excluded from the defence, by subsection 2 but section 168 of the Act abolishes the rule excluding that condition from the scope of diminished responsibility.⁷¹

C.62 The word “appreciate” rather than “know” as used in the M’Naghten Rules brings the defence closer to the Model Penal Code model. The Scottish Law Commission in its report⁷² said that “in our view the particular value of the concept of appreciation is that it connotes something wider than simple knowledge and includes a level of (rational) understanding. It therefore avoids the narrowness of the M’Naghten Rules, as they have been traditionally interpreted”.

C.63 The phrasing “unable ... to appreciate” rather than simply “(did not) know” also roots the approach firmly in capacity rather than mere knowledge. However it differs from the Model Penal Code approach in that there is no volitional element.

C.64 Subsection 4 provides that only the accused may raise the defence, not the prosecution as was previously possible and as is the case in England and Wales. This can be criticised on the basis that, given the disposal powers available to the court upon a verdict of insanity, the prosecution will often have good reason to raise the “defence” and seek to have the accused detained in hospital, especially if they cannot prove mens rea due to the accused’s mental condition.⁷³

OTHER APPROACHES

Jersey (A Crown Dependency)

C.65 Article 2 of the Criminal Justice (Insane Persons) (Jersey) Law 1964 provides for a special verdict of not guilty “on the ground that [the accused] was insane so as not to be responsible according to law at the time”. There is a presumption of sanity and the burden is on the defendant to rebut it.

⁷¹ See Scot Law Com 195, para 2.62.

⁷² Scot Law Com 195, para 2.47.

⁷³ See J Chalmers, “Section 117 of the Criminal Justice and Licensing (Scotland) Bill: a Dangerous Loophole?” [2009] *Scottish Criminal Law* 1240 for criticism of this provision.

C.66 In *Attorney General v Prior*,⁷⁴ the Bailiff⁷⁵ adopted the test that a person is “insane” within the meaning of Article 2:

If, at the time of the commission of the offence, his unsoundness of mind affected his criminal behaviour to such a substantial degree that the jury consider that he ought not to be found criminally responsible.⁷⁶

C.67 This test is reminiscent of the “Durham Rule” or “product test” which was adopted by the Circuit Court of Appeals for the District of Columbia in *Durham v United States*⁷⁷ and subsequently by some other US States in the 1950s and 1960s. The rule states that “an accused is not criminally responsible if his unlawful act was the product of mental disease or defect”. In Jersey the defence is available if the accused’s behaviour was “affected (by unsoundness of mind) to a substantial degree”, which is similar to saying it was influenced or caused by that unsoundness to such a degree as to be a product of it. The test in the US was widely regarded as being too wide and giving too much discretion to psychiatric and psychological expert witnesses, as well as being inadequately defined and difficult to apply. The rule was abandoned in *S v Brawner*⁷⁸ and is now used only by the State of New Hampshire.

C.68 The law as it stands in England and Wales, following *M’Naghten*, does not form part of the law of Jersey.⁷⁹ The Bailiff in *Prior* held that the rules, if enacted in Jersey, would in fact breach article 5(1)(e) of the European Convention on Human Rights, contrary to the position in Guernsey. This ruling was upheld on appeal⁸⁰ (see paragraphs C.70 and C.73 below).

C.69 The test in Jersey also differs from that in England and Wales because it includes a volitional element.⁸¹

⁷⁴ [2001] JLR 146.

⁷⁵ The Bailiff is the first civil officer in Jersey (Guernsey also has its own Bailiff) who serves as president of the legislature and of the Royal Court.

⁷⁶ *A-G v Jason Prior* [2001] JLR 146, 158 to 159. *A-G v Prior* remains the test for insanity in Jersey: *Simao v A-G* [2005] Jersey Law Reports 374 at [23].

⁷⁷ (1954) 214 F 2d 862. The rule was originally introduced in New Hampshire in the case of *State v Pike* (1870) 49 NH 399.

⁷⁸ (1972) 471 F 2d 969.

⁷⁹ *A-G v Jason Prior* [2001] JLR 146 at [30].

⁸⁰ [2002] JLR 11.

⁸¹ [2002] JLR 11 at [32].

Guernsey (A Crown Dependency)

- C.70 As in England and Wales, there is the possibility of a special verdict under the Criminal Justice (Special Verdicts) (Guernsey) Law 1961 where a person is found to have been “insane”. The question of what test of insanity should be applied arose in the case of Derek Lee Harvey.⁸² The common law of Guernsey included reference to the test in the M’Naghten Rules and these rules accordingly form part of Guernsey law,⁸³ unlike in Jersey following *Prior*.
- C.71 The Bailiff in the case of Derek Lee Harvey heard argument that a test of insanity in terms of the M’Naghten Rules was incompatible with article 5(1)(e) of the ECHR, and that a Bailiff in the Royal Court of Jersey had taken this view, but was not persuaded.⁸⁴ This forms a stark contrast with the case of *Prior* in Jersey in which the Bailiff explicitly found that the M’Naghten Rules, if adopted, would be incompatible with the ECHR. The Bailiff in *Harvey* opined that Jersey had fallen into error by “confusing with the issue of detention, the circumstances of making a finding of insanity about which there seems to be little European learning”.⁸⁵
- C.72 Subsequently, in *Prior*’s appeal, the Jersey Court of Appeal commented on the approach of the Guernsey court.⁸⁶ Upholding the ruling of the Bailiff in *Prior*, the Court expressed dissatisfaction that the approaches of the two Crown dependencies now differ. It went on to say that “the whole law of insanity and diminished responsibility is under consideration in jurisdictions in the United Kingdom and it would seem highly desirable that any reform of the law should result from legislation and involve a co-ordinated law applicable in all jurisdictions in the United Kingdom and in the jurisdictions of Jersey and Guernsey”.⁸⁷ However as Mackay points out,⁸⁸ the laws of England and Scotland may well also come to differ following our review of insanity, and there is no reason why the laws of the two channel island jurisdictions need to be the same.
- C.73 More significantly, the court doubted the correctness of the Guernsey ruling and said that:

For our part, we consider that at some more appropriate time the correctness of that ruling may have to be re-visited, not least because, in our opinion, the argument that the McNaghten Rules are incompatible with the European Convention on Human Rights does not seem to us to be correctly based.

⁸² (3 Aug 2001) Guernsey (unreported). The case was heard in the Royal Court of Guernsey, which is equivalent to the Crown Court in England and Wales. See also R D Mackay, “The Insanity Defence – Recent Developments in Jersey and Guernsey” (2003) 7(2) *Jersey Law Review* 185.

⁸³ (3 Aug 2001) Guernsey (unreported).

⁸⁴ R D Mackay, “The Insanity Defence – Recent Developments in Jersey and Guernsey” (2003) 7(2) *Jersey Law Review* 185.

⁸⁵ This is a quote from *Harvey*, cited in R D Mackay, “The Insanity Defence – Recent Developments in Jersey and Guernsey” (2003) 7(2) *Jersey Law Review* 185 at para 12.

⁸⁶ [2002] JLR 11.

⁸⁷ [2002] JLR 11 at [15].

⁸⁸ R D Mackay, “The Insanity Defence – Recent Developments in Jersey and Guernsey” (2003) 7(2) *Jersey Law Review* 185, para 19.

The court did not, however, go into detail as to the reasons for this disagreement and the issue may therefore need to be revisited in a future case.

South Africa

- C.74 South African law distinguishes between pathological criminal incapacity (a mental illness-based defence) which will usually lead to detention in hospital, and non-pathological incapacity (incapacity caused by “factors such as intoxication, provocation and emotional stress”)⁸⁹ which leads to an unqualified acquittal.⁹⁰
- C.75 Section 78(1) of the Criminal Procedure Act 51 of 1977, as amended by the Criminal Matters Amendment Act 68 of 1998 following a review by the South African Law Reform Commission,⁹¹ provides that:

A person who commits an act or makes an omission which constitutes an offence, and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable:

- (a) of appreciating the wrongfulness of his or her act or omission; or
- (b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission,

shall not be criminally responsible for such act or omission.

- C.76 The defence therefore incorporates a moral and volitional element but no cognitive element. There is no statutory definition of “mental illness or mental defect”. Section 78(1A) states the presumption of sanity, while 78(1B) provides that the burden of proof rests on the party who raises the issue of capacity.

Northern Ireland

- C.77 The law in Northern Ireland incorporates cognitive, moral and volitional elements. By virtue of section 3 of the Criminal Justice Act (Northern Ireland) 1966, a person who is found to have been “an insane person” at the time of the alleged crime shall not be convicted. “Insane person” is defined in section 1 as

a person who suffers from mental abnormality which prevents him—

- (a) from appreciating what he is doing; or
- (b) from appreciating that what he is doing is either wrong or contrary to law; or
- (c) from controlling his own conduct; and

“insanity” shall be construed accordingly.⁹²

⁸⁹ *Eadie* (2002) 3 SA 719 (SCA) at [21], by Navsa JA.

⁹⁰ See *Laubscher* (1988) 1 SA 163 (A), 167.

⁹¹ South African Law Reform Commission, *The Declaration and Detention of Persons as State Patients under the Criminal Procedure Act 1977 and the Discharge of such Persons under the Mental Health Act 1973, including the Burden of Proof with regard to the Mental State of an Accused or Convicted Person*, Project 89 (1995).

- C.78 “Mental abnormality” is defined as “an abnormality of mind which arises from a condition of arrested or retarded development of mind or any inherent causes or is induced by disease or injury”.

AUTOMATISM

Australia

- C.79 All of the Australian criminal codes, with the exception of Victoria and New South Wales, contain provisions relating to automatism. For example, section 23 of the Criminal Code Act 1899 (Qld) and section 23A(2) of the Criminal Code Act Compilation Act 1913 (WA), both provide that:

A person is not criminally responsible for an act or omission that occurs independently of the exercise of the person’s will.

- C.80 Section 15 of the Criminal Code 2002 (ACT) and section 43AF of the Criminal Code Act (NT) both provide:

(1) Conduct can only be a physical element if it is voluntary.

(2) Conduct is voluntary only if it is a product of the will of the person whose conduct it is.

- C.81 Section 13(1) of the Criminal Code Act 1924 (Tas) provides that:

No person shall be criminally responsible for an act, unless it is voluntary and intentional.

- C.82 There is no great practical difference in the law under the automatism provisions of the different Australian jurisdictions,⁹³ despite variations in wording, and it is therefore unnecessary to quote them all in full.

- C.83 The High Court of Australia observed in *Falconer*,⁹⁴ the first question a court must consider is whether the act in question was “willed” or not, that is whether it was done “of [the accused’s] own free will and by decision” or by “the making of a choice to do” so. The notion of will imports “a consciousness in the actor of the nature of the act and a choice to do an act of that nature”. It does not include any element of intention, which relates to the consequences and not to the act itself. Unless the contrary is proved, it is presumed that an act done by a person who is apparently conscious is willed or done voluntarily.⁹⁵

⁹² Section 6 makes provision for the special case where the accused is charged with murder and his or her “insanity” at the time of the killing was temporary and due to voluntary intoxication.

⁹³ S Bronitt and B McSherry, *Principles of the Criminal Law* (3rd ed 2010) p 254.

⁹⁴ (1990) 65 ALJR 20.

⁹⁵ *Falconer* (1990) 65 ALJR 20 at [8], by Mason CJ, Brennan and McHugh JJ.

- C.84 Once it is established that the act was not willed, “the question is whether the aetiology of that condition is or is not mental disease or natural mental infirmity”.⁹⁶ In *Falconer*⁹⁷ a majority of the Australian High Court rejected the internal defect/external influence distinction established in *Hennessy, Quick and Sullivan* in England and Wales as an all-encompassing test.⁹⁸ Chief Justice Mason, Justice Brennan and Justice McHugh (in a joint judgment) held that “there seems to be no reason in principle why psychological trauma which produces a transient non-recurrent malfunction of an otherwise healthy mind should be distinguished from a physical trauma which produced like effect”.⁹⁹ Justice Toohey found that “the application of the “external factor” test is artificial and pays insufficient regard to the subtleties surrounding the notion of mental disease.”¹⁰⁰
- C.85 The court instead focused on the notion of a “diseased mind”, which it held to be the objective standard of an “ordinary person”: “if the mind’s strength is below that standard, the mind is infirm; if it is of or above that standard, the mind is sound or sane”.¹⁰¹ A condition that results from the reaction of a healthy mind to extraordinary external stimuli is not within the definition of mental illness, although such a condition may be evidence of mental illness if it involves some abnormality and is prone to recur. Sleepwalking and hypoglycaemia, for example, could fall within the category of non-insane automatism in Australia, in contrast to the law in this jurisdiction.
- C.86 As in England and Wales, the evidential burden of proving sane automatism is on the accused but, where the accused calls evidence which puts the voluntariness of his or her act in question, the prosecution must ultimately prove to the ordinary criminal standard that the act was willed. On the other hand, if unsoundness of mind is raised then the burden is on the accused, as in England and Wales.¹⁰²

New Zealand

- C.87 The leading case is *Kilbride v Lake* in which Justice Woodhouse said:

It is fundamental that quite apart from any need there might be to prove mens rea, “a person cannot be convicted of any crime unless he has committed an overt act prohibited by the law, or has made default in doing some act which there was a legal obligation upon him to do. The act or omission must be voluntary”: 10 *Halsbury’s Laws of England* (3rd ed) p 272. He must be shown to be responsible for the physical ingredient of the crime or offence.¹⁰³

⁹⁶ *Falconer* (1990) 65 ALJR 20 at [19].

⁹⁷ (1990) 65 ALJR 20.

⁹⁸ See C.2 above for further discussion of the judgment.

⁹⁹ (1990) 65 ALJR 20 at [25].

¹⁰⁰ (1990) 65 ALJR 20 at [30].

¹⁰¹ (1990) 65 ALJR 20 at [25].

¹⁰² *Falconer* (1990) 65 ALJR 20 at [13].

¹⁰³ [1962] NZLR 590, 591 to 592. For a critical analysis of the case, see F Adams, “Voluntariness in Crime: A Critical Examination of *Kilbride v Lake*” [1972] *Ottawa Law Review* 5; (1972) 2 *Otago Law Review* 426.

