Chapter 13

MENTAL DISORDER AT THE TIME OF THE OFFENCE

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13.01 Introduction

There are four instances to be discussed in this chapter where the mental state of the defendant at the time of the offence is material: insanity, non-insane automatism, diminished responsibility and infanticide. The **insanity defence** has had a long established history, and its original objective was to excuse the defendant from punishments associated with the crime of murder—first the death sentence and now the mandatory life sentence.

The courts have usually been quite unwilling to accept the defence of **non-insane automatism** (which results in a simple acquittal) particularly in cases where the defendant's violent behaviour may recur in future.

In 1957 the plea of **diminished responsibility** was introduced into the law of England and Wales. Diminished responsibility is not a complete defence to murder but a plea in mitigation. If a person is found to have reduced responsibility due to an abnormality of mind the charge is reduced from murder to manslaughter. Since the introduction of this plea the number of cases in which the insanity defence has been put forward and returned has dropped significantly—from an average of

20% of all persons committed for trial for murder between 1947–56,[1] to less than 1% in recent years. Courts have been indulgent in their construction of "abnormality of mind" in diminished responsibility. The plea has the further advantage that it does not tie the hands of the judge. He can make any disposal within his power. **Infanticide** was a forerunner of diminished responsibility and works on the similar principle of reducing the responsibility of the defendant so that, instead of a conviction for murder, she will be punished as if she were guilty of manslaughter. Infanticide is a narrow doctrine applying only where a mother causes the death of her child before the age of twelve months.

A. THE INSANITY DEFENCE

13.02 Background to the Reforms in the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991

The use of the insanity defence has had distinct disadvantages in the past. First, the M'Naghten Rules provide an exceedingly narrow definition of insanity, making it extremely difficult to excuse the person from criminal punishment. Even a person with a severe form of mental disorder may understand the physical nature of his act and that it is unlawful. That is, he will comprehend the act he is doing and that it is against the law – *e.g.*, the person will know that to strike a person will produce injury and that he will be subject to arrest and prosecution for the crime. The psychiatrist will prefer to understand the person's behaviour by examining his emotions, thinking and volition rather than solely by what he knows – *e.g.*, whether the person was driven to the act by delusions or other distorted perceptions of reality. (See para. **13.04.6** below). Despite this criticism of the M'Naghten Rules, it continues to be the legal test used by the courts to determine insanity.

The second criticism of the insanity defence is that "disease of the mind" has been construed by the courts to exclude internal causes. Thus, automatism caused by internal conditions such as sleep walking and epilepsy may not be regarded as legal insanity. The reasoning of the courts is that, even though the person is not mentally disordered and in need of treatment, the dangerous condition might recur.

Lord Justice Lawton in *R. v. Quick*[2] said that "common sense is affronted by the prospect of a diabetic being sent to . . . hospital, when in most cases the disordered medical condition can be rectified by pushing a lump of sugar into the patient's mouth". So, too, would it be inappropriate to place a person suffering from arteriosclerosis or epilepsy into a mental hospital.

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[1] See N. Walker (vol. 1; 1968) *Crime and Insanity in England*, University Press, Edinburgh, p. 159.

[2] [1973] Q.B. 910, at 922.

Confinement in a mental hospital of a person not suffering from a treatable mental disorder within the meaning of the Mental Health Act would be custodial not therapeutic. Such involuntary confinement of persons not medically classified as mentally disordered and not susceptible to psychiatric treatment is incompatible with the ostensible rationale in the insanity defence of compassion and exculpation from criminal punishment.

The Parliamentary debates preceding the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 referred frequently to the injustice of admitting a person with epilepsy to hospital following a special verdict.[1] Persons with epilepsy who had been charged with trivial offences faced the prospect of a hospital order with restrictions on discharge if they were found not guilty by reason of insanity. The 1991 Act did not amend the M'Naghten Rules or the way they are construed by the judiciary. Accordingly, a person with epilepsy may still be found to be not guilty by reason of insanity. But, the Act did provide the courts with wider discretion in disposing of a case following the special verdict.

The final criticism of the insanity defence was the mandatory disposition following the special verdict. Under the Criminal Procedure (Insanity) Act 1964 the court had **no choice** but to make a hospital order with restrictions on discharge without limit of time. This mandatory disposition was considered unjust because the person may have been charged with a comparatively minor offence and/or he may not have been mentally disordered and in need of treatment. In Britain, with the abolition of the death penalty, the defence has been of little practical importance because of the mandatory restriction order.[2]

It had been widely accepted that granting discretion to the judge in disposing of the case would be beneficial.[3] The 1991 Act amends the 1964 Act,[4] and provides for a flexible range of disposals following the special verdict in all cases except where the person was charged with

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[1] See *e.g.*, Official Report 1 March 1991, p. 1271 (discussing cases where persons with epilepsy were charged with shoplifting or with simple assault); 19 April 1991, p. 275 ("At the time when the M'Naghten Rules were written, medical understanding of epilepsy was poor . . . When a person is charged with an offence committed during an epileptic attack it is not medically possible for that person to be guilty of a wilful criminal act." The British Epilepsy Association is opposed to epilepsy being legally classified as "any kind of insane manifestation.")

[2] S. Dell (1983) Wanted: An Insanity Defence that can be Used, *Crim. L. Rev.* 431–37. Compare with the insanity defence in the United States. L. Gostin (1981) Justifications for the Insanity Defence in Great Britain and the United States. *Bull. Amer. Acad. Psychiat. and Law*, vol. 9, p. 100.

[3] *Report of the Committee on Mentally Abnormal Offenders* (1975: Lord Butler) Cmnd. 6244, HMSO, London, Para. 18.42; Criminal Law Revision Committee (1963) Cmnd. 2149, para. 34, L. Gostin (1977; Vol. 2) *A Human Condition*, MIND, London, p. 190.

[4] See Parliamentary debates on the Criminal Procedure (Insanity and Unfitness to Plead) Bill 19 April 199, pp. 724–731 (Third Reading); 1 March 1991, pp. 1269–1282 (Second Reading).

murder.[1] The disposals available to the court are a hospital order with or without restrictions on discharge, a guardianship order, a supervision and treatment order, and an order for absolute discharge.

13.02A Insanity Distinguished from Non-Insane Automatism

Automatism connotes the state of a person who, though capable of action, is not conscious of what he is doing. It is a defence "because the mind does not go with what is being done". There are two forms of automatism (insane and non-insane) which have quite different consequences. **Insane automatism** within the meaning of the M'Naghten Rules is founded upon a defence of lack of reason caused by a disease of the mind (see para. **13.04** below). The burden is on the defence to prove insanity on a balance of probabilities.[2] A successful plea of insanity results in the special verdict (see para. **13.03** below).

Non-insane automatism is where the defendant acts unconsciously and involuntarily but not by reason of a disease of the mind. Before the issue of non-insane automatism can be left to the jury, a proper evidential foundation must have been laid.[3] Once such evidence exists the burden of proof is on the prosecution to negative automatism beyond a reasonable doubt.[4] The question whether there is an evidential foundation for non-insane automatism, then, is one of law for the judge.[5] A successful defence of non-insane automatism results in an ordinary acquittal. Involuntary action by reason of concussion is an example.[6]

The distinction as to whether a medical condition is to be treated as insane or non-insane automatism is far from being clear or rational. Any inherent medical condition which affects the proper functioning of the mind and which may result in a recurrence of violence is treated as insanity.[7] (see para. **13.04.1** below). The reason given by the courts is that if violence is likely to recur the defendant ought to be made subject to detention in hospital.[8] Consequently, epilepsy,[9] arterioscler-

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[1] In murder cases, the court must make a restriction order without limit of time following the special verdict.

