Epilepsy and the Defence of Insanity – Time for Change?

By R.D. Mackay, Professor of Criminal Policy and Mental Health, De Montfort Law School, De Montfort University, Leicester and Dr. Markus Reuber, Senior Clinical Lecturer, Academic Neurology Unit, University of Sheffield

Introduction

Epilepsy holds an almost unique place in English criminal law. It has resulted in two appeals to the Judicial Committee of the House of Lords, the highest appeal court in the land. This in turn has led to a pair of legal decisions which in many ways have shaped the development of the defence of insanity and its relationship to automatism. This report will provide a unique insight into how the criminal justice process operates when epilepsy results in a successful defence of insanity by reporting 13 such cases. In addition this report will critically analyse the status of the insanity defence in English law and call for wholesale reform.

The Insanity Defence and Epileptic Automatism

In English criminal law the defence of insanity is contained in the M’Naghten Rules which date from 1843. This defence looks at the state of the accused's mental condition at the time of the alleged offence. The legal criteria for insanity derive from M'Naghten's Case when the accused attempted to murder the Prime Minister, Sir Robert Peel, but killed Peel's private secretary by mistake. Evidence was given that he suffered from paranoid delusions. He was acquitted of murder and found “not guilty by reason of insanity” (NGRI). This verdict was debated in the House of Lords which asked the judiciary a number of questions about the defence of insanity. The answers to these questions are called the M'Naghten Rules, the most important of which is as follows:

...the jurors ought to be told that in all cases every man is 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 committing 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.

Once these criteria are satisfied the accused is subject to the special verdict of NGRI. Before 1992 all such verdict resulted in indeterminate hospitalisation. Although this was clearly unfair, the concept of “disease of the mind” has consistently been

1 (1843) 10 Cl. & F. 200 at 210.
2 Ibid.
interpreted widely by the judiciary. As a result it encompasses epilepsy and has resulted in some individuals with epilepsy being hospitalised indefinitely irrespective of medical need. The inherent unfairness of this was recognised in the enactment of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 which was implemented on 1st January 1992. The 1991 Act introduced much needed disposal flexibility in all such cases except those charged with murder. Although this was a step in the right direction, two problems remained. First, any person charged with murder and found NGRI was still the subject of mandatory and indeterminate hospitalisation irrespective of medical need. Fortunately, this has recently been changed by the Domestic Violence, Crime and Victims Act 2004 which ensures that any such hospital disposal must in future comply fully with the requirements of the Mental Health Act 1983 (i.e. a hospital disposal can no longer be given to individuals charged with murder who have killed during an epileptic automatism but have no mental disorder as defined by the 1983 act). Although this is an improvement, it does nothing to address the second problem which is as follows.

None of these recent statutory changes alter the M’Naghten Rules or the nomenclature of the special verdict. This means that people with epilepsy are still at risk of falling within the ambit of the Rules and of being declared “insane”. In short the existing legal position continues to discriminate against those suffering from epilepsy by perpetuating stigma. Why is this? In order to answer this question it is necessary to explore how the M’Naghten rules have developed. The rules make it clear that there are two limbs to the insanity defence. A defendant (D) will be found legally insane either if he did not know the nature and quality of his act OR even if he did know it, if he did not know it was wrong.¹ But no matter which limb D relies on (he may rely on both) the first and fundamental issue is whether at the time of the offence D was suffering from “a disease of the mind”. The reason why this question has troubled the courts more than any other has much to do with the complex relationship between insanity and automatism. This needs to be explained.

**Disease of the Mind (DOM)**

In many ways the insanity defence revolves around this phrase which the judges, when expounding the Rules, seem to have regarded as analogous to insanity. Neither "DOM" nor "insanity" are recognised as medical concepts. They are not meaningful in psychiatric nosology and are no longer used in clinical medicine. The most apt medical equivalent to DOM is probably "mental disorder," and for "insanity" perhaps "functional psychoses" which include schizophrenia and affective disorders such as manic-depression but certainly not epilepsy.

Clearly then, insanity and DOM are legal concepts which have little to do with current psychiatric thinking. This, despite the fact that psychiatric evidence is essential if an insanity defence is to succeed.

Instead, what has occurred is that the concept of DOM has developed in the light of two conflicting principles, each struggling for dominance. They are:

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¹ (1843) 10 Cl & F 200, 210.
1. The need to protect society from certain types of mentally abnormal offender who are classed in law as “mentally diseased” whilst at the same time recognising that if such a person is found legally insane then he is irresponsible and cannot be "punished"; hence the “special verdict” of NGRI.

2. The need to control the scope of DOM so that certain types of condition can be excluded where it would be "an affront to common sense" to declare such a person "insane." This principle in turn led to the development of the automatism defence and indeed it is this defence's development, which has regularly caused the judiciary to consider whether particular mental conditions should be classed as “diseases of the mind”.