C.88 There is some uncertainty in New Zealand as to whether the defence of automatism is a denial of the actus reus (the physical element) or mens rea (the mental element) of an offence. The passage above suggests that automatism goes to the actus reus. However, other New Zealand cases speak of automatism as negating intent,¹⁰⁴ which suggests that the defence goes to mens rea (as is the case in Scotland: see paragraph C.98 below). However Franke and Pike argue that “in most serious cases there will be no difference in applying the defence to mens rea rather than the actus reus”.¹⁰⁵ Indeed, the approach taken by the courts does not seem to distinguish between the two elements: for example in *Burr* North P says that “the element of ‘intent’ is absent if a person acts in what has come to be called a state of ‘automatism’” then later says that for the defence of automatism to succeed there must have been an “unconscious involuntary act”. Orchard has argued that the two are separate elements but that:

When the only crime in question requires awareness of essential circumstances or an intention to cause a particular result, a state of impaired consciousness which might arguably constitute automatism might preclude a finding of the requisite mens rea, in which case there will be no need to decide whether the conduct was voluntary. In such a case an adequate direction on the evidence and the need for the requisite “intention” should mean that a further direction on the need for a “voluntary” or “willed” act will not be necessary, for proof of the former will involve proof of the latter.¹⁰⁶

¹⁰⁴ See eg *Burr* [1969] NZLR 736, 743, by North P; *Cottle* [1958] NZLR 999, 1007 and 1012, by Gresson P; and *Bannin* [1991] 2 NZLR 237, 243.

¹⁰⁵ S Franke and J Pike, *The Laws of New Zealand* (1997) vol 9, para 14.

¹⁰⁶ G Orchard, *Crimes Update* (New Zealand Law Society Seminar, Wellington, 1990) 42 to 43, quoted in S Yeo, “Putting Voluntariness back into Automatism” (2001) 32(2) *Victoria University of Wellington Law Review* 387, n 5.

- C.89 There is also debate as to the level of unconsciousness required. In *Burr*¹⁰⁷ the Court of Appeal provided that for a defence of automatism to be allowed to go to a jury, evidence must be provided that the accused acted through his body and without the assistance of his mind, in the sense that he was unable to make the necessary decisions and to determine whether or not to do the act. North P held the defence of automatism does not require that the accused was entirely unconscious since there can be no movement of any muscle without some direction from the mind.¹⁰⁸ For the defence to succeed, however, “all the deliberative functions of the mind must be absent so that the accused person acts automatically”,¹⁰⁹ although some evidence of consciousness revealed by a partial or incomplete memory of the events will not necessarily bar the defence.¹¹⁰ In the more recent case of *Campbell*, Justice Tompkins said that the accused must have been “acting involuntarily in the sense that his actions are independent of his will, and therefore not subject to any *conscious* control”.¹¹¹ Yeo has argued that this focus on lack of consciousness is in fact misplaced and that the defence should in fact be based on “the total inability to contain one’s conduct”.¹¹²
- C.90 As in England and Wales, the accused bears an evidential burden but, once automatism is sufficiently put in issue, the onus is on the prosecution to prove to the criminal standard that the accused was not in a state of automatism at the time of the act.¹¹³
- C.91 In 1991 the Casey Committee recommended against introducing a provision on involuntariness in the Crimes Bill 1989, being content to state that in the absence of such a provision, “the courts will continue to apply relatively well-settled common law principles”.¹¹⁴ However this has been criticised on the basis that the fact that principles are well-settled does not make them legally sound, and that they are in fact uncertain and open to challenge,¹¹⁵ as we have seen in the preceding paragraphs.

Canada

- C.92 The leading case is *Rabey*,¹¹⁶ in which the Supreme Court of Canada adopted the following definition of automatism from Justice Lacourcière of the Court of Appeal of Ontario in the case of *R v K*:¹¹⁷

¹⁰⁷ [1969] NZLR 736.

¹⁰⁸ [1969] NZLR 736, 745.

¹⁰⁹ [1969] NZLR 736, 745.

¹¹⁰ *Charlson* [1955] 1 WLR 317.

¹¹¹ (1997) 15 CRNZ 138, 146 (emphasis added).

¹¹² S Yeo, “Putting Voluntariness back into Automatism” (2001) 32(2) *Victoria University of Wellington Law Review* 387.

¹¹³ *Cottle* [1958] NZLR 999, 1007 to 1008, by Gresson P.

¹¹⁴ Department of Justice, Wellington, *Report of the Crimes Consultative Committee on the Crimes Bill 1989* (1991) 12 chaired by Justice Casey.

¹¹⁵ S Yeo, “Putting Voluntariness back into Automatism” (2001) 32(2) *Victoria University of Wellington Law Review* 387.

¹¹⁶ [1980] 2 SCR 513.

¹¹⁷ (1970) 3 CCC (2d) 84.

Automatism is a term used to describe unconscious, involuntary behaviour, the state of a person who, though capable of action, is not conscious of what he is doing. It means an unconscious involuntary act where the mind does not go with what is being done.¹¹⁸

C.93 Subsequently, in *Stone*,¹¹⁹ Justice Bastarache described automatism as:

A state of impaired consciousness, rather than unconsciousness, in which an individual, though capable of action, has no voluntary control over that action.

C.94 The accused has an evidential burden, when sane automatism is raised, which amounts to proving that the defence has an “air of reality” and is supported by medical evidence.¹²⁰ In other words:

Is there in the record any evidence upon which a reasonable trier of fact, properly instructed in law and acting judicially, could conclude that the defence succeeds?¹²¹

If this evidential burden is satisfied then, in contrast to other Commonwealth jurisdictions, the accused has the burden of proving, on the balance of probabilities, that he or she acted as an automaton.¹²²

C.95 The distinction between internal and external factors was adopted in *Rabey*, but doubt was cast on the usefulness of the test in *Parks*.¹²³ Two possible approaches were identified in *Parks*, both of which stem from a concern for public safety: the “internal cause” theory, which is the basis of the internal/external factor distinction; and the “continuing danger” theory, which says that any condition likely to present a recurring danger should be treated as insanity.

¹¹⁸ As quoted in *Rabey* [1980] 2 SCR 513 from Lacourcière J of the Court of Appeal of Ontario in *R v K* (1970) 3 CCC (2d) 84.

¹¹⁹ *Stone* [1999] 2 SCR 290 at [156].

¹²⁰ *Stone* [1999] 2 SCR 290. For references to an “air of reality” see [21] and [138] and for further detail relating to the requirement of medical evidence see [183] to [187].

¹²¹ *Fontaine* [2004] 1 SCR 702 at [57].

¹²² *Stone* [1999] 2 SCR 290 at [179].

¹²³ [1992] 2 SCR 871.

- C.96 The court in *Parks*, while recognising the utility of these theories, held that they should not be mechanically applied and did not assist on the facts of the case. Justice La Forest felt that categorising sleepwalking as a “disease of the mind” would undermine the utility of the internal cause theory itself and therefore downgraded the internal/external factor distinction from an all-encompassing test to an “analytical tool” to be considered alongside the continuing danger theory and any other relevant policy considerations.¹²⁴ This approach was approved by the court in *Stone*¹²⁵ and *Bouchard-Lebrun*.¹²⁶
- C.97 In *Bouchard-Lebrun*, the Supreme Court found that the accused was not suffering from a mental disorder as a result of toxic psychosis caused by voluntary intoxication.¹²⁷ First, on the internal cause theory, the defendant’s intoxication was an external cause, and the loss of toxic psychosis symptoms coincided with the duration of his intoxication. In other words the accused suffered from no disease of the mind before the act and once the effects of his drug-taking had passed. Secondly, there was no evidence indicating that the defendant’s mental condition was inherently dangerous, and he presented no continuing danger.

Scotland

- C.98 In Scotland, a plea of automatism is treated as a denial of mens rea rather than of the actus reus of the offence. This is because the defence, arising where apparently purposeful conduct has occurred, “is concerned not with what the accused did but with whether his or her conscious mind was in control of the actions”¹²⁸ and is therefore seen as going to the mental element of the offence. In *Ross v HM Advocate* Lord Justice-General Hope said that:

In principle it would seem that in all cases where a person lacks the evil intention which is essential to guilt of a crime he must be acquitted. Hume on *Crimes* (3rd edn), i, 21 describes *dole* or *mens rea* as “that corrupt and evil intention which is essential (so the light of nature teaches, and so all authorities have said) to the guilt of any crime”. So if a person cannot form any intention at all because, for example, he is asleep or unconscious at the time, it would seem impossible to hold that he had *mens rea* and was guilty in the criminal sense of anything he did when he was in that state.¹²⁹

¹²⁴ [1992] 2 SCR 871. Note, in *Burgess* [1991] 2 QB 92 it was distinguished purely on the grounds that the expert evidence in that case was “completely different” and the court did not rule out sleepwalking being categorised as insanity in another case and on other evidence.

¹²⁵ [1999] 2 SCR 290 at [68], by Binnie J (giving judgment for the minority) and at [206], by Bastarache J (for the majority).

¹²⁶ [2011] SCC 58.

¹²⁷ [2011] SCC 58.

¹²⁸ J M Ross, “A Long Motor Run on a Dark Night: Reconstructing *HM Advocate v Ritchie*” [2010] *Edinburgh Law Review* 193, 194.

¹²⁹ 1991 JC 210 at [7].

- C.99 In *Ross v HM Advocate*¹³⁰ the accused's drink had, unbeknownst to him, been spiked with a mixture of LSD and temazepam. This caused him to scream continuously and lunge about in an uncontrolled manner holding a knife, causing serious injury to several people. The defence argued that the drugs ingested had caused him to lose all self-control and that he could not therefore have formed the mens rea necessary for any offence. The Crown contended that the only plea available on those grounds would have been insanity, which had not been pleaded. The judge agreed with this submission and directed the jury that the evidence of the accused's mental state at the time could not result in an acquittal. He was accordingly convicted.
- C.100 The High Court of Justiciary found that the defence of automatism should have been available and that a miscarriage of justice had therefore occurred. This re-established the ruling in *HM Advocate v Ritchie*,¹³¹ which had been disapproved in a trio of later cases¹³² on the grounds that to allow such a special defence would be a "startling innovation" with no principled basis and that to do so "would lead to laxity and confusion in our criminal law which could do nothing but harm".¹³³ Lord Hope said in *Ross*:

I do not see why laxity or confusion should result if we were to recognise that, where the point is sufficiently put in issue, an accused should be acquitted if the jury are not satisfied that the Crown has proved mens rea. That would be entirely consistent with the principle that the onus rests throughout on the Crown. The requirements that the external factor must not be self-induced, that it must be one which the accused was not bound to foresee, and that it must have resulted in a total alienation of reason amounting to a complete absence of self-control, provide adequate safeguards against abuse.¹³⁴

- C.101 Lord Allanbridge said:

I agree that the case of *Cunningham*, along with the following cases of *Clark* and *Carmichael*, should now be overruled in so far as they conflict with the view that an accused will not have the necessary mens rea if his mind is so affected by a non-self-induced and unforeseeable factor that the result is a total loss of control over his actions which have led to the alleged crime charged being committed.¹³⁵

- C.102 The case thus established four elements which must all be present in order for the defence of automatism to be successful: there must be 1) a total alienation of reason, 2) caused by an external factor which was neither 3) self-induced nor 4) foreseeable.

¹³⁰ 1991 JC 210.

¹³¹ 1926 JC 45.

¹³² *HM Advocate v Cunningham* 1963 JC 80; *Carmichael v Boyle* 1985 SLT 399; and *Clark v HM Advocate* 1968 JC 53.

¹³³ *HM Advocate v Cunningham* 1963 JC 80, 83, by Lord Clyde.

¹³⁴ 1991 JC 210 at [24].

¹³⁵ 1991 JC 210 at [53].

- C.103 The internal/external factor distinction therefore applies as a general test in Scotland as it does in England and Wales, and is open to the same criticisms. Indeed, in Scotland the same basis – an inability to form the necessary mens rea for the offence – underlies both insanity and automatism (both sane and insane), the distinction between the two lying purely in whether the cause of that inability was an internal “disease of the mind” or some external influence.¹³⁶ It is however notable that the courts have not expressly decided how to categorise the main conditions which give rise to illogical results when this distinction is applied (for example sleepwalking and epilepsy)¹³⁷ and it is therefore possible that they will interpret the dichotomy in a different way in relation to such conditions.
- C.104 Where the defendant’s state is self-induced the defence of automatism will fail. In *Finegan v Heywood*¹³⁸ the High Court of Justiciary held that “the defence of automatism cannot in our view be established upon proof that the appellant was in a transitory state of parasomnia which was the result of, and indeed induced by, deliberate and self-induced intoxication”. In that case the defendant had experienced similar episodes of sleepwalking after drinking alcohol on three separate occasions and therefore could be said to have knowingly induced the state he was in, in contrast to *Ross* where the defendant was drugged entirely without his knowledge. It is unclear what the position would be in a case in which the accused voluntarily took the substance in question but was unaware of or indifferent to its effects.¹³⁹

¹³⁶ See further *Ross v HM Advocate* 1991 JC 210.

¹³⁷ See eg *Finegan v Heywood* 2000 JC 444 in which the High Court of Justiciary declined to consider whether sleepwalking should be viewed as sane or insane automatism.

¹³⁸ 2000 JC 444.

¹³⁹ For the law of England and Wales on this point see *Bailey* [1983] 1 WLR 760.

APPENDIX D

PREVIOUS REFORM PROPOSALS

- D.1 Numerous proposals for reform of the insanity defence have been made during the century and a half since M’Naghten’s case. Only a few aspects of these have been successful; for example the verdict “guilty but insane” was changed by the 1964 Act to “not guilty by reason of insanity” following recommendations in three different reports.¹ However, proposals for more sweeping changes have not been implemented.
- D.2 The general thrust of the proposals has been towards modernising the language of the defence in order to align it more closely with the current medical understanding of mental disorder. The proposals have, at the same time, sought to retain the legal scope and definition of the defence as a matter of law for the court to decide. Attitudes to other aspects of the defence have varied across the different proposals. For example, while some earlier reports suggested that the accused’s mental disorder need not have any causal link to the alleged criminal conduct, the most recent reform proposals have maintained the need for a causal link. Similarly, different approaches have been taken to the question of the burden of proof.