[2] Although the M'Naghten Rules require the defendant clearly to prove his insanity, the view now accepted is that the burden is only on the balance of probability. *Sodeman v. R.* [1936] W.N. 190; [1936] 2 All E.R. 1138. It has been proposed that, since the burden rests on the prosecution to prove the mental element, they should also bear the burden of negating an insanity defence. Criminal Law Revision Committee *(1972) Eleventh Report*, Cmnd. 4991, para. 140; *The Report of the Committee on Mentally Abnormal Offenders* (1975; Lord Butler), Cmnd. 6244, HMSO, London, para. 18–39. See also *Antelic* (1973) 1 ACTR at 5 (Aus.)

[3] *Bratty* [1963] A.C. at 406; *R.v. Sullivan* [1983] 2 All E.R. 673 at 677, H.L.

[4] *Obiter* in *Bratty* [1963] A.C. 386; *R. v. Burns* (1973) 58 Cr. App. R. 364.

[5] *Rabey* (1980) 15 C.R. (3d.) 225; *Bratty* [1963] A.C. at 411–412.

[6] *Bratty* [1963] A.C. at 403, 409; *R. v. Quick* [1973] Q.B. 910 at 918, 920–22.

[7] *R. v. Hennessy* [1989] 2 All E.R. 9; [1989] 1 W.L.R. 287, C.C.A.

[8] See, *e.g.*, *ibid*; *R. v. Sullivan* [1983] 2 All E.R. 673, H.L.

[9] *R. v. Sullivan* [1983] 2 All E.R. 673, H.L.

osis[1] and hyperglycaemia (high blood sugar) in diabetes[2] may be considered diseases of the mind under the M'Naghten Rules.

The question of whether sleepwalking should be classified as insane or non-insane automatism was raised in *R. v. Burgess*.[3] The Court of Appeal held that sleepwalking should be classified as insane automatism within the M'Naghten Rules because the defendant's abnormality was a "disease of the mind," due to an internal factor, whether functional or organic, and manifested itself in violence and might recur. The fact that the sleepwalking was in this case "transitory and unlikely to recur in the form of serious violence" is not a reason for saying that it cannot be a disease of the mind.

In contrast, if the violent behaviour is caused by some unforeseeable accident or external factor and is unlikely to lead to future violence, then it may result in a finding of automatism or simple acquittal.[4] A momentary failure to concentrate, such as in the case of absent-mindedness in shoplifting is not a disease of the mind; it should not be dealt with under the insanity defence, even though the person may have been suffering from a minor depression at the time.[5] Hypoglycaemia (low blood sugar) caused by an external factor such as an insulin injection, rather than from an inherent condition, can be automatism.[6]

For completeness it should be added that automatism resulting from intoxication as a result of voluntary ingestion of alcohol or dangerous drugs does not negative the *mens rea* necessary for crimes of basic intent.[7] However, self-induced automatism, other than that due to intoxication from alcohol or drugs, may provide a defence to crimes of basic intent. Thus if a person who suffers from diabetes is at fault in failing to take food after an injection of insulin, he may still be permitted to rely on the defence of non-insane automatism for example if he were not aware that he might thereby become aggressive.[8]

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[1] *R. v. Kemp* [1956] 3 All E.R. 249

[2] *R. v. Hennessy* [1989] 2 All E.R. 9, C.C.A.

[3] [1991] 2 W.L.R. 1206, C.C.A.

[4] *R. v. Quick* [1973] Q.B. 910; (1973) 57 Cr. App. R. 722, C.A.

[5] *R. v. Clarke* (1972) 56 Cr. App. R. 225

[6] *R. v. Quick* [1973] Q.B. 910, C.A. See *R. v. Bingham* [1991] Crim. L.R. 433 (transcript: Martin Walsh Cherer) 8 February 1991, CA (hypoglycaemia may raise difficult problems about the M'Naughten Rules, while hypoglycaemia generally does not give rise to any question of a verdict of not guilty by reason of insanity. Since hypoglycaemia is not caused by the diabetes itself but by taking too much insulin or not enough food, it is regarded as an external cause. If it is established and if it shows the necessary intent is lacking it can produce a satisfactory defence).

[7] See *DPP v. Majewski* [1976] 2 All E.R. 142 at 150, 169, [1977] A.C. 443 at 475, 496. The fact that the automatism is self-induced, however, does not make the defendant guilty of a crime of specific intent.

[8] *R. v. Bailey* [1983] 2 All E.R. 503, 507. For a discussion of some of the conceptual issues see C. Wells [1983] *Crim L. Rev.* pp. 787–797.

13.03 The Special Verdict

The Trial of Lunatics Act 1883, section 2(1)[1] provides: if it appears to the jury that the defendant did the act or made the omission charged, but was insane at the time so as not to be responsible, the jury shall return a special verdict that the defendant is not guilty by reason of insanity. Several elements of this provision require emphasis:

(*i*) **Who can raise the issue of insanity?** As insanity is a defence it is normally for the defendant alone to raise the issue. However, if the defendant raises the issue of diminished responsibility, (see para. **13.06** below), the prosecution can call evidence as to insanity.[2] The judge could, of his own volition raise the issue of insanity and leave it to the jury only if there was medical evidence which went to all of the factors in the M'Naghten test (see para. **13.04** below). This would be very rare, and before doing so the judge would have to ensure that counsel had both been given ample opportunity to call whatever evidence they deemed necessary.[3]

(*ii*) ***Mens rea* as an element of the offence**—The common law defence of insanity is available to a defendant only in cases in which *mens rea* is an element of the offence charged. In *Director of Public Prosecutions v. H*[4] the defendant had been acquitted by reason of insanity of a charge of driving with excess alcohol. This offence is one of strict liability; *mens rea* is not an element of the crime. Therefore it is irrelevant whether or not the defendant may have been insane at the time of the offence. On the prosecution's appeal, the court ordered that a conviction be entered against the defendant.

(*iii*) **Insanity defence available in summary proceedings in magistrates' courts**—The defence of insanity appears to be available to a defendant in summary proceedings in the magistrates' courts for the following reasons.[5] Insanity is a common law defence that is available in any case where *mens rea* is in issue. The Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 does not expressly remove insanity as a defence to charges which are tried before the magistrates' courts. Rather, Parliament legislated merely to provide a special verdict procedure in relation to trials on indictment in the Crown Court; the statute changes only the medical evidence required to establish

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[1] As amended by the Criminal Procedure (Insanity) Act 1964, s. 1. As to the history of the special verdict see para. **1.03.2** *ante*.

[2] Criminal Procedure (Insanity) Act 1964, s. 6.

[3] *R. v. Dickie* [1984] Crim L. Rev. 497. See also E. Griew (Oct. 26, 1984) Another nail for M'Naghten's Coffin? *N.L.J.*, pp. 935–936.

[4] [1997] 1 WLR 1406 (Q.B.D.).

[5] *R. v. Horseferry Road Magistrates' Court, ex parte K*, Q.B.D. [1977] QB 23, [1996] 3 All ER 719, [1996] 3 W.L.R. 68, [1997] Crim LR 129, [1997] BMLR 28.

the defence and the disposals that can be lawfully made. (See para. **13.05** below). Since Parliament has not decided otherwise, the common law defence of insanity survives in summary proceedings. This does leave an anomaly in the Mental Health Act when a magistrates' court acquits a person of an offence by reason of insanity. Section 37 of the 1983 Act makes no provision for magistrates to commit such persons for imposition of a restriction order. The absence of such a power of committal to the Crown Court for a restriction order, however, does not remove the common law defence of insanity from summary trials in magistrates' courts.

(*iv*) **Proof that defendant committed the act charged**—The prosecution must prove beyond a reasonable doubt that the defendant "did the act or made the omission charged". They must prove here the *actus reus* of the offence.[1] If they fail to prove this, the defendant is entitled to a simple acquittal irrespective of whether he was insane at the time of the alleged offence.