This struggle is encapsulated in the two early decisions of Charlson\textsuperscript{4} and Kemp.\textsuperscript{5} In Charlson the accused was acquitted of aggravated assault on the ground that he was suffering from a cerebral tumour which made him liable to outbursts of uncontrollable violence. The issue of insanity was not raised by the defence and the medical evidence was to the effect that the accused at the time of the assault was not suffering from a disease of the mind. Barry J in his direction to the jury said:

If he did not know what he was doing, if his actions were purely automatic and his mind had no control over the movement of his limbs, if he was in the same position as a person in an epileptic fit and no responsibility rests on him at all, then the proper verdict is 'not guilty'.

In Kemp the facts were of a similar nature in that the accused struck his wife with a hammer whilst he was suffering from arteriosclerosis. All the medical witnesses agreed that at the time of the assault the accused did not know what he was doing. However, the same witnesses could not agree as to whether the accused’s condition constituted a disease of the mind within the M'Naghten Rules. The defence argued that although the accused's conduct was due to a defect of reason, he was not suffering from a disease of the mind, but from a purely organic or physical illness and should therefore be given an unqualified acquittal, as was Charlson. Devlin J rejected this argument and, by emphasising the use of the word "mind" as opposed to "brain" in the M'Naghten Rules concluded that the law "is not concerned with the origin of the disease or the cause of it but simply with the mental condition which has brought about the act....In my judgement the condition of the brain is irrelevant and is so the question of whether the condition of the mind is curable, incurable, transitory or permanent.” The evidence of automatism was therefore regarded as evidence of insanity and the jury were directed to return a special verdict. His Lordship distinguished Charlson on the basis that there the doctors were agreed that the accused was not suffering from a disease of the mind, but this was not so in Kemp. In truth, however, the two decisions appear to be irreconcilable and modern judicial opinion has clearly come down in favour of the approach adopted in Kemp, a decision which heralded the creation of the distinction between sane and insane automatism, a dichotomy which has continued to cause considerable problems to the

\textsuperscript{4} [1955] 1 All ER 859.
\textsuperscript{5} [1957] 1 QB 399.
courts.

It must be understood that the automatism defence is one which has much in common with insanity. In essence it recognises the need for the prosecution to prove that D’s acts were both conscious and voluntary. So, automatism was defined in *Bratty v A G for Northern Ireland* as "unconscious involuntary action".  

**The House of Lords and Epileptic Automatism**

The approach favoured in *Kemp* has been followed by the House of Lords on two occasions both of which concern epilepsy. First, in *Bratty v. AG for Northern Ireland*, D in answer to a murder charge put forward defences of insanity and automatism based on a black-out due to psychomotor epilepsy. In the course of his judgement, Lord Denning said:

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

As a result it seems to have been accepted that as the only explanation for D’s automatism was his epilepsy then, if it was found that he was in a state of automatism at the time of the killing, this in turn must result in a verdict of insanity. In essence, therefore, this decision creates two forms of automatism, namely the insane and non-insane varieties. However, little more is said in *Bratty* to explain why epilepsy should be classed as a DOM, other than that psychomotor epilepsy was said by the three medical witnesses to be a functional disorder amounting to a defect of reason due to disease of the mind. It is clear that the medical witnesses themselves accepted that this was so with Lord Denning remarking:

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

But some years later in the second House of Lords’ decision this was clearly not the case. The case is *R v Sullivan* in which D who had had epilepsy since early childhood, claimed in answer to an assault charge that he was in the final stage of recovery from a minor epileptic seizure at the time the offence was committed. Lord Diplock summarised the medical evidence as follows:

> The evidential foundation that counsel laid before the jury in the instant case consisted of the testimony of two distinguished specialists from the

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7 Ibid.
8 Ibid. at 412.
9 Ibid. 415.
10 [1983] 2 All ER 673.
neuropsychiatry epilepsy unit at the Maudsley Hospital, Dr Fenwick and Dr Taylor, as to the pathology of the various stages of a seizure due to psychomotor epilepsy. Their expert evidence, which was not disputed by the prosecution, was that the appellant’s acts in kicking Mr Payne had all the characteristics of epileptic automatism at the third or post-ictal stage of petit mal, and that, in view of his history of psychomotor epilepsy and the hospital records of his behaviour during previous seizures, the strong probability was that the appellant’s acts of violence towards Mr Payne took place while he was going through that stage.

The evidence as to the pathology of a seizure due to psychomotor epilepsy can be sufficiently stated for the purposes of this appeal by saying that after the first stage, the prodram, which precedes the fit itself, there is a second stage, the ictus, lasting a few seconds, during which there are electrical discharges into the temporal lobes of the brain of the sufferer. The effect of these discharges cause him in the post-ictal stage to make movements which he is not conscious that he is making, including, and this was a characteristic of previous seizures which the appellant had suffered, automatic movements of resistance to anyone trying to come to his aid. These movements of resistance might, though in practice they very rarely would, involve violence.\(^{11}\)