ATKIN COMMITTEE ON INSANITY AND CRIME 1923²

- D.3 This Committee’s terms of reference were:

To consider what changes, if any, are desirable in the existing law, practice and procedure relating to criminal trials in which the plea of insanity is raised, and whether any and, if so, what changes should be made in the existing law and practice in respect of cases falling within the provisions of section 2(4) of the Criminal Lunatics Act 1884.³

- D.4 The Committee recommended that the M’Naghten Rules should be retained but that a further provision should be added. That recommendation was that a person charged with an offence is irresponsible for his or her act when the act is committed under an impulse which the accused was by mental disease in substance deprived of any power to resist.⁴ This recommendation was emphatically rejected by the House of Lords in the debate which followed the report.⁵

¹ Committee on Insanity and Crime (1923) Cmd 2005; Report of the Royal Commission on Capital Punishment (1953) Cmd 8932; and Criminal Law Revision Committee, Third Report, Criminal Procedure (Insanity) (1963) Cmnd 2149.

² Committee on Insanity and Crime (1923) Cmd 2005, “The Atkin report”. The Committee was established in response to a reprieve issued by the Home Secretary following the case of *True* (1922) 16 Cr App R 164, on the grounds of the accused’s mental condition even though his plea of insanity had not succeeded.

³ The Atkin report, p 3.

⁴ The Atkin report, pp 8 and 21.

⁵ *Hansard* (HL), 15 May 1924, vol 57, cols 443 to 476, see Lord Hewart at 464.

- D.5 The Committee further criticised the “guilty but insane” verdict, in use at the time under section 2 of the Trial of Lunatics Act 1883, as “illogical ... [since] an accused cannot be guilty of a physical act which is not in itself an offence”.⁶ It recommended that the verdict should be “that the accused did the act (or made the omission) charged, but is not guilty on the ground that he was insane so as not to be responsible according to law at the time”.⁷

ROYAL COMMISSION ON CAPITAL PUNISHMENT 1949 – 1953 REPORT⁸

- D.6 The Royal Commission was set up in order to consider whether the use of capital punishment for murder should be modified or limited. The Commission considered that within their terms of reference was the question of whether insanity, mental deficiency or other forms of mental abnormality should limit criminal responsibility so as to restrict the use of the death penalty for murder.⁹
- D.7 It was clear to the Commission that the medical profession had perceived the M’Naghten Rules as defective since their inception. Moreover, objections from doctors with mental health expertise had “remained in substance unchanged throughout the last hundred years”.¹⁰ The objection was that the test was:

Based on an entirely obsolete and misleading conception of the nature of insanity, since insanity does not only, or primarily, affect the cognitive or intellectual faculties, but affects the whole personality of the patient, including both the will and the emotions.¹¹

- D.8 In practice, the Commission found that the M’Naghten Rules were liberally interpreted by judges and “perhaps even more loosely applied by juries”.¹² Nevertheless, the Commission identified 12 cases between 1923 and 1950 in which a person had been deprived of the special verdict as a result of the shortcomings of the M’Naghten Rules.¹³ The Commission was critical of the need to “stretch” the M’Naghten Rules in order to do justice. The Commission went so far as to say that the rules brought the criminal law into disrepute.¹⁴

⁶ The Atkin report, p 11.

⁷ The Atkin report, p 21.

⁸ Report of the Royal Commission on Capital Punishment (1953) Cmd 8932, “Royal Commission on Capital Punishment report”.

⁹ Royal Commission on Capital Punishment report, para 15.

¹⁰ Royal Commission on Capital Punishment report, para 227.

¹¹ Royal Commission on Capital Punishment report, para 227.

¹² Royal Commission on Capital Punishment report, para 232. For example, the evidence of the British Medical Association to the Commission was that justice was roughly done, but only by “straining the meaning of words” or outright disregard of the law: para 236.

¹³ Royal Commission on Capital Punishment report, para 242.

¹⁴ Royal Commission on Capital Punishment report, para 293.

D.9 The Royal Commission was also critical of the failure of the M’Naghten Rules to accommodate the accused who “could not help doing it.”¹⁵ The Commission objected to the use of the term “irresistible impulse”, as used by the Atkin Committee.¹⁶ This was regarded as being too narrow and “carr[ying] an unfortunate and misleading implication that, where a crime is committed as a result of emotional disorder due to insanity, it must have been suddenly and impulsively committed after sharp internal conflict.”¹⁷ In its Report, the Commission’s preferred option was not explicit about whether a person who “could not help doing it” would be entitled to the defence, though it may be assumed that that was the preference.

D.10 The Royal Commissioners set out what they termed a “fundamental assumption” before considering their options for reform:

It has for centuries been recognised, if a person was, at the time of his unlawful act, mentally so disordered that it would be unreasonable to impute guilt on him, he ought not to be held liable to conviction and punishment under the criminal law. Views have changed and opinions have differed, as they differ now, about the standards to be applied in deciding whether an individual should be exempted from criminal responsibility for this reason; but the principle has been accepted without question.¹⁸

D.11 The Royal Commission endorsed the Atkin Committee’s recommendation that the verdict should be in the form of an acquittal.¹⁹ The Commission considered two possible routes of reform. The first was to extend the M’Naghten Rules through the addition of an extra “limb” to the rules. The alternative was to abrogate the rules entirely and “[leave it] to the jury to determine whether at the time of the act the accused was suffering from disease of the mind (or mental deficiency) to such a degree that he ought not to be held responsible”. It concluded that while both were preferable to the existing law, the latter was to be preferred,²⁰ although three of the Royal Commissioners dissented from this option.²¹

D.12 The Royal Commission’s preferred option would have involved leaving a broader question for the jury to determine:

¹⁵ Royal Commission on Capital Punishment report, para 311.

¹⁶ See para D.4 above.

¹⁷ Royal Commission on Capital Punishment report, para 314.

¹⁸ Royal Commission on Capital Punishment report, para 278.

¹⁹ See para D.5 above and the Atkin report, p 21.

²⁰ Royal Commission on Capital Punishment report, para 333.

²¹ Royal Commission on Capital Punishment report, para 333. There were twelve Commissioners appointed. One further Commissioner dissented from the conclusion that the M’Naghten Rules were in need of reform.

Whether at the time of the act the accused was suffering from disease of the mind (or mental deficiency) to such a degree that he ought not to be held responsible.²²

D.13 The dissenting Royal Commissioners thought that:

It is the traditional duty of our criminal law to lay down by definition – as clearly as possible – the essential elements of liability to conviction and punishment. From the difficulties of the matter we cannot infer that the law should be allowed to shirk its duty by requiring the jury to come to a decision without the guidance of a general principle or criterion.²³

And that:

To have no rule at all would be to leave the decision on which often a man's life depends to the uncertain variations of ethical standard and emotional reaction which may influence the minds of members of a jury.²⁴

D.14 The Royal Commission also thought that the reach of the M'Naghten Rules should be extended so that the defence of insanity could be founded on the basis of "mental deficiency" as well as "disease of the mind". By "mental deficiency" the Royal Commission meant "arrested or incomplete development of mind." The Government did not pursue the recommendation and the Homicide Act 1957 although introducing the defence of diminished responsibility left the M'Naghten Rules untouched.

CRIMINAL LAW REVISION COMMITTEE, THIRD REPORT, CRIMINAL PROCEDURE (INSANITY) (1963)²⁵

D.15 In 1963, the Criminal Law Revision Committee ("the CLRC") considered the state of the law on insanity under five headings:

- (1) The form of the special verdict;
- (2) The procedure to be adopted for determining the issue of fitness to be tried;
- (3) Appeals against a special verdict or finding of unfitness to plead;
- (4) The treatment of persons found not guilty by reason of insanity; and
- (5) The power of the prosecution to adduce evidence relevant to the accused's state of mind.

²² Royal Commission on Capital Punishment report, para 333.

²³ Royal Commission on Capital Punishment report, para 286.

²⁴ Royal Commission on Capital Punishment report, para 287.

²⁵ Criminal Law Revision Committee, Third Report, Criminal Procedure (Insanity) (1963) Cmnd 2149, "The CLRC's third report".

- D.16 The review by the CLRC was prompted by a number of procedural uncertainties,²⁶ and by an evolving understanding of mental disorder.

The form of the “special verdict”

- D.17 At the time of the CLRC’s report, the form of the verdict was “guilty but insane”.²⁷ The CLRC described this as “in substance a verdict of acquittal”, but “sometimes thought to be in form one of conviction”.²⁸ The CLRC followed the Atkin Committee and the Royal Commission in concluding that the verdict should be an acquittal in the form “not guilty by reason of insanity”.²⁹

Other recommendations in the CLRC’s report

- D.18 At the time of the CLRC’s report, there was no right of appeal against the “special verdict”. The CLRC thought that there should be a right of appeal against either the part of the verdict which found that the accused had done the act or made the omission charged, or against the finding of insanity, or both.
- D.19 We discussed the CLRC’s recommendations with regard to unfitness to plead in our CP on fitness to plead.³⁰ In brief, the CLRC found that the criteria for determining unfitness to plead were satisfactory, as was the use of the jury to determine that issue.³¹ The CLRC’s primary recommendations concerned provision for a right of appeal against a finding of unfitness,³² and for a procedure under which the latest stage at which unfitness could be raised was the opening of the case for the defence.³³
- D.20 The CLRC also considered the disposal of a person who has been found unfit to plead or who has been found not guilty by reason of insanity. The main question for the CLRC was whether it was right for the court to make an order “whereby the place of detention and eligibility for release depend on decision by the Home Secretary” or whether these matters should all be decided by the court.³⁴ Overall, the CLRC was content to leave questions in relation to the place of detention and the eligibility for release with the Home Secretary. It concluded that “uniformity of practice in dealing with these cases is highly desirable and is much more likely to be achieved if they are handled by a single experienced authority than by a great

²⁶ As late as 1958 there still seemed to be uncertainty eg about where the burden of proof in unfitness to plead hearings should lie: see S Prevezer, “Fitness to Plead and the Criminal Lunatics Act 1800” [1958] *Criminal Law Review* 144, 150. In *Podola* [1960] 1 QB 325, it had been held that if the issue was raised by the defence the court had to be satisfied as to that issue on the balance of probabilities. It was also not until *Podola* was decided that it became clear that there was a right of appeal from unfitness to plead hearings.

²⁷ As provided for by s 2(1) of the Trial of Lunatics Act 1883 (which has subsequently been amended). Prior to that Act, the verdict had been in the form of an acquittal: s 1 Criminal Lunatics Act 1800.

²⁸ The CLRC’s third report, para 4.

²⁹ The CLRC’s third report, para 5.

³⁰ CP 197, paras 2.6 to 2.11.

³¹ The CLRC’s third report, paras 14 to 15.

³² The CLRC’s third report, para 29.

³³ The CLRC’s third report, para 28.

³⁴ The CLRC’s third report, para 31.

many different courts".³⁵ The CLRC did, however, think that the court should have a discretionary power to order the immediate release of the accused person³⁶ if it considered that this was safe for both the accused and the public.³⁷

- D.21 Finally, the CLRC addressed the question of whether the prosecution should, on a charge of murder, be permitted to adduce evidence of insanity when the defendant put forward a defence of diminished responsibility.³⁸ As a result of the CLRC's recommendations, it became possible both for the prosecution to call evidence of insanity if diminished responsibility was pleaded by the defence and for the prosecution to call evidence supporting a verdict of diminished responsibility where the defence pleaded insanity.
- D.22 The CLRC's third report was accepted and implemented in the 1964 Act.

BUTLER, REPORT OF THE COMMITTEE ON MENTALLY ABNORMAL OFFENDERS (1975)³⁹

- D.23 The terms of reference of this Committee were:
- (a) To consider to what extent and on what criteria the law should recognise mental disorder or abnormality in a person accused of a criminal offence as a factor affecting his liability to be tried or convicted, and his disposal;
 - (b) To consider what, if any, changes are necessary in the powers, procedure and facilities relating to the provision of appropriate treatment, in prison, hospital or the community, for offenders suffering from mental disorder or abnormality, and to their discharge and aftercare; and to make recommendations.
- D.24 We mention here only those of the Committee's recommendations which related to insanity as a defence.

³⁵ The CLRC's third report, para 33.

³⁶ The CLRC uses the term "accused" to refer to a person found to be unfit to stand trial or NGBRI.

³⁷ The CLRC's third report, para 34.

³⁸ The CLRC's third report, paras 39 to 41.

³⁹ Report of the Committee on Mentally Abnormal Offenders (1975) Cmnd 6244, "The Butler report."

The form of the “special verdict”

- D.25 The Committee thought that the common law defence was too narrowly-drawn.⁴⁰ It thought that there should be a specific defence of insanity,⁴¹ and a special verdict, but in a new form, namely “not guilty on evidence of mental disorder”.⁴² The special verdict should be available in the magistrates’ courts as well as in the Crown Court.⁴³
- D.26 The Committee thought that there were “certain basic requirements” which any insanity defence would have to meet: to avoid the use of medical terms, and to allow psychiatrists to state the facts without judging the defendant’s responsibility.⁴⁴ In other words, the Committee wanted the defence to remain in the province of the jury or magistrates, not to become solely a matter of expert evaluation.
- D.27 There would be two elements to this new special verdict: a mens rea element, and an exemption from responsibility even where mens rea was proved. In relation to the mens rea element, the Committee recommended that:
- Where medical or other evidence is given of mental disorder ... for the purpose of negating a state of mind required for the offence (intention, foresight or knowledge), if the jury find that the defendant did the act or made the omission they should return a verdict of “not guilty on evidence of mental disorder”. Magistrates should make a similar finding on summary trial.⁴⁵
- D.28 Thus the jury or magistrates might, as a result of the evidence about the defendant’s mental state, be unsure that he or she had the mental element required by the offence charged, and this would lead to the special verdict.⁴⁶
- D.29 The Committee recommended an express exclusion “for evidence of transient states not related to other forms of mental disorder and arising solely as a consequence of (a) the administration, mal-administration or non-administration of alcohol, drugs or other substances or (b) physical injury”.⁴⁷ Thus the proposed new special verdict would not be available for a case such as that where the offence was committed by someone suffering concussion, or in a state of intoxication. In such cases, simple acquittal or conviction would be the available verdicts.