(*v*) **Requirements as to medical evidence**—A jury cannot return a special verdict except on the written or oral evidence of two or more registered medical practitioners, at least one of whom is duly approved under section 12 of the Mental Health Act 1983.[2] (As to approved medical practitioners see para **6.17.5** *ante*). Section 54(2) (3) of the 1983 Act has effect with respect to the proof of the accused's medical condition. Under section 54(2), a medical report can be received into evidence without proof of the signature of the practitioner or that he has the requisite medical qualifications; but the court may require the signatory of the report to be called to give oral evidence. Where, in pursuance of a direction of the court, the medical report is not tendered on behalf of the accused, a copy of the report must be provided to his counsel or solicitor. (If he is not represented, the substance of the report must be disclosed to him or, if he is a minor, to his parent or guardian). The accused may require the signatory of the report to be called to give oral evidence, and he may tender his own medical evidence.[3]

(*vi*) **Insanity at time of offence**—The insanity must relate to the defendant's action at the time of the alleged offence; his mental disorder or need for treatment at the time of the trial is not a relevant consideration.

(*vii*) **The special verdict**—It is the duty of the judge to direct the jury that if they accept the evidence of insanity the law requires them to bring in a special verdict and none other.[4] (The Act of

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[1] *Att.-Gen's. Reference (No. 3 of 1998)* (1999) TLR 10/5/99.
[2] Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 1(1).
[3] Mental Health Act 1983, s. 54(3).
[4] *R. v. Sullivan* [1983] 2 All E.R. 673, 677, H.L.

1883 says "the jury **shall** return a special verdict".). The special verdict is one of "not guilty by reason of insanity" and the jury must find that the defendant was "insane, so as not to be responsible, according to the law for his actions". Despite this formulation suggesting that the person is to be excused from responsibility, the essence of the special verdict is not that the defendant can be set free but that he can be dealt with in a number of ways, including a hospital order with or without restrictions on discharge. The purpose of the special verdict, ever since its origin in 1880, "has been to protect society against recurrence of the dangerous conduct".[1] Whatever the therapeutic benefit to the patient, it is incidental to this primary objective.

13.04 The M'Naghten Rules

The test of insanity, negating criminal responsibility, is not to be found in statute. It rests in England and Wales upon the unadorned M'Naghten Rules which were formulated by the judges in 1843 in answer to questions submitted by the House of Lords following the acquittal of murder of Daniel M'Naghten on the grounds of insanity.[2] The M'Naghten Rules, in their essential part, say that a person is presumed by law to be sane. To establish a defence 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 [1] not to know the nature and quality of the act he was doing, or, if he did know it, [2] that he did not know he was doing what was wrong . . . [3] [If the defendant] labours under [a] partial delusion only, and is not in other respects insane, we think he must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real".[3]

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[1] *Ibid.*, at 677–678.

[2] M'Naghten was under an insane delusion about the Conservative Party which focused upon the Prime Minister, Sir Robert Peel. On January 20, 1843 he shot Sir Robert's Private Secretary, Drummond, believing him to be Sir Robert. M'Naghten successfully pleaded insanity (1843) 10 Cl. & F. 200, 8 E.R. 718. He was admitted to Bethlem Hospital and later became one of the first male patients admitted to Broadmoor, where he died of tuberculosis. The House of Lords subsequently decided to require the judges to answer a number of hypothetical questions. This is their traditional right, but one which they seldom exercise. The answers to these questions constitute the M'Naghten Rules. Such answers do not have the force of law, but have been followed so consistently by the courts that they are now established principles of law. See *e.g.*, *R. v. True* (1922) 16 Cr. App. R. 164; *R. v. Windle* (1952) 36 Cr. App. R. 85.

[3] Limb 3 of the Rules has fallen into disuse because any instance where it would provide a ground for the special verdict could be grounded instead upon limb 1 or 2. The Court of Appeal in *Sullivan* [1983] Crim. L. Rev. 257 took the unusual course of considering the state of the common law before the formulation of the M'Naghten Rules. However, the House of Lords in *Sullivan* [1983] Crim. L. Rev. 740 made it clear that the Rules covered **all** determinations in respect of the insanity defence.

The M'Naghten Rules set up a cognitive test for exemption from criminal responsibility. The jury must decide whether the defendant was suffering from a "**defect of reason**" due to a "**disease of the mind**". If they find he was so suffering there are further questions they must decide: (1) in consequence of the defect of reason, did the defendant "**know the nature and quality of his act**"? (2) If he did, did he "**know it was wrong**"? The following is intended to clarify the essential elements of the Rules as they have been applied by the courts.

13.04.1 *"Disease of the Mind"*

"Disease of the mind" and "insanity"[1] are legal terms developed at common law and cannot be equated with any statutory term such as mental disorder or mental illness, or any medical term such as schizophrenia. Accordingly, the question of whether a defendant had a disease of the mind or was insane under the M'Naughten Rules is a matter of law for the judge to decide. It is not a conclusion which it is appropriate for a medical expert to draw.[2]

Disease of the mind "means a disease which affects the proper functioning of the mind".[3] The word "mind" in the Rules is used in the ordinary sense of the mental faculties of reason, memory and understanding.[4] If the effect of a disease is to impair these faculties so severely as to come within either of the two limbs of the M'Naghten Rules, it does not matter whether the aetiology of impairment is organic or functional, or whether the impairment is transitory and intermittent, provided that it subsisted at the time of the act or omission charged.[5] The law is concerned only with the state of mind of the defendant at the material time, and not how or why he came to be in that state. Thus the cause or duration of the impairment of the mental faculties of reason (particularly if there is a risk of recurrence) "cannot on any ground be relevant to the application by the courts of the M'Naghten Rules".[6] It appears as though any physical malfunction of the brain—for example, associated with arteriosclerosis[7] (hardening of the arteries),

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[1] These two terms are not identical. A mentally disordered person, for example, may have a "disease of the mind" but this would not amount to legal "insanity" or justify a special verdict unless that disease produces the required defect of reason within the M'Naghten Rules.

[2] *R. v. Hennessy* [1989] 2 All E.R.9; [1989] 1 W.L.R. 287, C.C.A.

[3] *Ibid.*

[4] The law is concerned only with cognition and not emotion or volition.

[5] *R. v. Kemp* [1956] 3 All E.R. 249 at 253, [1957] 1 Q.B. 399 at 407, per Devlin J., approved by the House of Lords in *Bratty* [1963] A.C. 386 and *Sullivan* [1983] 2 All E.R. at 677.

[6] *Sullivan* [1983] 2 All E.R. at 678.

[7] *R. v. Kemp* [1956] 3 All E.R. 249 (arteriosclerosis can be a disease of the mind). But see *R. v. Charlson* (1955) 39 Cr. App. R. 37 (epilepsy or brain tumour were not diseases of mind, even though they led to violent action). The position in *Kemp* **not** *Charlson* is the law. See *Bratty* [1963] A.C. 386, per Denning L.J.

psychomotor epilpesy[1] or cerebral tumor – can be a disease of the mind under the Rules where it is shown on evidence to be capable of affecting the mind in such a way as to cause a defect of reason, whether temporarily or permanently. This expansive view of "disease of the mind" was supported by the House of Lords in *Bratty's* case: "any mental disorder which manifests 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".

The term "disease of the mind" as established in *Kemp* and *Bratty* would have inappropriate results if applied without identifiable boundaries. In *R. v. Quick*[2] the court held that "a malfunctioning of mind of transitory effect caused by the application to the body of some external factor such as violence, drugs, including anaesthetics, alcohol and hypnotic influences cannot fairly be said to be due to disease". *Quick* was concerned with hypoglycaemia (a deficiency in blood sugar). The defendant was a diabetic and became violent after an injection of insulin. The injection of insulin was an external factor causing hypoglycaemia and the subsequent violence. But the court indicated that if the malfunction was due to the inherent disease of diabetes, not due to an insulin injection, it may be a disease within the M'Naughten Rules.