⁴⁰ “Many offenders who know what they are doing and that it is wrong and therefore are not within the scope of the M’Naghten Rules are nevertheless undoubtedly so severely disordered that they ought not to be held responsible for their actions.” Para 18.14.

⁴¹ The Butler report, para 18.10.

⁴² The Butler report, para 18.18.

⁴³ The Butler report, para 18.19.

⁴⁴ The Butler report, para 18.17.

⁴⁵ The Butler report, para 18.20.

⁴⁶ As to which party would bear the burden of proof, see paras D.37 and following below.

⁴⁷ The Butler report, para 18.23.

D.30 Griew argued that this exclusion should not be limited to cases of intoxication or physical injury. He gave the examples of a short illness, somnambulism and temporary disorder as a result of emotional trauma, which should all be excluded from the mental disorder verdict unless they can be shown to be related to any underlying pathology, but none of which would fall within the exclusion in the Butler report.⁴⁸

D.31 The second element consisted in a special verdict being returned “if at the time of the act or omission the defendant was suffering from severe mental illness or severe subnormality”.⁴⁹ The Committee accepted the definition of severe subnormality in section 4(2) of the Mental Health Act 1959:

A state of arrested or incomplete development of the mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or guarding himself against serious exploitation, or will be incapable when of an age to do so.

D.32 The Committee then proposed the following definition of “severe mental illness”:

A mental illness is severe when it has one or more of the following characteristics:

(a) Lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity.

(b) Lasting alteration of mood of such a degree as to give rise to delusional appraisal of the patient’s situation, his past or his future, or that of others, or to lack any appraisal.

(c) Delusional beliefs, persecutory, jealous or grandiose.

(d) Abnormal perceptions associated with delusional misinterpretation of events.

(e) Thinking so distorted as to prevent reasonable appraisal of the patient’s situation or reasonable communication with others.⁵⁰

⁴⁸ E Griew, “Let’s Implement Butler on Mental Disorder and Crime!” (1984) *Current Legal Problems* 47, 54.

⁴⁹ The Butler report, para 18.30.

⁵⁰ The Butler report, para 18.35.

A link between the mental disorder and the commission of the offence

- D.33 The Committee recommended that the defence should be available even if there was no causal connection between the mental state and the commission of the offence. It commented that “it is theoretically possible for a person to be suffering from a severe mental disorder which has in a causal sense nothing to do with the act or omission for which he is being tried: but in practice it is very difficult to imagine a case in which one could be sure of the absence of any such connection”.⁵¹ It also commented that “it has to be borne in mind that the mental conditions included in our definitions are of such severity that the causative links between the offence and the defendant’s mental condition can safely be presumed”.⁵² This recommendation proved controversial and was not followed in later reform proposals. Griew argued that, as the report concedes, it would be theoretically possible for a person with a severe mental illness to have full cognitive powers and thus to bear responsibility for committing a crime and in that event, he or she should be convicted: “this no doubt rare case could be provided for without difficulty and the Butler scheme seems to be marginally defective in not so proposing”.⁵³
- D.34 Under the Committee’s proposal, a special verdict on the second element would require evidence from two psychiatrists with special experience in the diagnosis or treatment of mental disorders.
- D.35 With regard to the “wrongfulness” limb of the M’Naghten test, the Committee said that it should not be included “in terms”. It criticised the approach taken in *Windle*⁵⁴ that “wrong” means simply “legally wrong”, arguing that:

Knowledge of the law is hardly an appropriate test on which to base ascription of responsibility to the mentally disordered. It is a very narrow ground of exemption since even persons who are grossly disturbed generally know that murder and arson are crimes.⁵⁵

The notion of knowledge of wrongfulness would, however, in substance be covered by the broader test contained in the second element.⁵⁶

- D.36 Ashworth has criticised the recommendations of the Butler Committee as having a:

⁵¹ The Butler report, para 18.29.

⁵² The Butler report, para 18.29.

⁵³ E Griew, “Let’s Implement Butler on Mental Disorder and Crime!” (1984) *Current Legal Problems* 47, 56.

⁵⁴ [1952] 2 QB 826.

⁵⁵ The Butler report, para 18.8.

⁵⁶ The Butler report, para 18.24.

somewhat static view of mental disorder, confining it more or less to the major psychoses. It fails to recognize the variety of mental disorders, and the fact that some of them may substantially impair the patient's practical reasoning even though the diagnosis contains some prominent evaluative elements.⁵⁷

The burden of proof

- D.37 The Butler Committee commented that placing the burden of proof of the insanity defence on the defendant was hard to understand, being an exception to the general rule that the prosecution bears the burden of proving the mental element of an offence.⁵⁸ The example was given of a person who says he thought he was shooting a fox when he was shooting a baby, and states that "the burden of proving that he knew he was shooting a baby must rest on the prosecution, whether the defendant's mistake as to the 'nature and quality of his act' was the result of 'insanity' or not."⁵⁹
- D.38 The Butler Committee recommended that "the burden of proving the requisite mental state should rest on the prosecution, and if the prosecution fail to prove this a verdict of not guilty must follow".⁶⁰ In relation to the first limb of the proposed defence, where the prosecution fail to prove the mental element, the defendant should be acquitted unless the jury finds that, on the balance of probability, he or she was mentally disordered.
- D.39 Similarly for the second limb of the proposed defence, "the jury would be directed to convict unless satisfied on the balance of probability that the defendant was suffering from severe mental illness or severe abnormality."⁶¹ The first limb of the defence would only be available where the prosecution have not proved the requisite mental element of the offence in question. In contrast, the defence under the second limb would be available where the prosecution have proved both the conduct and mental element of the offence. The Butler Committee thought that in this context the standard of proof should be on the balance of probabilities, in order to avoid confusing the jury with differing standards of proof.
- D.40 The result of having two limbs for the test can, however, make the procedure and the accompanying burden of proof difficult to follow. A reading of the relevant paragraphs of the report⁶² suggests that this is the process that the Committee envisaged for the operation of the proposed defences:
- (1) Have the prosecution proved beyond reasonable doubt that the defendant did the act or made the omission charged?

⁵⁷ *Principles of Criminal Law* p 145.

⁵⁸ The Butler report, para 18.39.

⁵⁹ The Butler report, para 18.39.

⁶⁰ The Butler report, para 18.39.

⁶¹ The Butler report, para 18.39.

⁶² The Butler report, paras 18.39 to 18.41.

- (2) If not, the jury must acquit. Otherwise, the jury would move on to consider whether the prosecution proved beyond reasonable doubt that the defendant had the requisite mental element at the time of the offence.
- (3) If not, then the jury would acquit *unless* it finds that on the balance of probabilities that the defendant was mentally disordered, in which case they would find the defendant “not guilty on the evidence of mental disorder”.
- (4) If the prosecution have proved the requisite mental element, then the jury must convict *unless* it finds that on the balance of probabilities the defendant was suffering from a severe mental illness or severe subnormality at the time of the offence.

**CRIMINAL LAW REVISION COMMITTEE, FOURTEENTH REPORT,
OFFENCES AGAINST THE PERSON (1980)⁶³**

- D.41 The CLRC’s fourteenth report on offences against the person examined and made recommendations on diminished responsibility as a partial defence to murder,⁶⁴ though it did not discuss the defence of insanity. Its comments on the burden of proof are nevertheless of interest in relation to reform of the defence of insanity.
- D.42 The CLRC noted that the reason that section 2(2) of the Homicide Act 1957 put the burden of proof on the defendant was probably in order to bring the partial defence of diminished responsibility into line with the defence of insanity. However, the CLRC – agreeing with the Butler Committee in this respect – argued that the burden of proof in relation to the defence of diminished responsibility should be changed so that it fell on the prosecution. The CLRC commented that “it is unusual for the burden of proof to be placed on the defendant in serious charges, particularly in relation to his state of mind, and we agree with the Butler Committee that the defence of diminished responsibility should fall under the general rule”.⁶⁵ This was to avoid confusing the jury by the burden of proof being on one party for one purpose and on another party for another purpose, and having more than one standard of proof. On the CLRC recommendations, the defence would only be required to adduce sufficient evidence to raise the issue of diminished responsibility.

⁶³ Criminal Law Revision Committee, Fourteenth Report, Offences Against the Person (1980) Cmnd 7844, “The CLRC’s fourteenth report”.

⁶⁴ The CLRC’s fourteenth report, paras 91 to 99.

⁶⁵ The CLRC’s fourteenth report, para 94.

CODIFICATION OF THE CRIMINAL LAW – A REPORT TO THE LAW COMMISSION (1985)⁶⁶

- D.43 This report was made by a Code Team to the Law Commission and dealt with codification generally and not just in relation to mental defences. The Butler Committee's recommendations formed the basis of the recommendations with regard to mental disorder and incapacity in this report, although some modifications were suggested.

A link between the mental disorder and the commission of the offence

- D.44 In particular, those who reported to the Law Commission did not agree with the Butler Committee that there need be no requirement to show a causal link between the mental disorder and the crime. The Law Commission pointed out that:

Some people ... take the view that it would be wrong in principle that a person should escape conviction if, although severely mentally ill, he has committed a rational crime which was uninfluenced by his illness and for which he ought to be liable to be punished. They believe that the prosecution should be allowed to persuade the jury (if it can) that the offence and the disorder were unconnected.⁶⁷

The Law Commission felt that "there is undoubtedly force in this point of view" and, although bound to draft in accordance with the Butler report, it emphasised that the relevant clause (38(1)(a)) could easily be amended if this view were accepted.

Form of the "special verdict"

- D.45 Clause 38 followed the main substantive proposal in Chapter 18 of the Butler report which changed the "special verdict" based on insanity to a "mental disorder verdict" of "not guilty on evidence of mental disorder". Such a verdict could be returned in two situations:

One situation is that in which the defendant committed the offence charged but was at the time suffering from severe mental disorder (clause 38(1)(a)). The other is that in which evidence of the defendant's mental disorder at the time of his act is the reason why he is not proved to have committed the offence charged (clause 38(1)(b)).⁶⁸

- D.46 Clause 38(1)(a) would thus have covered cases where the conduct element and the fault element could be proved against the defendant, and clause 38(1)(b) the cases where the fault element was not proved because of the mental disorder. The former is not a "defence" within the proper meaning of that term: as the

⁶⁶ Codification of the Criminal Law – A Report to the Law Commission (1985) HC 270 Law Com No 143, "Law Com 143".

⁶⁷ Law Com 143, para 12.6.

⁶⁸ Law Com 143, para 12.5.

report acknowledged, “the word ‘defence’ is inappropriate in a case within clause 38(1)(b) where a required fault element has not been proved”.⁶⁹

- D.47 The report followed the Butler Committee’s definition of “severe mental illness” (see paragraph D.32 above), intending for this definition to be “closely defined and restricted to serious cases of psychosis”.⁷⁰ The report also adopted the Butler Committee’s definition of “severe subnormality” (see paragraph D.31 above), although it noted this term had since been replaced by “severe mental impairment” in the legislation. However, the definition of “severe mental impairment” in section 1(1) of the Mental Health Act 1983 was regarded as “not a happy one for present purposes” and the report recognised that further consideration would need to be given to both terminology and definition in this area.⁷¹
- D.48 The report, in clause 38(2)(b), also adopted the Butler Committee’s exclusion of purely transient disorders caused by the administration, mal-administration or non-administration of alcohol, drugs or other substances, or by physical injury. This exclusion was based on the principle that where the disorder is not associated with any underlying condition which is prone to recur there is no need for public protection through the use of the special verdict.⁷² It therefore extended the exclusion to a somewhat wider range of disorders where there is no such need, including those caused by “illness, shock or hypnosis or occurring during sleep”,⁷³ except where such illness is “a condition ... that may cause a similar disorder on another occasion”.⁷⁴

Burden of proof

- D.49 Clause 38(1) provided that proof may be made by either the prosecution or the defence, and that the jury must be satisfied by the evidence on the balance of probabilities; in other words, the burden of proof does not rest on either party.⁷⁵ The report explained that it may sometimes be in the interests of the prosecution to prove mental disorder, for example, where the defendant might otherwise secure an absolute acquittal because of a lack of fault but may still be a danger to the public.⁷⁶ It therefore made sense for whichever party who wished to secure a mental disorder verdict to bear the burden of proving it.

⁶⁹ Law Com 143, para 12.20(v).

⁷⁰ Law Com 143, para 12.7.

⁷¹ Law Com 143, para 12.8.

⁷² Law Com 143, para 12.12.

⁷³ Law Com 143, para 12.12.

⁷⁴ Law Com 143, para 12.14.

⁷⁵ Law Com 143, para 12.17.

⁷⁶ Law Com 143, para 12.18.

LAW COMMISSION CRIMINAL LAW: A CRIMINAL CODE FOR ENGLAND AND WALES (1989)⁷⁷

- D.50 In Part 11 of the draft Code the Law Commission included the recommendations of the Butler Committee with some modifications. The report included a draft Bill, clauses 33 to 40 of which concerned incapacity and mental disorder.

Automatism

- D.51 Clause 33 replaced the old form of automatism with a definition which had nothing to do with “external” or “internal” elements. It stated simply:

A person is not guilty of an offence if

(a) he acts in a state of automatism, that is, his act

is a reflex, spasm or convulsion; or

occurs while he is in a condition (whether of sleep, unconsciousness, impaired consciousness or otherwise) depriving him of effective control of the act; and

(b) the act or condition is the result neither of anything done or omitted with the fault required for the offence nor of voluntary intoxication.

- D.52 For example, a person who suddenly falls into a coma due to a drop in blood sugar will be acquitted under this provision, but not if he or she had, with the fault required for the offence, omitted to take the necessary medication before the loss of consciousness.

Mental disorder verdict

- D.53 This verdict would be returned if “the defendant is proved to have committed an offence but it is proved on the balance of probabilities (whether by the prosecution or by the defendant) that he was at the time suffering from severe mental illness or severe mental handicap”.⁷⁸

- D.54 The Code therefore followed the reasoning of the report to the Law Commission in 1985 (see paragraph D.49 above) in declining to assign the burden of proof. Instead, it was recommended that it should fall on whichever party wished to secure a verdict of mental disorder to prove it on the balance of probabilities. The report did, however, acknowledge the “obvious argument for requiring proof beyond reasonable doubt of the case for exposing him, through a mental disorder verdict, to the disposal powers of the court”. It was not made explicit why this argument was rejected, though presumably the Law Commission wanted to avoid confusing the jury with different burdens and standards of proof.

⁷⁷ Criminal Law: A Criminal Code for England and Wales (1989) Law Com No 177, “Law Com 177”.

⁷⁸ Clause 35(1). Clauses 35(1) and 36 of the Draft Criminal Code followed the structure of cl 38(1) of the earlier report, which in turn was based on the structure advocated by the Butler Committee. Clause 35(1) was equivalent to 38(1)(a), and was described as “a true defence”, and cl 36 was equivalent to 38(1)(b).

D.55 A mental disorder verdict would also be returned where:

- (a) The defendant is acquitted of an offence only because, by reason of evidence of mental disorder or a combination of mental disorder and intoxication, it is found that he acted or may have acted in a state of automatism, or without the fault required for the offence, or believing that an exempting circumstance existed; and
- (b) It is proved on the balance of probabilities (whether by the prosecution or by the defendant) that he was suffering from mental disorder at the time of the act.

The rule regarding intoxication is also reiterated in clause 22(4), which contains an exception to the general rule that a voluntarily intoxicated person is taken to have been aware of any risks or circumstances of which he or she would have been aware when sober for a person whose unawareness arises from a combination of mental disorder and voluntary intoxication.

Definitions

D.56 Clause 34 defined “mental disorder” as:

- (a) Severe mental illness; or
- (b) A state of arrested or incomplete development of mind; or
- (c) A state of automatism (not resulting only from intoxication) which is a feature of a disorder, whether organic or functional and whether continuing or recurring, that may cause a similar state on another occasion.

D.57 This is much narrower than the wide definition proposed by the Butler Committee, which the Law Commission felt could “subject too many acquitted persons to a possibly stigmatising or distressing verdict and to inappropriate control through the courts’ disposal powers”.⁷⁹

D.58 “Severe mental illness” is defined as meaning a mental illness which has one of the following characteristics (this follows the wording in the Butler report exactly, see paragraph D.32 above):

- (a) Lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity;
- (b) Lasting alteration of mood of such degree as to give rise to delusional appraisal of the defendant’s situation, his past or his future, or that of others, or lack of any appraisal;
- (c) Delusional beliefs, persecutory, jealous or grandiose;

⁷⁹ Law Com 177, para 11.27.

(d) Abnormal perceptions associated with delusional misinterpretation of events;

(e) Thinking so disordered as to prevent reasonable appraisal of the defendant's situation or reasonable communication with others.

D.59 "Severe mental handicap" is defined as:

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

D.60 This departs from the term "severe subnormality" which has ceased to feature in the legislation since it was used by the Butler Committee. It also rejects the term "severe mental impairment", defined in section 1(2) of the Mental Health Act 1983 as:

A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

The Law Commission felt that this definition would be inappropriate in the context of a mental disorder defence since "exemption from criminal liability on the ground of severe mental handicap should not be limited to cases where the handicap is associated with aggressive or irresponsible conduct".⁸⁰

D.61 Ashworth has criticised the proposed definition of mental disorder for including "pathological automatism that is liable to recur" and for classifying epilepsy and diabetes within "mental disorder". He writes that this is "contrary to the principle of fair labelling and in violation of the European Convention, and should be abandoned."⁸¹

A link between the mental disorder and the commission of the offence

D.62 Following the example of the Code team's report, the Law Commission diverged from the Butler Committee in recommending that there *should* be a causal link between the mental disorder and the commission of the alleged offence. Clause 35(2) had the effect that a jury could not return a "mental disorder verdict" if the court or jury was "satisfied beyond reasonable doubt that the offence was not attributable to the severe mental illness or severe mental handicap". The Law Commission agreed with the observation in the 1985 report that "it would be wrong in principle that a person should escape conviction if, although severely mentally ill, he has committed a rational crime which was uninfluenced by his illness and for which he ought to be liable to be punished" and that therefore requiring causation "must improve the acceptability of the Butler Committee's generally admirable scheme as the basis of legislation".⁸²

⁸⁰ Law Com 177, para 12.8.

⁸¹ *Principles of Criminal Law* p 146.

⁸² Law Com 177, para 11.16.

The role of medical practitioners

- D.63 Clause 35(3) stated that the mental disorder verdict was only to be available if evidence of mental disorder was given by two approved medical practitioners.

Availability of the verdict

- D.64 The Law Commission took the view that the verdict should be available in the magistrates' courts as well as in the Crown Court.⁸³
- D.65 Clause 37 of the draft Bill provided for the verdict to be entered without a trial: if the defendant pleaded not guilty by reason of mental disorder and the court accepted the plea, then that would be the verdict. If the court did not accept the plea then the defendant would be deemed to have pleaded not guilty.

Restriction on prosecution evidence

- D.66 The draft Bill restricted prosecution evidence of mental disorder as follows: the prosecution would not be allowed to adduce such evidence unless the defendant had given or adduced evidence that he acted without the fault required for the offence, or believing that an exempting circumstance existed, or in a state of automatism, or (on a charge of murder) when suffering from mental abnormality (as defined in the Bill).

SCOTTISH LAW COMMISSION RECOMMENDATIONS

- D.67 In its report *Insanity and Diminished Responsibility*⁸⁴ the Scottish Law Commission recommended a new defence, with modern terminology. It thought that it was important that the "conceptual framework" for mental health law in the civil field should not be vastly different from that in the criminal field, while acknowledging that they serve different purposes. It recommended a new statutory defence of lack of criminal responsibility by reason of mental disorder. It considered whether mental disorder should be left undefined, but decided it was better to define it in the statute as mental illness, personality disorder, or learning disability,⁸⁵ and that the statutory test itself should indicate which mental disorders displace criminal responsibility.

⁸³ Law Com 177, para 11.12.

⁸⁴ Report on Insanity and Diminished Responsibility, Scot Law Com No 195 (2004), "Scot Law Com 195".

⁸⁵ Scot Law Com 195, para 2.30.

- D.68 The Scottish Law Commission suggested that there should be some kind of “connecting link” between the disorder and the alleged offence.⁸⁶ However, the Commission agreed with those who reported to the Law Commission that it was “wrong in principle that a person should escape conviction if, although severely mentally ill, he has committed a rational crime which was uninfluenced by his illness and for which he ought to be liable to be punished”.⁸⁷ It gave the example of a person with a mental condition who receives a speeding ticket which is unrelated to his condition; the fact that he has a mental disorder which has no bearing on the offence in question, should not mean he may escape liability. It is notable that the Scottish Law Commission chose not to refer to this link in terms of causation, since “mental disorders do not typically deprive persons of all control over their behaviour. More usually their effect is to lead to such persons having unusual or distorted motivations and reasons for acting.”⁸⁸ The Commission suggested that “the defence should be defined in terms of specific and particular effects which the accused’s mental disorder had on his reasons and motivations for engaging in criminal conduct”.⁸⁹
- D.69 The Scottish Law Commission therefore went on to consider the nature of the connecting link and recommended that the new defence should first include a cognitive limb – an inability at the time of the offence to appreciate either the nature or the wrongfulness of his or her conduct.⁹⁰ By “appreciation” it meant “something wider than simple knowledge [which] includes a level of (rational) understanding”.⁹¹ This expressly departs from the M’Naghten requirement that the accused did not know the nature or quality of the act and brings the approach closer to that taken by the US Model Penal Code and adopted in several US States and other jurisdictions.⁹²
- D.70 With regard to whether the defence should include a “volitional” limb,⁹³ the Scottish Law Commission noted that respondents to their Discussion Paper had been divided on this issue. The Scottish Law Commission concluded that a volitional element should not be included in the defence.⁹⁴ This conclusion was reached having regard to the “appreciation” test in the proposed defence, and that on consultation mental health experts were “virtually unanimous in rejecting a category of mental disorder which was purely volitional in nature and which had no impact on cognitive functions”.
- D.71 The Scottish Law Commission took the view that a psychopathic personality disorder/anti-social personality disorder should be specifically excluded from the mental disorder defence. This is because:

⁸⁶ Scot Law Com 195, para 2.31.

⁸⁷ Law Com 143, para 12.6, cited by the Scottish Law Commission at para 2.34 of their report.

⁸⁸ Scot Law Com 195, para 2.40.

⁸⁹ Scot Law Com 195, para 2.41.

⁹⁰ Recommendation 6 in Scot Law Com 195.

⁹¹ Scot Law Com 195, para 2.47.

⁹² See paras C.50 and following in Appx C.

⁹³ For the meaning of “volitional”, see para 4.54 above.

⁹⁴ Scot Law Com 195, paras 2.52 to 2.56.

Psychopathy does not have the effect that the person's reasons for acting as he did are in any way "abnormal" or "crazy" or "disordered". Rather, psychopathic personality disorder has the effect that because of the psychological make-up of the accused he has difficulties, not shared by the ordinary person, in complying with the requirements of the law. But such difficulties do not remove the person completely from responsibility for his actions. He appreciates what he is doing.⁹⁵

It went on to say that for a person with such a disorder it will at most be more difficult, but not impossible, to control his or her actions; though as already indicated, the report does not recommend that the defence include a volitional element.

D.72 These recommendations were enacted in Part 7 of the Criminal Justice and Licensing (Scotland) Act 2010.⁹⁶

⁹⁵ Scot Law Com 195, para 2.60.

⁹⁶ In force 25 June 2012. The clause as enacted is in almost identical terms to the draft clause appended to the Commission's report. See para C.60 in Appx C.

APPENDIX E

THE INSANITY DEFENCE – DATA ON VERDICTS OF NOT GUILTY BY REASON OF INSANITY FROM 2002 TO 2011

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INTRODUCTION

- E.1 Prior to 1990 little was known about the operation of the defence of insanity other than that the number of those found “not guilty by reason of insanity” (“NGRI”) was small. This was confirmed in a first empirical study which revealed that the defence of insanity was rarely used which in the light of the mandatory disposal of indeterminate hospitalisation under the Criminal Procedure (Insanity) Act 1964 was hardly surprising.² This was followed by two other empirical studies both of which were conducted after the introduction of flexibility of disposal under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. They revealed a small but steady increase in findings of NGRI during the ten year period 1992 to 2001. In the first such study the following conclusion was reached:

Although the special verdict remains a relatively rare occurrence it does seem likely that as the legislative changes contained in the 1991 Act have become more widely known the number of findings of NGRI has slowly begun to rise. The introduction of flexibility of disposal (except in murder cases)³ removed a central disincentive to seeking a verdict of NGRI and a striking finding during the research period was that community based disposals were being fully utilised by the courts, with just over 50 per cent of defendants being subject to such disposals.⁴

- E.2 This was echoed in the second study which also concluded:

¹ With thanks to the Law Commission for commissioning this research and to the Nuffield Foundation for their continued support of my research into the insanity defence.

² See R D Mackay “Fact and Fiction about the Insanity Defence” [1990] *Criminal Law Review* 247.

³ On 31 March 2005 these disposals were reduced to three by virtue of s 23 of the Domestic Violence, Crime and Victims Act 2004. This provision abolished guardianship as an option and now permits the court to make a hospital order (with or without a restriction order); a supervision order; or an order for an absolute discharge. The hospital order is now identical to one made under the Mental Health Act 1983 and where the unfit to plead accused is charged with murder and the court has the power to make such an order, it must impose restrictions. These changes were prompted by concerns that the 1991 Act disposal regime was not compliant with the Human Rights Act 1998.

⁴ R D Mackay and G Kearns, “More Fact(s) about the Insanity Defence” [1999] *Criminal Law Review* 714, 725.

Although findings of NGRI continue to remain a relatively rare occurrence in the context of the totality of cases prosecuted in Crown Courts, the changes ushered in by the 1991 Act appear to have slowly halted any decline in the number of special verdicts. It would seem, therefore, that as these legislative changes have become more widely known the number of findings has continued to rise.

- E.3 In relation to insanity, flexibility of disposal was a major change contained in the 1991 Act. This removed a central disincentive of seeking a verdict of NGRI with the result that community based disposals continue to be well utilised by the courts, with over 50% of defendants continuing to be the subject of such disposals.⁵
- E.4 What follows is a study of verdicts (successful pleas) of “not guilty by reason of insanity” during the ten year period from 2002 to 2011 in order to assess the continued impact of flexibility of disposal together with the effect of the changes implemented by the Domestic Violence, Crime and Victims Act 2004 referred to above. At the outset, however, the limitations of this current study need to be emphasised for, unlike the three earlier studies, on this occasion access to court files, and in particular relevant psychiatric reports, was unavailable. Despite this however, it is hoped that the following research will give an up to date picture relating to insanity verdicts in England and Wales. Although the Statistics of Mentally Disordered Offenders continue to give the number of NGRI cases annually in relation to restricted patients,⁶ no official statistics are published on the use of the insanity defence where other disposals are given. A final caveat, therefore, relates to the consistency of the data which were collected for this study using three major sources, namely two statistical returns from the Ministry of Justice and one from the Mental Health Casework Section. Inevitably, although some disparity has been found in relation to these three sources as complete a picture as seems possible of NGRI verdicts has emerged for the purpose of this research for which grateful thanks is acknowledged to the agencies and personnel involved for all the assistance given.

⁵ R D Mackay, B J Mitchell and L Howe, “Yet More Facts about the Insanity Defence” [2006] *Criminal Law Review* 399, 410

⁶ See Ministry of Justice, *Offender Management Caseload Statistics 2010* (2010) annual tables at Table A6.5. It should also be noted that the Ministry of Justice figures are based on the date of the hospital warrants rather than the date of the finding. This may have led to minor inconsistency in relation to the actual number of annual findings. Thus, the total number of NGRI verdicts which resulted in hospital orders with restrictions recorded by the Ministry of Justice in the above Table for the nine year period 2002 to 2010 is 60 while the number contained in this study for the same nine years is 57, see Table 8c below.