In *R. v. Hennessy*[3] hyperglycaemia owing to diabetes was considered a disease of the mind. But the defendant's violent behaviour was exacerbated by stress, anxiety and depression. The Court of Appeal held that these external factors were not separately or together, capable in law of causing or contributing to the state of automatism. They constitute a state of mind that is prone to recur. They lack the feature of novelty or accident which distinguishes automatism from insanity.

The Criminal Court of Appeal adopted the distinction between external and internal causes in *R. v. Burgess*.[4] The Court ruled that violence during sleepwalking was an internal cause and, therefore, should be classified as a disease of the mind. Lord Lane CJ adopted the statement of Martin J and approved by the Supreme Court of Canada in *Rabey v. the Queen*:[5] "Any malfunctioning of the mind or mental disorder having its source primarily in some subjective condition or weakness internal to the accused (whether fully understood or not) may be a 'disease of the mind' if it prevents the accused from knowing what he was doing, but transient disturbances of consciousness due to certain external factors do not fall within the concept of disease of the mind."

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[1] *Bratty* [1963] A.C. 386; *Sullivan [1983]* 2 All E.R. 673. The suggestion in *R. v. Isitt* (1977) 67 Cr. App. R. 44, C.A. that epilepsy is not a disease of the mind is contrary to the decisions of the House of Lords.

[2] [1973] Q.B. 910, (1973) 57 Cr. App. R. 722, C.A.

[3] [1989] 2 All E.R.9; [1989] 1 W.L.R. 287, C.C.A.

[4] [1991] 2 W.L.R. 1206.

[5] [1980] 2 SCR 513, 519 (ordinary stresses and disappointments of life do *not* constitute an external cause).

The House of Lords has yet expressly to affirm the principle in *Quick*. But Lord Diplock in *Sullivan* did not exclude "the possibility of non-insane automatism, for which the proper verdict would be a verdict of not guilty, in cases where temporary impairment not being self-induced by consuming drink or drugs, results from some external physical factor such as a blow on the head causing concussion or the administration of an anaesthetic for therapeutic purposes".[1] If there is to be any clear logic and consistency to be read into the caselaw, it is that the courts will make a judgment as to whether there is a risk of recurrence of the dangerous behaviour.[2] It is odd that the question of whether there exists a disease of the mind should be dealt with by the courts by reference, not solely to medical evidence of a person's state of mind, but also to the future risk of danger. Yet this may be the only rational way of distinguishing the caselaw which suggests that arteriosclerosis and epilepsy can constitute diseases of the mind, but that insulin induced hypoglycaemia and even mild depression may not.

13.04.2 *"Defect of Reason"*

In examining the phrase "defect of reason" as a consequence of disease of the mind, it must be shown that the accused was, at the material time, deprived of the power of reasoning. The M'Naghten Rules do not apply to those who retain the power of reasoning but who fail to use their powers to the full, such as a shoplifter who took groceries forgetting to pay for them.[3] When the defendant has established that, at the time of the offence, he was suffering from a defect of reason from disease of the mind, he must further establish that, as a consequence of this defect of reason, his knowledge was critically deficient in one of the following respects.

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[1] [1983] 2 All E.R. at 678.

[2] If a person had an impairment of mental faculties (*e.g.*, epilepsy) but the offence was not serious or the risk of recurrence minimal, would that then be a disease of the mind? See *e.g. Hill v. Baxter* (1958) 42 Cr. App. R. 51 (an epileptic seizure while driving a car can amount to non-insane automatism). Could it be that the determination of whether a person has a disease of the mind turns on the likelihood of recurred violence? Are the courts creating a legal fiction simply to set policy?

[3] *R. v. Clarke* (1972) 56 Cr. App. R. 225.

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13.04.3 *"The Nature and Quality of the Act"*

These words apply to the physical, not the moral or legal character of the Act.[1] The concept is more clearly expressed as "he did not know what he was doing".[2] Thus a defendant is excused from responsibility only if he had no comprehension of the physical act he performed—*e.g.*, if he did not know he was killing someone. This first limb of the M'Naghten Rules is a particular statement of the doctrine of *mens rea*. Usually an offence is committed only where the defendant has proceeded with intention or recklessness in respect of all the circumstances of the act which constitutes the *actus reus* of the crime. However this statement of the requirement of a guilty mind is co-extensive with the provision in M'Naghten that the defendant did not know the nature and quality of his act; a person who is unable to comprehend the physical quality of his act could not have formed an intent in respect of that act. Total impairment in comprehension of the physical act, therefore, excuses the actor from criminal responsibility irrespective of whether it is a product of a disease of the mind. The critical difference between lack of *mens rea* due to a disease of the mind and lack of *mens rea* due to other causes has already been described: absence of the mental element necessary for a particular offence will result in freedom for the sane actor, but an indefinite period of confinement in hospital for the insane actor.[3]

13.04.4 *"Did Not Know He Was Doing What Was Wrong"*

The M'Naghten Rules provide that a person who knows the physical quality of his act will, nevertheless, be excused from criminal responsibility if (under the second limb of the Rules) he did not know it was wrong. Knowledge of the wrongfulness of an act may be interpreted variously: understanding it is contrary to law; contrary to the general morals of the community; or contrary to one's own moral standards. It can be envisaged that a person may recognise that an act is unlawful, but nevertheless believe it is morally acceptable to his fellow man, or morally acceptable only to himself; a person who believes he is carrying out the will of God will know an act is unlawful, but not morally wrong in a personal sense. The modern authority in England is that wrongfulness refers solely to the legal understanding.[4] This is a highly restrictive test, for few people (even if severely mentally ill) will fail to appreciate that, for example, killing or setting fire to a building is not contrary to the law of the land.

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[1] *R. v. Codere* (1916) 12 Cr. App. R. 21.

[2] *R. v. Sullivan* [1983] 2 All E.R. at 678.

[3] For the policy argument see L. Gostin (1981) Justifications for the Insanity Defence in Great Britain and the United States, *Bull Am. Acad. Psychiat. & Law*, vol. 9, pp. 100, 115.

[4] *R. v. Windle* [1952] 2 Q.B. 826 (murdered his wife with the belief he was morally justified, but said "I suppose they will hang me for this").

Insanity established on the second limb of the Rules, however limited, provides the only basis upon which an insane defendant might be excused from responsibility in circumstances that would otherwise render him criminally responsible. Knowledge by a sane actor of the wrongfulness of his act is not within the prosecution's case; accordingly, a deficiency in such knowledge would not be a ground for acquittal.

The law of England and Wales, then, is that the special verdict will be returned if, as a consequence of defect of reason resulting from a disease of the mind, the actor did not know the physical quality of his act, or he did not know that the particular act was unlawful.

13.04.5 *How Severe a Mental Disorder must a Person have to Prove Insanity under the Rules?*

Mental disorder, even of a serious kind, does not necessarily constitute 'insanity' within the M'Naghten Rules. The Rules are pre-eminently concerned with the ability to reason. A disease of the mind must affect the comprehension of the defendant, not his emotion, will or volition. In particular, the fact that a person had an uncontrollable impulse to commit an offence is not of itself a defence.[1] Peter Sutcliffe's (the "Yorkshire Ripper") doctors maintained that he was suffering from serious delusions; he was told by God to kill prostitutes, and he believed that it was morally right to do so. Yet, under the M'Naghten Rules he is responsible so long as he knew that to strike a woman with an axe would cause death and that to kill is unlawful.