Table 1- Findings of NGRI by 5 Year Periods from 1987-2011

| <u>1a</u> <u>1964</u> <u>Act</u> | | <u>1b</u> <u>1991</u> <u>Act</u> | | <u>1c</u> <u>1991</u> <u>Act</u> | | <u>1c</u> <u>1991</u> <u>Act</u> | | <u>1d</u> <u>1991</u> <u>Act</u> | |
|--|-----------|---|-----------|---|-----------|---|------------|---|------------|
| <u>Final 5</u> <u>years</u> | | <u>1st 5</u> <u>years</u> | | <u>2nd 5</u> <u>years</u> | | <u>3rd 5</u> <u>years</u> | | <u>4th 5</u> <u>years</u> | |
| Year | Number | Year | Number | Year | Number | Year | Number | Year | Number |
| 1987 | 2 | 1992 | 6 | 1997 | 10 | 2002 | 23 | 2007 | 13 |
| 1988 | 4 | 1993 | 5 | 1998 | 16 | 2003 | 16 | 2008 | 28 |
| 1989 | 3 | 1994 | 8 | 1999 | 17 | 2004 | 19 | 2009 | 27 |
| 1990 | 4 | 1995 | 12 | 2000 | 14 | 2005 | 20 | 2010 | 20 |
| 1991 | 7 | 1996 | 13 | 2001 | 15 | 2006 | 23 | 2011 | 34 |
| Total | 20 | Total | 44 | Total | 72 | Total | 101 | Total | 122 |

THE RESEARCH FINDINGS

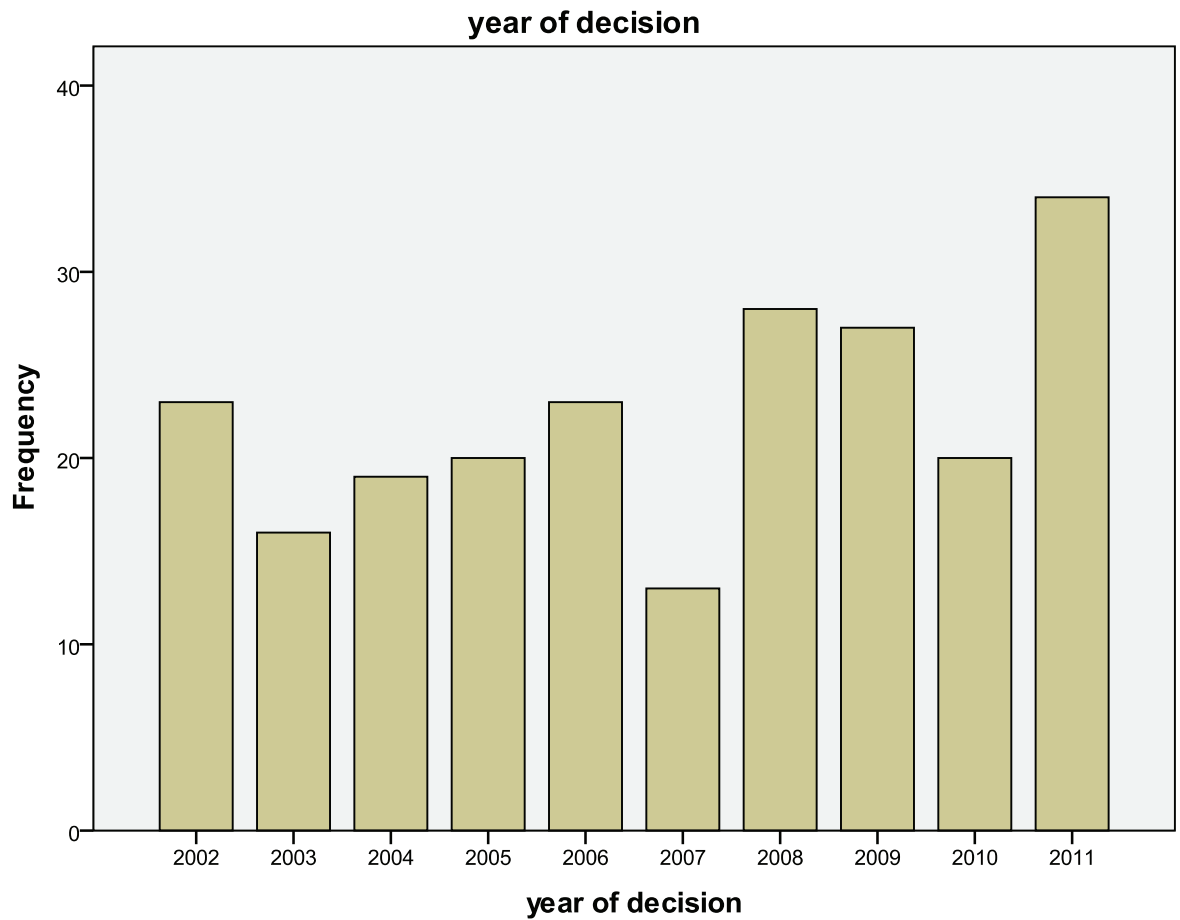
The number of NGRI findings

- E.5 Table 1 above gives the annual number of findings of NGRI for the last 5 years of the operation of the original 1964 Act, the first 5 years, the second 5 years and the third and fourth 5 years of the 1991 Act. The picture is of a gradual but steady rise in the number of NGRI verdicts. In the fourth 5 years there was an annual average of 24.4 NGRI verdicts compared with an average of 20.2, 14.4 and 8.8 verdicts in the third, second and first five year periods respectively. This compares to an average of 4 from 1987 to 1991 (and 3.6 in the previous 5 years from 1982 to 86, n=18) with an overall total for the first twenty years of the 1991 Act of 359, giving an annual average of 17.95 NGRI verdicts.
- E.6 Table 2a below gives the annual number of NGRI verdicts for the research period for this study, namely the ten years from 2002 to 2011. The total of NGRI verdicts during this period was 223, giving an annual average of 22.3. In essence, therefore, the annual average number of NGRI verdicts has now reached over twenty for the first time, with the total for 2011 having exceeded 30, also for the first time. Table 2b shows the annual percentage of NGRI verdicts.

Table 2a –NGRI Verdicts 2002-2011

| | Frequency | Percent | Cumulative Percent |
|-------|-----------|---------|--------------------|
| 2002 | 23 | 10.3 | 10.3 |
| 2003 | 16 | 7.2 | 17.5 |
| 2004 | 19 | 8.5 | 26.0 |
| 2005 | 20 | 9.0 | 35.0 |
| 2006 | 23 | 10.3 | 45.3 |
| 2007 | 13 | 5.8 | 51.1 |
| 2008 | 28 | 12.6 | 63.7 |
| 2009 | 27 | 12.1 | 75.8 |
| 2010 | 20 | 9.0 | 84.8 |
| 2011 | 34 | 15.2 | 100.0 |
| Total | 223 | 100.0 | |

Table 2b



Some demographic data

- E.7 As far as sex and age distribution are concerned, Table 3a shows that the vast majority of those found NGRI continue to be males at 91.5% (n=203), compared to only 8.5% for females (n=19). Table 3b gives the age ranges as a percentage while Table 3c shows the age cross tabulated with the year of the NGRI finding. The mean age at the time of the offence was 35.3 (range 15 to 74), with males having a mean age of 35.2, whilst females had a higher mean age of 37. The most prevalent age range for males is 20 to 29 (n=69) and for females 30 to 39 and 40 to 49 (n=6 for both groups) with the vast majority of those found NGRI falling within the age ranges of 20 to 29 or 30 to 39 (n=145, 65%). The available data for ethnicity is presented below in Table 4. However, this information is very sketchy as in the vast majority of cases it was either unavailable or not recorded.
- E.8 Neither was any information available on criminal records, psychiatric history or psychiatric diagnoses.⁷

Table 3a - Sex/age Distribution

| | | sex of accused | | Total |
|----------------------|----------|----------------|--------|-------|
| | | male | female | |
| age range of accused | up to 15 | 1 | 0 | 1 |
| | 15-19 | 9 | 0 | 9 |
| | 20-29 | 68 | 5 | 73 |
| | 30-39 | 66 | 6 | 72 |
| | 40-49 | 30 | 6 | 36 |
| | 50-59 | 22 | 2 | 24 |
| | 60-69 | 6 | 0 | 6 |
| | 70-79 | 1 | 0 | 1 |
| | 26 | 1 | 0 | 1 |
| Total | | 204 | 19 | 223 |

⁷ For data relating to these issues see my earlier studies referred to above at nn 4 and 5.

Table 3b

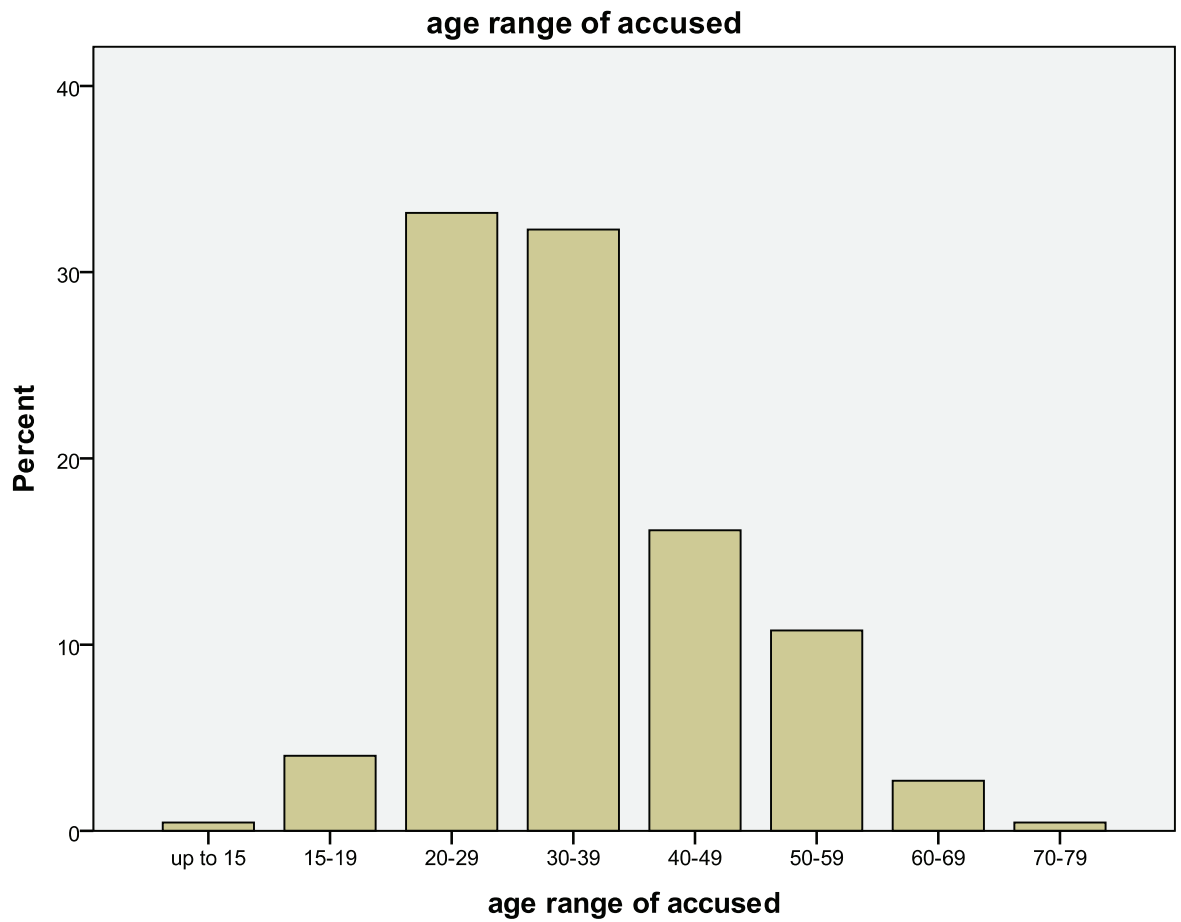


Table 3c Year of Decision * Sex of Accused Cross Tabulation

| | | sex of accused | | Total |
|------------------|-------|----------------|--------|-------|
| | | male | female | |
| year of decision | 2002 | 21 | 2 | 23 |
| | 2003 | 16 | 0 | 16 |
| | 2004 | 17 | 2 | 19 |
| | 2005 | 19 | 1 | 20 |
| | 2006 | 22 | 1 | 23 |
| | 2007 | 10 | 3 | 13 |
| | 2008 | 24 | 4 | 28 |
| | 2009 | 25 | 2 | 27 |
| | 2010 | 18 | 2 | 20 |
| | 2011 | 32 | 2 | 34 |
| | Total | 204 | 19 | 223 |

Table 4 – Ethnicity

| | Frequency | Percent | Cumulative Percent |
|------------------------------|-----------|---------|--------------------|
| white | 47 | 21.1 | 21.1 |
| black | 24 | 10.8 | 31.8 |
| Asian (Indian sub-continent) | 10 | 4.5 | 36.3 |
| other | 7 | 3.1 | 39.5 |
| not known/not recorded | 135 | 60.5 | 100.0 |
| Total | 223 | 100.0 | |

The courts involved in NGRI proceedings

- E.9 Table 5 below gives a breakdown of the Crown Courts which were involved in the NGRI proceedings. It can be seen from this that there was a wide geographical distribution with Inner London Crown Court the most frequent venue with 21 cases (9.4%).