Psychopathic disorder and mental handicap, like mental illness, would likely to be considered a disease of the mind. But could they ever amount to insanity under the Rules? It would be difficult if not impossible, for a person suffering from psychopathic disorder to set up a M'Naghten defence. Even if it were suggested that a psychopath did not have control or choice in respect of a particular act (note that there are an infinite number of unlawful acts that even the most ardent psychopath resists), could it ever be said that by reason of psychopathic disorder alone he did not know what he was doing or that it was wrong? Do persistent attempts to evade detection and capture suggest that the person knows he has acted unlawfully? Mental handicap, even of a severe kind, usually does not completely rob a person of understanding and it is to be expected that few mentally handicapped people would come within the Rules. Nevertheless a severely mentally handicapped person may fail to recognise the nature or quality of his act or that it was wrong. Much would depend upon whether "nature and quality" included a full appreciation of the likely consequences of the act.

[1] *R. v. Kopsch* (1925) 19 Cr. App. R. 50; *Sodeman v. R.* [1936] 2 All E.R. 1138, [1936] W.N. 190; *Att.-Gen. for S. Aus. v. Brown* (1960) 44 Cr. App. R. 100. The 'irresistible impulse' test has been adopted in a number of United States jurisdictions. See American Law Institute (1962) *Model Penal Code*, para. **4.01**.

13.04.6 *Criticism of the M'Naghten Rules*

Because they use solely a cognitive test, the Rules make it difficult for psychiatrists to give evidence. Psychiatry is unable to explain behaviour except by examining variations in mood, thinking and volition. By requiring the doctor to explain behaviour solely by what a man knows produces an inaccurate jurisprudential understanding of medical concepts and places an impediment to full and expert testimony. The Butler Committee recommended that in place of the Rules the jury should return a special verdict where at the time of the act the defendant was suffering from severe mental illness which the Committee suggested could be defined by statute.[1]

13.05 Powers to Deal with Persons Not Guilty by Reason of Insanity

Prior to the implementation of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 in January 1992,[2] when the special verdict was returned the court had no choice but to order the defendant to be admitted to hospital with restrictions on discharge without limit of time. Section 3 of the 1991 Act[3] empowers the court to make any of the following orders after a return of the special verdict: admission to hospital with or without restrictions on discharge, guardianship, supervision and treatment, and absolute discharge. However, where the offence to which the special verdict relates has a sentence that is fixed by law (*i.e.*, murder) the court must make a hospital order with restrictions on discharge without limit of time.[4]

13.05.1 *A hospital order with or without restrictions on discharge*

When the special verdict is returned the Crown Court or the Court of Appeal is empowered to make an order that the person should be admitted to such hospital as may be specified by the Secretary of State.[5] Such an order is sufficient authority for any person acting under the authority of the Secretary of State to take the person and convey him at any time within a period of two months[6] (beginning with the day the order was made) to the specified hospital. The statutory period

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[1] *The Report of the Committee on Mentally Disordered Offenders* (1975) Cmnd. 6244, HMSO, London, Chap. 18.

[2] The Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, (Commencement) Order 1991, No. 2488. The Act is described in detail in Home Office Circular No. 93/1991.

[3] Criminal Procedure (Insanity) Act 1964, s. 5, substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 3.

[4] Criminal Procedure (Insanity) Act 1964, s. 5(3), substituted by the Criminal Procedure (Insanity and Unfitness to Plead Act) 1991, s. 3, Sch. 1, para. 2(2).

[5] Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, Schedule 1.

[6] In relation to an admission made under Section 14A of the Criminal Appeal Act 1968, substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 4(2) the relevant period is seven days. See para. **13.05A.3** below.

cannot be extended and if the person is not admitted within that time the order lapses.[1] It is to be observed that there is no requirement for the court or Secretary of State to be satisfied that arrangements have been made on behalf of the managers of the hospital that a bed is made available (see para. **3.03.1** *ante*). The Home Office in the past has been prepared to override any objections within the receiving hospital and to compel admission. The court is entitled to give directions for the conveyance of the person to a place of safety pending his admission to the hospital within the two month period. The hospital managers are authorised to detain the patient in hospital as if he had been admitted in pursuance of a hospital order (on the date of the admission order made by the court). If the court directs, he can be held as if the hospital order had been made with restrictions on discharge without limitation of time or during a specified period. This gives the court discretion for the first time to make the hospital order without restrictions on discharge. However, the court has no such discretion if the offence to which the special verdict relates is an offence the sentence for which is fixed by law. Where the offence is murder, therefore, the court must make a restriction order, without limit of time.

13.05.2 *Guardianship Order*

The court has the power following a return of the special verdict to make a guardianship order.[2] The effect of the guardianship order is the same as under section 37 of the Mental Health Act 1983.[3] Thus, the person cannot be required to undergo treatment without his consent (see para. **15.22** *post*). If the court is of the opinion that treatment is required, it can make a supervision and treatment order, as described below.

13.05.3 *Supervision and Treatment Order*

The court has the power following the return of the special verdict to make a supervision and treatment order,[4] which is modelled on a psychiatric probation order.[5] A supervision and treatment order is an order requiring the person (the "supervised person") to be under the supervision of a social worker or probation officer (the "supervising officer") for a specified period of not more than two years; and to be under treatment (during the whole period or a specified lesser period)

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[1] Criminal Procedure (Insanity) Act 1964, s. 5, as amended by the Courts Act 1971, s. 56, sch. 11.

[2] Criminal Procedure (Insanity) Act 1964, s. 5(2) (b) (i), substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, S. 3.

[3] Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 5(2).

[4] Criminal Procedure (Insanity) Act 1964, s. 5(2) (b) (ii), substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 3; Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, S. 5(3), Sch. 2.

[5] *Hansard*, 1 March 1991, p. 1274, 1280; Home Office Circular No. 93/1991.

by or under the direction of a registered medical practitioner with a view to the improvement of his mental condition.

The court can make a supervision and treatment order only if it satisifed that, having regard to all the circumstances, the order is the most suitable means of dealing with the case; and the mental condition of the person requires and may be susceptible to treatment, but does not warrant a hospital or guardianship order. The court must have written or oral evidence of two or more registered medical practitioners, at least one of whom is duly approved (see para. **6.17.5** *ante*).[1] Home Office Circular 93/1991 recommends consideration of a supervision and treatment order when release of the patient into the community will not pose an unacceptable risk to the public and the patient needs treatment.

The court must also be satisifed that the supervising officer is willing to undertake supervision, and that arrangements have been made for the treatment intended in the order (including arrangements for reception of the person where he is to be required to be under treatment as a resident patient).

The supervision and treatment order must either require the person to be under the supervision of a social worker of the local social services authority or a probation officer appointed for the petty session area in which the person resides or will reside. The court must explain to the supervised person in ordinary language the effect of the order and the power of the magistrate's court to revoke or amend the order on the application of the supervised persòn or the supervising officer.

A supervision and treatment order *must* include a requirement that the supervised person (during the entire period of the order or a shorter specified period) be under one of the following kinds of treatment:

(*i*) treatment as a resident patient in a hospital or mental nursing home (but not a special hospital);[2]
(*ii*) treatment as a non-resident patient;
(*iii*) treatment by or under the direction of a registered medical practitioner.

The order cannot indicate what the nature of the treatment should be, as this is a matter for the medical practitioner. The medical practitioner, with the consent of the supervised person, can make arrangements for the supervised person to be treated in another place in which treatment can be given more effectively or conveniently. The new place of treatment need not be one which could have been specified in the original order.

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[1] The medical evidence provided to the court must comply with section 54(2) (3) of the 1983 Act.

[2] The role of the supervising officer while the person is a resident patient is limited to supervision as may be necessary for the purpose of revocation or amendment of the order.

A supervision and treatment order *may* include a requirement to reside in a particular place. The person, for example, might be treated as a patient in a hospital or might receive treatment in the community. Before issuing a residency requirement the court must consider the home circumstances of the supervised person.

Schedule 2, Part III of the 1991 Act provides for the revocation and amendment of supervision and treatment orders. The power to revoke or amend the order is provided to the magistrates' court on the application of the supervised person or supervising officer. The magistrates' court can revoke the order in the interests of the person's health or welfare, amend it by reason of a change in the person's residence, or cancel existing requirements or insert new requirements. The supervising officer must apply for the variation or cancellation of a treatment requirement when he receives a report to that effect from the medical practitioner who is directing the treatment.

The supervision and treatment order introduced by the 1991 Act is innovative in several ways. Most importantly, it provides the court with a flexible order that can be crafted to the individual needs of the person found not guilty by reason of insanity. This provides an attractive series of less restrictive alternatives, which is preferable to the mandatory restriction order required under the 1964 Act. The supervision and treatment order also provides one of the first formal mechanisms for treatment of mentally ill people in the community. The person can be treated in hospital as an out-patient or in-patient, or he can be treated in the community. It, therefore, maximizes a person's freedom and ability to live normally near his family and community, while still making him subject to supervision. The availability of less restrictive alternatives in dealing with a person found not guilty by reason of insanity gives the special verdict a new meaning and importance that it has not had previously.

Some ambiguity, however, remains regarding the purpose and effect of supervision and treatment orders. The Home Office regards the order as non-punitive. The order should usually be made with the patient's consent, but the court can reserve the right to impose it even if he is unwilling to comply. The justification is that the patient may not be able to provide meaningful consent, although the court is not statutorily obliged to first find the patient incompetent. Still, the court or supervising officers have no specific powers to enforce compliance – penal sanctions do not apply. Treatment must be administered only with the patient's consent. If the patient's medical and social supervisors believe compulsory medical treatment is required they will have to use the procedures for involuntary admission to hospital under Part II of the Act and seek recourse to compel treatment under Part IV.

13.05.4 *Order for Absolute Discharge*

The court has the power following the return of the special verdict to order an absolute discharge.[1] The special verdict of not guilty by reason of insanity has always been perplexing. Although the verdict found the person "not guilty," it nevertheless required deprivation of liberty. This presents a paradox, for if a person truly did not have the requisite intent to establish a guilty mind, no offence, in theory, is committed. In addition, if the person is not currently mentally ill and in need of treatment, admission to a mental hospital serves little public purpose. The discretion now given to courts under the 1991 Act to order an absolute discharge goes a long way towards rectifying the anomalies that have long plagued the insanity defence.

13.05A Appeals

13.05A.1 *Substitution of verdict of insanity for a conviction*

The Court of Appeal, on appeal against conviction, can substitute a verdict of not guilty by reason of insanity. The Court of Appeal must have written or oral evidence from two registered medical practitioners at least one of whom is duly approved. When the Court of Appeal substitutes a verdict of insanity it can dispose of the case in any way that would have been available to the Crown Court.[2] (See para. **13.05** above).

13.05A.2 *Appeal against verdict of insanity*

Despite the fact that the form of the special verdict is an acquittal, the person may appeal against the verdict. The accused person can appeal on any ground involving a question of law; or, with leave of the Court of Appeal, on any ground involving a question of fact alone or of mixed law and fact, or any other ground which appears sufficient to the Court of Appeal. However, if the judge of the trial grants a certificate that the case is fit for appeal on a ground involving a question of fact or of mixed law and fact, an appeal lies without leave of the Court of Appeal.[3]

13.05A.3 *Substitution of a verdict of acquittal for a verdict of insanity (admission for assessment)*

The Court of Appeal, under specified circumstances, is entitled to substitute a verdict of acquittal for the verdict of not guilty by reason of insanity.[4]

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[1] Criminal Procedure (Insanity) Act 1964, S. 5(2) (b) (iii), substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 3.

[2] Criminal Appeal Act 1968, s. 6, substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 4(1).

[3] Criminal Appeal Act 1968, s. 12.

[4] Criminal Appeal Act 1968, s. 13(4) (b).

In such a case the Court of Appeal must make an order that the appellant be admitted for assessment to a hospital specified by the Secretary of State if it makes the following findings. The Court of Appeal must find, on the written or oral evidence of two or more registered medical practitioners at least one of whom is duly approved, that the appellant is suffering from mental disorder of a nature or degree which warrants his detention for assessment (or for assessment followed by medical treatment) for at least a limited period; and he ought to be so detained in the interest of his own health or safety or with a view to the protection of others.[1]

A person who is admitted to hospital in pursuance of an admission order made under section 14A of the 1968 Act is treated as if he had been admitted (on the date of the admission order) in pursuance of an application for assessment under Part II of the Mental Health Act 1983.[2]

B. DIMINISHED RESPONSIBILITY

13.06 Introduction

The doctrine of diminished responsibility was introduced in England and Wales in 1957 essentially as a method of circumventing the mandatory sentence for murder; at the time the mandatory sentence included the death penalty for certain cases but today it is restricted to

[1] Criminal Appeal Act 1968, s. 14A, substituted by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s. 4(2).

[2] Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, Sch. 1, para. 3.

life imprisonment. The essence of diminished responsibility is that if the defendant can prove he was suffering, at the time of the unlawful killing, from an abnormality of mind as substantially impaired his mental responsibility, he will be convicted of manslaughter instead of murder. This will give the judge full discretion as to the sentence, which can range from a life sentence or a determinate sentence of imprisonment to a hospital order or a psychiatric probation order.

Section 2(1) of the Homicide Act 1957 provides for a defendant to be convicted of manslaughter with diminished responsibility instead of murder:

> "if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing".

Several procedural aspects of the plea require explanation:

(*i*) **Who can raise the plea**? The defence, not the prosecution, is entitled to introduce a plea of diminished responsibility on a trial of murder. However, where the defendant contends that he was insane under the M'Naghten Rules the prosecution is entitled to call evidence of diminished responsibility.[1] Where the issue of diminished responsibility is not raised by the defence, it is to be doubted whether the trial judge himself has discretion to call evidence.[2]

(*ii*) **Who carries the burden of proof**? Where the defendant raises the issue of diminished responsibility he carries the burden of proof by the balance of probabilities.[3] However, if in response to the defendant raising the insanity defence, the prosecution seeks to show diminished responsibility, it has the burden of proof beyond a reasonable doubt.[4]

(*iii*) **Medical evidence and the jury**—The 1957 Act does not specially require medical evidence to be adduced in support of a plea of diminished responsibility. However, as the burden of proof is on the defendant, medical evidence is a practical necessity if the plea is to have any chance of success. Thus, if no medical evidence is put forward the judge need not put the issue to the jury.[5] If medical evidence is put forward which plainly points to

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[1] Criminal Procedure (Insanity) Act 1964, s. 6. Alternatively, if the defendant raises the issue of diminished responsibility, the prosecution can call evidence as to insanity (see para. **13.03** above).

[2] *R. v. Kooken* (1982) 74 Cr. App. R. 30, C.A. See also *R. v. Campbell*, *The Times*, November 4, 1986, C.A.

[3] Homicide Act 1957, s. 2(2). See *R. v. Dunbar* (1958) 41 Cr. App. R. 182.

[4] *R. v. Grant* [1960] Crim. L. Rev. 424.

[5] *R. v. Dix* (1982) 74 Cr. App. R. 306.

diminished responsibility the judge is entitled to accept the plea without referring it to the jury.[1] Indeed, courts are likely to be quite indulgent in their acceptance of pleas of diminished responsibility; in only approximately 15% of all cases is the prosecution or court not prepared to accept a plea of guilty on grounds of diminished responsibility.[2] The plea should be accepted only when there is clear evidence of mental abnormality.[3] The court is entitled to take account of all of the facts and circumstances, and not only medical evidence. Thus, even where the medical evidence is all one way, the judge is entitled to put the issue to the jury.[4] The Court of Appeal will not interfere with a verdict unless it was a miscarriage of justice. If the medical evidence of diminished responsibility is unchallenged and no facts or circumstances throw doubt on the evidence, an appeal will lie against a verdict of guilty of murder.[5] However, if the medical evidence is contradictory, or if there are other facts or circumstances throwing the medical evidence into doubt, it is for the jury alone to determine the issue of diminished responsibility.[6]

(*iv*) **Direction to the jury**—The judge cannot simply read s. 2(1) to the jury but must explain the terms of the provision. Where lengthy medical evidence has been presented the judge should not provide the jury with a transcript, but should review the medical evidence with them.[7]

The plea of diminished responsibility is based upon two main factors: **abnormality of mind**, which must arise from specified causes or conditions; and the abnormality of mind must **substantially impair the person's responsibility**.