Table 5 – Crown Court

| | Frequency | Percent | Cumulative Percent |
|-------------|-----------|---------|--------------------|
| Not known | 10 | 4.5 | 4.5 |
| Aylesbury | 1 | .4 | 4.9 |
| Birmingham | 12 | 5.3 | 10.3 |
| Blackfriars | 7 | 3.1 | 13.5 |
| Bolton | 3 | 1.3 | 14.8 |
| Bournemouth | 1 | .4 | 15.2 |
| Bradford | 2 | .9 | 16.1 |
| Bristol | 6 | 2.7 | 18.8 |
| Cambridge | 1 | .4 | 19.3 |
| Canterbury | 2 | .9 | 20.2 |
| Cardiff | 1 | .4 | 20.6 |
| CCC | 11 | 4.9 | 25.6 |
| Chelmsford | 3 | 1.3 | 26.9 |
| Chester | 2 | .9 | 27.8 |
| Coventry | 3 | 1.3 | 29.1 |
| Croydon | 2 | .8 | 30.0 |
| Derby | 2 | .9 | 30.9 |
| Exeter | 1 | .4 | 31.4 |
| Guildford | 2 | .8 | 32.3 |

| | Frequency | Percent | Cumulative Percent |
|----------------|-----------|---------|-----------------------|
| Harrow | 6 | 2.7 | 35.0 |
| Inner London | 21 | 9.4 | 44.4 |
| Ipswich | 3 | 1.3 | 45.7 |
| Isleworth | 8 | 3.6 | 49.3 |
| Kingston | 7 | 3.1 | 52.5 |
| Leeds | 4 | 1.8 | 54.3 |
| Leicester | 5 | 2.2 | 56.5 |
| Lewes | 9 | 4.0 | 60.5 |
| Lincoln | 2 | .9 | 61.4 |
| Liverpool | 3 | 1.3 | 62.8 |
| Maidstone | 7 | 3.1 | 65.9 |
| Manchester | 6 | 2.7 | 68.6 |
| Mold | 1 | .4 | 69.1 |
| Newcastle | 4 | 1.8 | 70.9 |
| Nottingham | 2 | .9 | 71.7 |
| Portsmouth | 4 | 1.8 | 73.5 |
| Preston | 4 | 1.8 | 75.3 |
| Reading | 4 | 1.8 | 77.1 |
| Sheffield | 2 | .9 | 78.0 |
| Snaresbrook | 10 | 5.4 | 82.5 |
| Southampton | 3 | 1.3 | 83.8 |
| Southend | 1 | .4 | 84.2 |
| Southwark | 5 | 2.2 | 86.5 |
| St Albans | 2 | .9 | 87.4 |
| Stafford | 4 | 1.8 | 89.2 |
| Stoke-on-Trent | 1 | .4 | 89.7 |
| Swindon | 1 | .4 | 90.1 |
| Taunton | 1 | .4 | 90.6 |
| Teeside | 1 | .4 | 91.0 |
| Truro | 1 | .4 | 91.5 |
| Warwick | 1 | .4 | 91.9 |
| Winchester | 3 | 1.3 | 93.3 |
| Wolverhampton | 1 | .4 | 93.7 |
| Wood Green | 5 | 2.2 | 96.0 |
| Woolwich | 3 | 1.3 | 97.3 |
| Worcester | 5 | 2.2 | 99.6 |
| York | 1 | .4 | 100.0 |
| Total | 223 | 100.0 | |

The offences charged

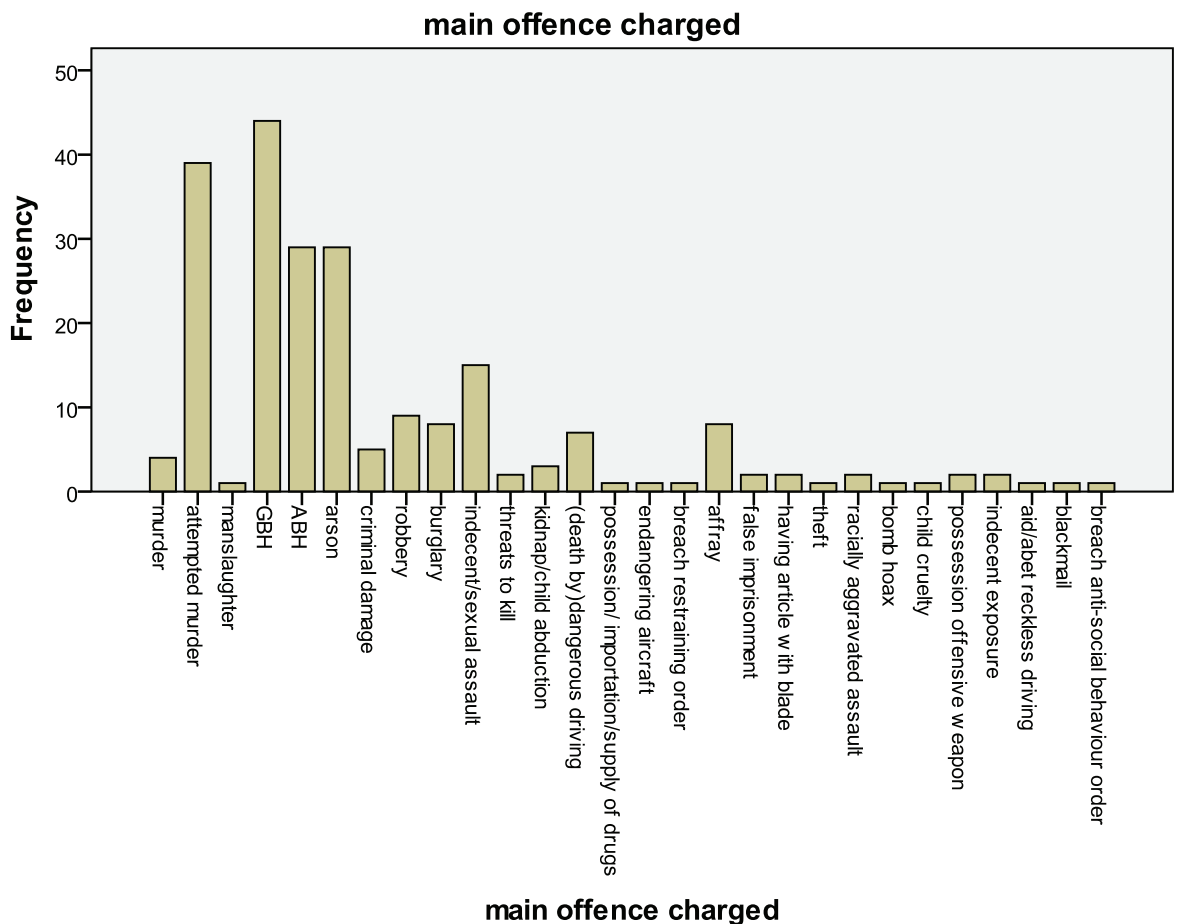
E.10 Tables 6a and 6b give the main offence charged which in each case led to a verdict of NGRI. It can be seen from this that there was a wide spread of offences, the most prevalent of which are GBH (n=46, 20.6%) and attempted murder (n=39, 17.5 %). Once again, however, what is apparent is the very small number of murder charges. In the 1997 to 2001 study the number of such charges was seven (9.7%). This has now fallen to only four (1.8%).

Table 6a Offences

| | Frequency | Percent | Cumulative Percent |
|---|-----------|---------|-----------------------|
| murder | 4 | 1.8 | 1.8 |
| attempted murder | 39 | 17.5 | 19.3 |
| manslaughter | 1 | .4 | 19.7 |
| GBH | 46 | 20.6 | 40.4 |
| ABH | 28 | 12.6 | 52.9 |
| arson | 29 | 13.0 | 65.9 |
| criminal damage | 5 | 2.2 | 68.2 |
| robbery | 9 | 4.0 | 72.2 |
| burglary | 8 | 3.6 | 75.8 |
| indecent/sexual assault | 15 | 6.7 | 82.5 |
| threats to kill | 2 | .9 | 83.4 |
| kidnap/child abduction | 3 | 1.3 | 84.8 |
| (death by) dangerous driving | 7 | 3.1 | 87.9 |
| possession/ importation/supply of drugs | 1 | .4 | 88.3 |
| endangering aircraft | 1 | .4 | 88.8 |
| breach restraining order | 1 | .4 | 89.2 |
| affray | 8 | 3.6 | 92.8 |
| false imprisonment | 2 | .9 | 93.7 |
| having article with blade | 2 | .9 | 94.6 |
| theft | 1 | .4 | 95.1 |
| racially aggravated assault | 2 | .9 | 96.0 |
| bomb hoax | 1 | .4 | 96.4 |

| | Frequency | Percent | Cumulative Percent |
|---------------------------------------|-----------|---------|--------------------|
| child cruelty | 1 | .4 | 96.9 |
| possession offensive weapon | 2 | .9 | 97.8 |
| indecent exposure | 2 | .9 | 98.7 |
| aid/abet reckless driving | 1 | .4 | 99.1 |
| blackmail | 1 | .4 | 99.6 |
| breach anti-social behaviour order | 1 | .4 | 100.0 |
| Total | 223 | 100.0 | |

Table 6b



E.11 Table 7 below gives a breakdown of the main offence charged cross tabulated with the broad types of offences involved. As in previous studies, however, offences against the person (including robbery, kidnap/child abduction, false imprisonment and child cruelty) remain the most common type of offence with a total of 130 (58.3%) non-fatal and only 5 (2.2%) fatal offences. Overall there has been an increase in GBH and ABH combined from 27.8% to 33.2% when compared to the five year period 1997 to 2001 with a reduction in attempted murder from 22.2% to 17.5%.

Table 7 Main Offence Charged * Type of Offence Cross Tabulation

| main offence charged | type of offence | | | | | | | | | | Total |
|--|-----------------|-------------------|--------------------|-----------------------|----------------|-----------------|---------------|-----------------------|---|----|-------|
| | fatal assault | non-fatal assault | damage to property | offence of dishonesty | sexual offence | driving offence | drugs offence | threatening behaviour | | | |
| murder | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | |
| attempted murder | 0 | 39 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 | |
| manslaughter | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| GBH | 0 | 46 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 46 | |
| ABH | 0 | 28 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 | |
| arson | 0 | 0 | 29 | 0 | 0 | 0 | 0 | 0 | 0 | 29 | |
| criminal damage | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | |
| robbery | 0 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | |
| burglary | 0 | 0 | 0 | 8 | 0 | 0 | 0 | 0 | 0 | 8 | |
| indecent/sexual assault | 0 | 0 | 0 | 0 | 15 | 0 | 0 | 0 | 0 | 15 | |
| threats to kill | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | |
| kidnap/child abduction (death by) | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | |
| dangerous driving | 0 | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 0 | 7 | |
| possession/importation/supply of drugs | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | |
| endangering aircraft | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | |

| | type of offence | | | | | | | | | | Total |
|------------------------------------|-----------------|-------------------|--------------------|-----------------------|----------------|-----------------|---------------|-----------------------|------------|---|-------|
| | fatal assault | non-fatal assault | damage to property | offence of dishonesty | sexual offence | driving offence | drugs offence | threatening behaviour | | | |
| breach restraining order | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| affray | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 8 |
| false imprisonment | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| having article with blade | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| theft | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| racially aggravated assault | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| bomb hoax | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| child cruelty | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| possession | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| offensive weapon | | | | | | | | | | | |
| indecent exposure | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| aid/abet reckless driving | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| blackmail | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| breach anti-social behaviour order | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Total | 5 | 130 | 34 | 9 | 17 | 8 | 1 | 19 | 223 | | |

The disposals

E.12 Previous studies of the insanity defence revealed that community based disposals formed slightly over 50% of all the disposals. In the 1997 to 2001 study the figure was 52.8%, although if the seven mandatory disposals given in relation to the murder charges are ignored this total rose to 58.5%. Tables 8a, 8b and 8c below give the disposals for the current study. It can be seen from this that the number of hospital orders with and without restrictions was 108 (48.4%) which is similar to the total for the 1997 to 2001 study which was 47.2%. However, the percentage of restriction orders has fallen from 37.5% to 28.7% with a marked increase in those without restrictions from 9.7% to 19.7%. It is also clear that community based disposals continue to be well utilised, accounting for 51.2% (n=112) of all disposals (ignoring the single case where the jury could not reach a verdict after insanity was pleaded and the defendant was discharged). Although the percentage of supervision (and treatment) orders has fallen from 41.7% to 36.8%, absolute discharges have risen from 9.7% to 13.5% (n=30). Overall, therefore, this figure of 51.2% is similar to that in the 1997 to 2001 study of 52.8% community disposals.

Table 8a Disposals

| | Frequency | Percent | Cumulative Percent |
|---|-----------|---------|--------------------|
| restriction order without limit of time | 64 | 28.7 | 28.7 |
| hospital order | 44 | 19.7 | 48.4 |
| guardianship order | 2 | .9 | 49.3 |
| supervision (& treatment) order - 2 years | 63 | 28.3 | 77.6 |
| supervision (& treatment) order - under 2 years | 19 | 8.5 | 86.1 |
| absolute discharge | 30 | 13.5 | 99.6 |
| defendant discharged -hung jury | 1 | .4 | 100.0 |
| Total | 223 | 100.0 | |