13.07 "Abnormality of Mind"

The concept of "abnormality of mind" is distinct from, and considerably wider than, "defect of reason" under the M'Naghten

[1] *R. v. Cox* (1968) 52 Cr. App. R. 130, C. A.

[2] See Dell (1982) Diminished Responsibility Reconsidered, *Crim. L. Rev.*, pp. 809–18.

[3] *R. v. Vinagre* (1979) 69 Cr. App. R. 104. C.A.

[4] See *R. v. Sutcliffe, The Times*, May 26, 1982. (Court of Appeal refused leave to appeal against 13 murder convictions; jury was entitled to reject medical evidence, taking into account other circumstances such as his determination to avoid detention and capture); *R. v. Ahmed Din* (1962) 46 Cr. App. R. 269; *R. v. Walton* (1978) 66 Cr. App. R. 25; *R. v. Sanders* (1991) 93 Cr. App. R. 246, CCA (where the medical evidence of diminished responsibility is unequivocal and uncontradicted, the trial judge should direct the jury to accept it if there are no other circumstances to consider; where, however, other circumstances exist, the medical evidence should be assessed in light of those circumstances).

[5] *R. v. Matheson* (1958) 42 Cr. App. R. 145. But cf., *Walton v. R.* (1978) 66 Cr. App. R. 25, at 30. (The jury are entitled to reject medical evidence if they consider it to be of low quality and weight.)

[6] *R. v. Jennion* (1962) 46 Cr. App. R. 212.

[7] *R. v. Terry* (1961) 45 Cr. App. R. 180, C.A.

Rules. It means a state of mind so different from the ordinary that a reasonable man would term it abnormal. Abnormality of mind is wide enough to cover all the mind's activities—not only cognition and understanding as in the M'Naghten Rules but also volition and the ability to exercise will power.[1] Although it has been termed a 'borderline' insanity this is misleading, for the concept of abnormality of mind is not simply quantitatively, but qualitatively, different from legal insanity.[2] It does not simply enquire as to the *extent* of the deficiency in reason but examines other aspects of a man's personality including emotion and the ability to exercise self-control. Abnormality of mind encompasses an 'irresistible impulse'—*i.e.*, a person who could not help himself from acting as he did. Abnormality of mind is also to be distinguished from medical diagnoses or classifications of mental disorder under the Mental Health Act: all mental disorders will not provide grounds for a successful plea of diminished responsibility; nor are all "abnormalities of mind" mental disorders.[3]

The words in brackets in section 2(1) of the Homicide Act 1957 (see para **13.06** above) qualify the form of mental abnormality which can be taken into account in a plea of diminished responsibility. The abnormality of mind must: (*i*) arise from an "arrested or retarded development of mind"; or (*ii*) arise from "any inherent causes"; or (*iii*) be "induced by disease or injury".

(*i*) "*arrested or retarded development of mind*"—This phrase refers to mental handicap whether or not it was caused genetically or by brain damage.

(*ii*) "*any inherent causes*"—This phrase was intended to exclude emotions such as jealousy, greed or anger caused by external events. Ordinary emotions such as depression, obsessive jealousy or anger can sometimes be classified as mental disorders, and psychiatrists are sometimes prepared to testify that they are from inherent causes.

The bracketed phrase "inherent causes" also excludes the effects of drugs or alcohol.[4] Self-induced intoxication cannot of itself produce an abnormality of mind.[4] However, Lord Widgery, C. J. said in *R. v. Fenton* that "cases may hereafter arise where the accused proves such a craving for drink or drugs as to produce in itself an abnormality of mind."[5]

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[1] *R. v. Byrne* (1960) 44 Cr. App. R. 246, at 252. *Byrne* was followed in *Rose v. R.* (1961) 45 Cr. App. R. 102, P.C.; *R. v. Terry* (1961) 45 Cr. App. R. 180, C.A.; and *R. v. Gomez* (1964) 48 Cr. App. R. 310, C.A.

[2] *Rose v. R.* (1961) 45 Cr. App. R. 102, at 105–06. See *R. v. Seers* [1985] Crim. L. Rev. 315.

[3] Pre-menstrual tension, for example, has been accepted in a plea diminished responsibility. See S. Edwards (1982) Pre-Menstrual Tension, *Justice of the Peace News*, vol. 146, pp. 476–78.

[4] *R. v. Fenton* (1975) 61 Cr. App. R. 261; *R. v. Terry* (1961) 45 Cr. App. R. 180.

[5] 61 Cr. App. R. at 263.

In *R. v. Tandy*[1] the Court of Appeal, on the facts, rejected such a claim. The Court of Appeal re-affirmed *Fenton*, stating that drinking to excess is insufficient in itself to establish "abnormality of mind." In order to establish that it is an "abnormality of mind" the defendant must show that "the killing was due to the fact that she was a chronic alcoholic." The alcoholism must have "reached the level at which her brain had been injured by the repeated insult from intoxicants so that there was gross impairment of her judgment and emotional responses." Alternatively, the defendent must show that her drinking had become "involuntary", "that is to say she was no longer able to resist the impulse to drink." On the facts of the case the appellant could not show that her drinking was involuntary because she was able to exercise some control even after she had taken her first drink. Therefore the judge was correct in defining how great the craving for drink had to be before it could in itself produce an abnormality of mind.

If there is both an inherent condition such as psychopathic disorder and the use of alcohol or drugs, the jury must be directed to consider the inherent condition alone without reference to the intoxication. The jury should be directed to disregard what the effect of the alcohol or drugs on the defendant was; and then to consider whether the combined effect of the other matters which did fall within section 2(1) amounted to an abnormality of mind which substantially impaired his mental responsibility.[2] The courts have been prepared to accept psychopathic disorder as an inherent condition, even though there is legitimate disagreement in psychiatry as to the extent that psychopathy (or other forms of mental disorder) is inherited or acquired. For the purposes of the plea, however, it is safe to assume that any abnormality of mind acquired over a long period (as opposed to immediately caused by some external factor) amounts to an inherent cause. It is clear that the abnormality need not have been present at birth.[3]

(*iii*) "*induced by disease or injury*" Delirium from a fever, or uncontrollable acts caused by concussion or hypoglycaemia are examples of the kinds of abnormality which would be included. It would be doubtful whether the transient effect of drink, even if it produced a toxic effect on the brain, could amount to an "injury" under section 2(1).[4]

It has already been observed that the jury are not bound to accept medical evidence that the defendant has an "abnormality of mind"; however, the cause of that abnormality (*i.e.* whether it arose from mental handicap, inherent causes or disease or injury) is a matter to be determined upon expert evidence.[5]

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[1] *The Times*, December 23, 1987, [1988] Crim. L.R. 308.

[2] *R. v. Gittens* [1984] Crim. L. Rev. 553. See *R. v. Atkinson (John)* [1985] Crim. L. Rev. 314.

[3] See *R. v. Gomez* (1964) 48 Cr. App. R. 310, C.C.A.

[4] See *R. v. Di Duca* (1959) 43 Cr. App. R. 167.

[5] *R. v. Byrne* (1960) 44 Cr. App. R. at 253.