Table 8b Disposals

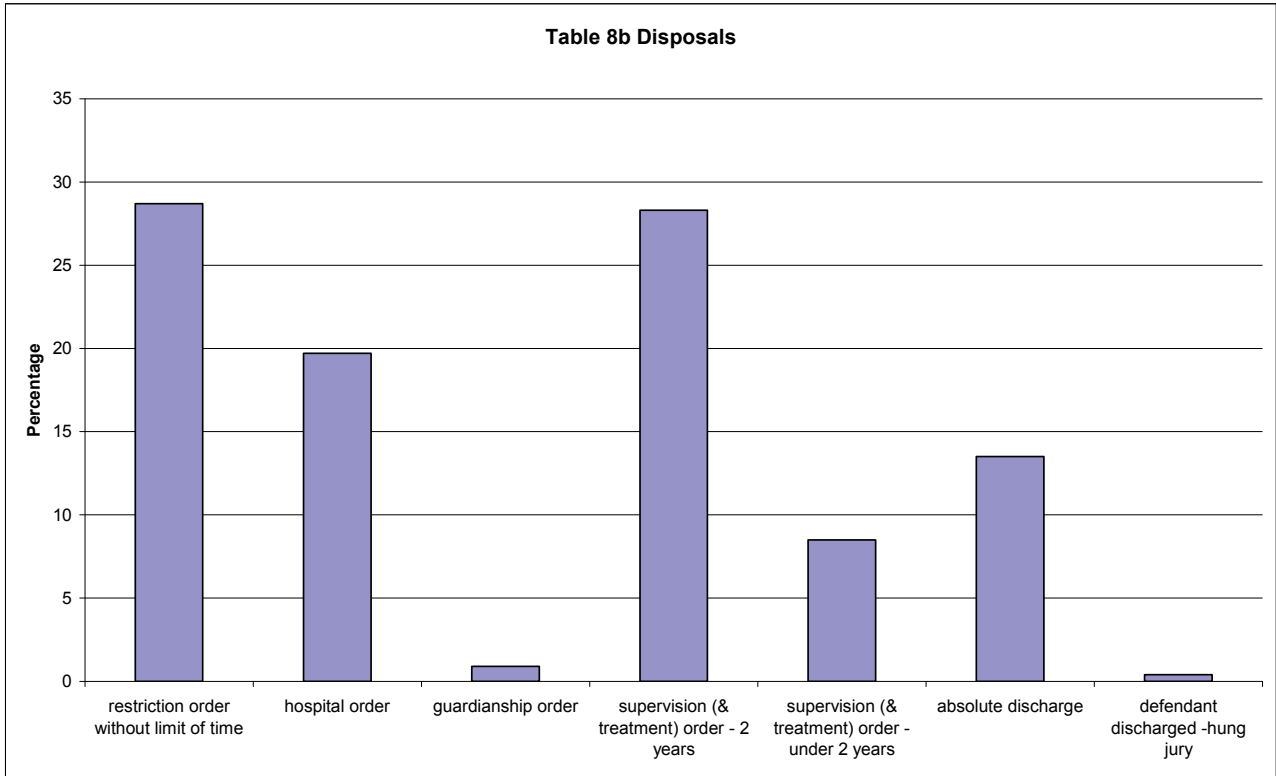


Table 8c - Disposals * Year of Decision Cross Tabulation

| | | year of decision | | | | | | | | | | Total |
|----------|---|------------------|------|------|------|------|------|------|------|------|------|-------|
| | | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | |
| disposal | restriction order without limit of time | 10 | 4 | 5 | 11 | 9 | 4 | 4 | 5 | 5 | 7 | 64 |
| | hospital order | 5 | 0 | 2 | 1 | 1 | 2 | 12 | 9 | 5 | 7 | 44 |
| | guardianship order | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | supervision (& treatment) order - 2 years | 5 | 6 | 7 | 5 | 5 | 2 | 8 | 8 | 9 | 8 | 63 |
| | supervision (& treatment) order - under 2 years | 1 | 4 | 1 | 0 | 2 | 1 | 3 | 2 | 1 | 4 | 19 |
| | absolute discharge | 1 | 1 | 4 | 3 | 5 | 4 | 1 | 3 | 0 | 8 | 30 |
| | defendant discharged - hung jury | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |

| | | year of decision | | | | | | | | | | Total |
|----------|---|------------------|------|------|------|------|------|------|------|------|------|-------|
| | | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | |
| disposal | restriction order without limit of time | 10 | 4 | 5 | 11 | 9 | 4 | 4 | 5 | 5 | 7 | 64 |
| | hospital order | 5 | 0 | 2 | 1 | 1 | 2 | 12 | 9 | 5 | 7 | 44 |
| | guardianship order | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | supervision (& treatment) order - 2 years | 5 | 6 | 7 | 5 | 5 | 2 | 8 | 8 | 9 | 8 | 63 |
| | supervision (& treatment) order - under 2 years | 1 | 4 | 1 | 0 | 2 | 1 | 3 | 2 | 1 | 4 | 19 |
| | absolute discharge | 1 | 1 | 4 | 3 | 5 | 4 | 1 | 3 | 0 | 8 | 30 |
| | defendant discharged - hung jury | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Total | | 23 | 16 | 19 | 20 | 23 | 13 | 28 | 27 | 20 | 34 | 223 |

E.13 Table 9 below again shows that community based disposals are being given for serious offences including murder, attempted murder, GBH, arson, robbery and threats to kill.

Table 9 - Main Offence Charged * Disposals Cross Tabulation

| main offence charged | CPI disposal | | | | | | | Total |
|--|---|----------------|--------------------|---|--|--------------------|----------------------------------|-------|
| | restriction order without limit of time | hospital order | guardianship order | supervision (& treatment) order - 2 years | supervision (& treatment) order -under 2 years | absolute discharge | defendant discharged - hung jury | |
| murder | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 4 |
| attempted murder | 21 | 9 | 0 | 8 | 0 | 1 | 0 | 39 |
| manslaughter | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| GBH | 15 | 15 | 0 | 8 | 3 | 4 | 1 | 46 |
| ABH | 6 | 3 | 0 | 9 | 3 | 7 | 0 | 28 |
| arson | 8 | 7 | 0 | 7 | 5 | 2 | 0 | 29 |
| criminal damage | 0 | 1 | 0 | 4 | 0 | 0 | 0 | 5 |
| robbery | 1 | 0 | 0 | 5 | 0 | 3 | 0 | 9 |
| burglary | 1 | 1 | 1 | 2 | 1 | 2 | 0 | 8 |
| indecent/ sexual assault | 2 | 2 | 0 | 5 | 4 | 2 | 0 | 15 |
| threats to kill | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| kidnap/child abduction | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 3 |
| (death by) dangerous driving | 1 | 1 | 0 | 2 | 1 | 2 | 0 | 7 |
| possession/ importation/ supply of drugs | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| endangering aircraft | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

| | CPI disposal | | | | | | | | Total |
|------------------------------------|---|----------------|--------------------|---|--|--------------------|----------------------------------|---|------------|
| | restriction order without limit of time | hospital order | guardianship order | supervision (& treatment) order - 2 years | supervision (& treatment) order -under 2 years | absolute discharge | defendant discharged - hung jury | | |
| breach restraining order | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| affray | 2 | 3 | 1 | 1 | 1 | 0 | 0 | 0 | 8 |
| false imprisonment | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| having article with blade | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 2 |
| theft | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| racially aggravated assault | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| bomb hoax | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| child cruelty | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| possession | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 |
| offensive weapon | | | | | | | | | |
| indecent exposure | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| aid/abet reckless driving | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| blackmail | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| breach anti-social behaviour order | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Total | 64 | 44 | 2 | 63 | 19 | 30 | 1 | | 223 |

The effect of the Domestic Violence, Crime and Victims Act 2004

- E.14 The 2004 Act was implemented on 31 March 2005. The Act reduced NGRI disposals to three, namely:
- (1) a hospital order (with or without a restriction order);¹
 - (2) a supervision order; and
 - (3) an order for an absolute discharge.
- E.15 With regard to the present study which spans a period of ten years, 39 (32.5%) months of the research period were prior to the implementation of the 2004 Act and 81 (67.5%) months post implementation. However, with this in mind it must be made clear that only those defendants arraigned on or after 31 March 2005 are subject to the new disposal regime.²
- E.16 The following tables give a split of these two respective periods in order to show something of the impact of the 2004 disposal regime. Table 10 below shows the numbers of NGRI cases involved pre and post the 2004 Act. It can be seen from this that 157 (70.4%) of the NGRI cases fell to be dealt with under the 2004 Act, compared to 66 (29.6%) dealt with before the Act.

¹ The hospital order is now identical to one made under the Mental Health Act 1983 and where the unfit to plead accused is charged with murder and the court has the power to make such an order, it must impose restrictions.

² See *R v Hussein* [2005] EWCA Crim 3556 at [14]: "The fact that the appellant was committed or sent to the Crown Court long before 31st March 2005 is nothing to the point". Although this decision deals with a case of UTP, Sch 12 para 8(2)(b) of the 2004 Act makes it clear that the same is true for the insanity defence.

Table 10 - Year of Decision

| Domestic Violence Act | | Frequency | Percent | Cumulative Percent |
|-----------------------|-------|-----------|---------|--------------------|
| pre-2004 Act | 2002 | 23 | 34.8 | 34.8 |
| | 2003 | 16 | 24.2 | 59.1 |
| | 2004 | 19 | 28.8 | 87.9 |
| | 2005 | 8 | 12.1 | 100.0 |
| | Total | 66 | 100.0 | |
| post-2004 Act | 2005 | 12 | 7.6 | 7.6 |
| | 2006 | 23 | 14.6 | 22.3 |
| | 2007 | 13 | 8.3 | 30.6 |
| | 2008 | 28 | 17.8 | 48.4 |
| | 2009 | 27 | 17.2 | 65.6 |
| | 2010 | 20 | 12.7 | 78.3 |
| | 2011 | 34 | 21.7 | 100.0 |
| | Total | 157 | 100.0 | |

E.17 Table 11 below gives a breakdown of the main offences charged in the two periods, pre and post the enactment of the 2004 Act. It can be seen from this that the pattern of offences has remained fairly consistent. However, the percentage of cases of attempted murder has fallen in the post-2004 Act period by around a third while cases of GBH have risen from 12.1% to 24.2%.

Table 11 – Main Offence Charged

| Domestic Violence Act | | Frequency | Percent | Cumulative Percent |
|-----------------------|------------------------------|-----------|---------|--------------------|
| pre-2004 Act | murder | 2 | 3.0 | 3.0 |
| | attempted murder | 15 | 22.7 | 25.8 |
| | GBH | 8 | 12.1 | 37.9 |
| | ABH | 6 | 9.1 | 47.0 |
| | arson | 10 | 15.2 | 62.1 |
| | criminal damage | 1 | 1.5 | 63.6 |
| | robbery | 2 | 3.0 | 66.7 |
| | burglary | 5 | 7.6 | 74.2 |
| | indecent/sexual assault | 2 | 3.0 | 77.3 |
| | threats to kill | 1 | 1.5 | 78.8 |
| | kidnap/child abduction | 1 | 1.5 | 80.3 |
| | (death by) dangerous driving | 2 | 3.0 | 83.3 |

| | | | | |
|------------------|---|-----|-------|-------|
| | possession/ importation/supply of drugs | 1 | 1.5 | 84.8 |
| | affray | 3 | 4.5 | 89.4 |
| | false imprisonment | 1 | 1.5 | 90.9 |
| | theft | 1 | 1.5 | 92.4 |
| | racially aggravated assault | 2 | 3.0 | 95.5 |
| | bomb hoax | 1 | 1.5 | 97.0 |
| | aid/abet reckless driving | 1 | 1.5 | 98.5 |
| | blackmail | 1 | 1.5 | 100.0 |
| | Total | 66 | 100.0 | |
| post-2004 Act | murder | 2 | 1.3 | 1.3 |
| | attempted murder | 24 | 15.3 | 16.6 |
| | manslaughter | 1 | .6 | 17.2 |
| | GBH | 38 | 24.2 | 41.4 |
| | ABH | 22 | 14.0 | 55.4 |
| | arson | 19 | 12.1 | 67.5 |
| | criminal damage | 4 | 2.5 | 70.1 |
| | robbery | 7 | 4.5 | 74.5 |
| | burglary | 3 | 1.9 | 76.4 |
| | indecent/sexual assault | 13 | 8.3 | 84.7 |
| | threats to kill | 1 | .6 | 85.4 |
| | kidnap/child abduction | 2 | 1.3 | 86.6 |
| | (death by) dangerous driving | 5 | 3.2 | 89.8 |
| | endangering aircraft | 1 | .6 | 90.4 |
| | breach restraining order | 1 | .6 | 91.1 |
| | affray | 5 | 3.2 | 94.3 |
| | false imprisonment | 1 | .6 | 94.9 |
| | having article with blade | 2 | 1.3 | 96.2 |
| | child cruelty | 1 | .6 | 96.8 |
| | possession offensive weapon | 2 | 1.3 | 98.1 |
| | indecent exposure | 2 | 1.3 | 99.4 |
| | breach anti-social behaviour order | 1 | .6 | 100.0 |
| | Total | 157 | 100.0 | |

E.18 Table 12 below gives the disposals for the two periods. What is of particular note is that although the percentage of restriction orders has fallen, there has been an increase in the use of hospital orders from 10.6% in the pre-2004 Act list to 23.6% in the post-2004 Act list. Indeed, overall the percentage of hospital based disposals has risen from 43.9% under the pre-2004 Act period to 50.3% under the post-2004 Act period, while the overall percentage of supervision (and treatment) orders has fallen from 40.9% (43.9% if guardianship orders are included) to 35.1% with the percentage of absolute discharges remaining fairly constant.

Table 12 - Disposals

| Domestic Violence Act | | Frequency | Percent | Percent | Cumulative Percent |
|-----------------------|---|-----------|---------|---------|--------------------|
| pre-2004 Act | restriction order without limit of time | 22 | 33.3 | 33.3 | 33.3 |
| | hospital order | 7 | 10.6 | 10.6 | 43.9 |
| | guardianship order | 2 | 3.0 | 3.0 | 47.0 |
| | supervision (& treatment) order - 2 years | 21 | 31.8 | 31.8 | 78.8 |
| | supervision (& treatment) order - under 2 years | 6 | 9.1 | 9.1 | 87.9 |
| | absolute discharge | 8 | 12.1 | 12.1 | 100.0 |
| | Total | 66 | 100.0 | 100.0 | |
| post-2004 Act | restriction order without limit of time | 42 | 26.8 | 26.8 | 26.8 |
| | hospital order | 37 | 23.6 | 23.6 | 50.3 |
| | supervision (& treatment) order - 2 years | 42 | 26.8 | 26.8 | 77.1 |
| | supervision (& treatment) order - under 2 years | 13 | 8.3 | 8.3 | 85.4 |
| | absolute discharge | 22 | 14.0 | 14.0 | 99.4 |
| | defendant discharged-hung jury | 1 | .6 | .6 | 100.0 |
| | Total | 157 | 100.0 | 100.0 | |

CONCLUDING REMARKS

- E.19 As in my earlier studies the number of verdicts of NGRI has continued to rise. The increase from a maximum of 17 findings in 1999 to a peak of 34 verdicts in 2011 certainly suggests that the legislative changes contained in the 1991 and 2004 Acts are having an ongoing effect. Overall during the ten year research period hospital based disposals have become marginally more prevalent, 108 (48.4%) than the overall percentage for the 1997 to 2001 study which was 47.2%. However, although community based disposals accounted for 51.2% (n=112) of NGRI cases which is broadly similar to that in the 1997 to 2001 study of 52.8%, absolute discharges have risen from 9.7% to 13.5% (n=30).
- E.20 With regard to the possible impact of the Domestic Violence, Crime and Victims Act 2004, what is of note is a reduction in the percentage of post-2004 Act non-hospital disposals from 56.1% to 49.1% post-2004 Act. Overall, therefore, the percentage of hospital based disposals has risen from 43.9% under the pre-2004 Act period to 50.3% under the post-2004 Act period.