13.07.1 *"Substantially Impaired His Mental Responsibility"*

The abnormality of mind must be such as to substantially impair the defendant's mental responsibility for his acts or omissions. This is a matter of degree and essentially is one for the jury. In particular, the question of whether the defendant could not resist his impulse or simply would not resist it, cannot be scientifically measured and is for the jury to decide.[1] The word "substantially" does not mean total so that the mental responsibility need not be totally impaired.[2]

13.08 Sentencing

In cases of manslaughter by reason of diminished responsibility a number of courses are open to the judge in sentencing the offender; his choice depends upon the circumstances. If psychiatric reports recommend and justify a hospital order, and there are no contrary indications, the judge should ordinarily make a hospital order.[3] That is the ordinary disposal where no punishment is intended and where the sole object of the sentence is that the offender should receive treatment for mental disorder.[4] If the offender would not pose a danger to others if released, he should not receive a restriction order.[5] Where a hospital order is not recommended or it is not appropriate, the court is entitled to pass a sentence of imprisonment, after taking into account the character and mental and physical condition of the offender.[6] The court is expected to assess the culpability of the offender and the future risk of dangerous behaviour.[7] If the offender constitutes a danger to the public for an indefinite period of time, and a "therapeutic" disposal is not indicated, then the sentence will probably be a life sentence. However, if the evidence indicates that the offender's responsibility was grossly diminished, the court can choose a lenient course such as a probation order with a condition of psychiatric treatment. The court can also pass a fixed sentence of imprisonment of whatever length.[8] It is to be

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[1] *Ibid.*

[2] *R. v. Lloyd* (1966) 50 Cr. App. R. 61, C.C.A.

[3] *R. v. Chambers* [1983] Crim. L. Rev. 688. See further A. Ashworth & L. Gostin (1984) Mentally Disordered Offenders and the Sentencing Process, *Crim. L. Rev.* pp.195–212.

[4] *R. v. Morris* (1961) 45 Cr. App. R. 185 (if offender is dangerous and there is no bed available in a secure hospital, the court can pass a sentence of imprisonment). But cf. *R. v. Cox* (1968) 52 Cr. App. R. 130, C.A. (if there is a bed in a secure hospital available, the proper course is a hospital order.) See further para. **15.03** *post.*

[5] *R v. Courtney* [1988] Crim. L.R. 130, C.A. See further para. **15.12** *post.*

[6] *R. v. Speake* (1957) 41 Cr. App. R. 222. *R. v. Leggett* [1996] 2 Cr. App. R (S) 77, C.A. (sentence of imprisonment justified where appellant did not have a treatable mental illness, and where her mental state was such as to diminish, but not altogether remove, her responsibility).

[7] For a somewhat confused discussion of the issue of culpability and dangerousness as between two co-defendants, one of whom was found to be of diminished responsibility, see *R. v. Partridge* [1982] Crim. L. Rev. 319.

[8] See *R. v. Poole* (1990) 11 Cr. App. R. (S) 382, [1990] Crim. L.R. 67; *R. v. Chambers* [1983] Crim. L. Rev. 688 and cases cited in commentary.

observed that "winning" on a plea of diminished responsibility does not necessarily mean that the offender will receive a "therapeutic" disposition or that his sentence of imprisonment will be less severe. Indeed, there is some evidence that offenders given a life sentence after a finding of diminished responsibility are detained longer than offenders found guilty of murder; this is thought to reflect the uncertainty of their mental condition and the future potential for dangerous behaviour.[1]

13.09 The Proposal for Abolition of Mandatory Life Sentence for Murder

The doctrine of diminished responsibility rests principally on the need to avoid the mandatory life sentence in murder cases where the defendant was not entirely responsible for his behaviour. The case for abolishing the mandatory life sentence for murder, and thus removing the need for the plea of diminished responsibility, has been made by the Butler Committee.[2] One of the most evident dilemmas associated with the plea of diminished responsibility is the 'intolerable choice' the defendant must make between pleading not guilty or raising the issue of diminished responsibility; it is exceedingly difficult to deny a criminal act and, at the same time, plead diminished responsibility in respect of that act. The abolition of the plea would relieve the defendant from making such a choice. It would also relieve the psychiatrist from seeking to make very difficult retrospective judgments about the cause of the mental abnormality and the degree of responsibility.

[1] The *Report of the Committee on Mentally Abnormal Offenders* (1975) Cmnd. 6244, HMSO, London.

[2] *Ibid.*, at paras. 19.8–19.21. See Home Office (1978) *Sentences of Imprisonment: A Review of Maximum Penalties. Cf.*, Criminal Law Revision Committee *(1980) Fourteenth Report*, Cmnd. 7844.

C. INFANTICIDE

13.10 The Infanticide Act 1938

Before the general plea of diminished responsibility in murder cases was introduced there already existed a special provision for reduced responsibility in cases where a mother caused the death of her child. The Infanticide Act 1938 superseded an earlier Act of 1922 which confined the offence to the case of a "newly born child". Section 1 of the 1938 Act is still in force. It provides that a woman who has wilfully caused the death of her child under the age of twelve months will be punished as if she were guilty, not of murder, but of manslaughter if:

> "at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child. . .".

As in the case of diminished responsibility the principal object of infanticide is to circumvent the mandatory life sentence for murder and give the judge full discretion in sentencing. In practice the mother is almost always dealt with quite leniently.[1] In *R. v. Sainsbury*[2] and *R. v. Lewis*,[3] the divisional court expressed a "duty to consider the needs of society," and sentenced two defendants found guilty of infanticide to twelve months imprisonment. The Court of Appeal varied both sentences to probation, noting that there was no reason to depart from the established pattern of sentencing.

The offence of infanticide is considered outdated and, in several respects, illogical. Environmental stress and a personality with low frustration tolerance are the usual aetiological factors where women kill their children; the relationship to "incomplete recovery from the effects of childbirth or lactation" is often remote.[4] Courts are nevertheless very indulgent in the acceptance of infanticide in almost all cases of mothers killing their children. A further criticism is that the offence may not apply if the child is injured but not killed,[5] or if the child is over the age of twelve months, or if the mother who has given birth

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[1] There were 48 cases of infanticide from 1976–1982. Only one involved a sentence of imprisonment, which was fully suspended; in the rest of the cases, probation/supervision or hospital orders (without restrictions) were made. Home Office (1983) *Criminal Statistics England and Wales 1982*, Cmnd. 904, HMSO, London. In the 59 cases of infanticide recorded between 1979 and 1988, none resulted in a custodial sentence. *R. v. Sainsbury* (1990) 11 Cr. App. R. (S) 533, [1990] Crim. L.R. 348.

[2] (1990) 11 Cr. App. R. (S) 533; [1990] Crim. L.R. 348.

[3] (1990) 11 Cr. App. R. (S) 577; [1990] Crim. L.R. 348.

[4] *The Report of the Committee on Mentally Abnormal Offenders* (1975), Cmnd. 6244, HMSO, London, paras. 19.24–19.25.

[5] See opinion expressed by the Criminal Law Revision Committee (1976) *Working Paper on Offences Against the Person*, para. 71; (1980) *Report on Offences Against the Person*, Cmnd. 7844, para. 113.

kills an older child. (But there is Crown Court authority to suggest that a plea of guilty to **attempted** infanticide contrary to section 1(1) of the Criminal Attempts Act 1981 was proper and appropriate.)[1] Repeal of the mandatory sentence for murder would make the Infanticide Act unnecessary; indeed, the current existence of the plea of diminished responsibility in murder cases renders the offence largely redundant.[2]

[1] *R. v. K. A. Smith* [1983] Crim. L. Rev. 739.

[2] Should the crime of infanticide be subsumed under the general law relating to diminished responsibility? For a discussion see K. O'Donovan (1984) The Medicalisation of Infanticide, *Crim. L. Rev.* pp. 259–264.