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

First, it is submitted the medical evidence in the instant case shows that psychomotor epilepsy is not a disease of the mind, whereas in \textit{Bratty}'s case it was accepted by all the doctors that it was. The only evidential basis for this submission is that Dr Fenwick said that in medical terms to constitute a ‘disease of the mind’ or ‘mental illness’, which he appeared to regard as interchangeable descriptions, a disorder of brain functions (which undoubtedly occurs during a seizure in psychomotor epilepsy) must be prolonged for a period of time usually more than a day, while Dr Taylor would have it that the disorder must continue for a minimum of a month to qualify for the description ‘a disease of the mind’.\(^{12}\)

His Lordship roundly rejected this line of medical opinion stating:

The nomenclature adopted by the medical profession may change from time to time; \textit{Bratty} was tried in 1961. But the meaning of the expression "disease of the mind", as a cause of a "defect of reason" remains unchanged for the purposes of the application of the M’Naghten Rules. I agree with what was said by Devlin J. in \textit{Kemp} that 'mind' in the M’Naghten Rules is used in the ordinary sense of mental faculties of reason, memory and understanding. If the effect of a disease is to impair these faculties so severely as to have either of the consequences referred to in the latter part of the rules, it matters not whether the aetiology is

\(^{11}\) Ibid. 675. \\
\(^{12}\) Ibid.
organic, as in epilepsy, or functional, or whether the impairment itself is permanent or is transient and intermittent, provided that it subsisted at the time of the commission of the act. The purpose of the legislation relating to the defence of insanity, ever since its origin in 1880, has been to protect society against the recurrence of dangerous conduct. The duration of a temporary suspension of the mental faculties of reason, memory and understanding ... cannot on any rational ground be relevant to the application by the courts of the M’Naghten Rules. 13

Such insanity verdicts have attracted considerable criticism and caused Lord Diplock to conclude:

My Lords it is natural to feel reluctant to attach the label of insanity to a sufferer from psychomotor epilepsy of the kind to which the appellant was subject….But the label is contained in the current statute, it has appeared in the statute’s predecessor ever since 1800. It does not lie within the powers of the courts to alter it. Only Parliament can do that. It has done so twice; it could do so again. 14

This reluctance felt by Lord Diplock is understandable, for to label such persons as "insane" is surely inappropriate and deeply stigmatic. Despite this it is clear that Sullivan favours an expansionary definition of DOM in order to ensure protection of the public. Taken at face value the scope of "disease of the mind" seems alarmingly wide and the only thing which stops it from encompassing every conceivable form of temporary mental impairment has been the recognition by the courts that it would be "an affront to common sense" to equate all forms of “disordered mental condition”15 with legal insanity. This concession was expressly made by Lord Diplock in R v Sullivan when he remarked that the defence of non-insane automatism (unconscious involuntary action arising from a condition other than a “disease of the mind”) should not be excluded "... in cases where temporary impairment ... results from some external physical factor such as a blow on the head causing concussion or the administration of an anaesthetic for therapeutic purposes."16 By implication his Lordship is admitting that such conditions are not proper candidates for "disease of the mind" classification, provided they are "temporal" and the result of “some external physical factor”. However, this “external factor” approach to distinguishing sane and insane automatism has led to the creation of a complex body of law which is manifestly unsatisfactory especially in the way in which it continues to stigmatise people with epilepsy.

The External Factor Doctrine and Epilepsy

A great many organic conditions can cause cerebral impairment leading to involuntary action. Some may result from the type of clear external physical factors described above by Lord Diplock in Sullivan, while others may be purely internal as in the case of a spontaneous epileptic seizure. But often it is not so straightforward; in the sense that there may be a number of interrelated factors involved. The criminal law has not

13 Ibid. 677-678.
14 Ibid. 678.
15 R v Quick [1973] 3 All ER at 352.
16 R v Sullivan [1983] 2 All ER at 678.
only been reluctant to recognise this but has also failed to develop any clear principles outlining how to deal with such problems.

For example, in cases involving epileptic automatisms, medication may often be a factor which could have influenced the onset or manifestation of a seizure. Indeed, in one unreported case an epileptic defendant was acquitted of murdering his mother on the basis of an automatism defense. Medical experts had attested that the accused’s automatism had been caused by his taking the prescribed drug maprotiline which had triggered a latent epileptic condition. It is also noteworthy that in Sullivan there was mention made in the Court of Appeal of the fact that the accused had been given drugs to control his fits and that ‘there were medical reasons to believe that he had not been taking the full dosage which had been prescribed for him, but this may have been due to a misunderstanding between him and the hospital’. Despite what, on the face of it, appears to have been an important external factor, the Court of Appeal chose to ignore the influence this may have had on the seizure which precipitated the alleged assault. Further, the House of Lords, in confirming that epilepsy must in law be regarded as a “disease of the mind”, failed to make any mention of the issue. The only conclusion which can be drawn from this is that the classification of epileptic automatism as an automatism of the insane variety cannot be avoided by an application of the external factor doctrine. Strictly speaking, therefore, all such cases should lead to a special verdict, unless as occurred in Sullivan the accused is permitted to plead guilty in order to avoid this. The only alternative would be for a court to completely ignore the obvious impact of Sullivan as apparently happened during the trial of Sandra McFarlane who was prosecuted for assaulting a police officer while the police were unsuccessfully searching her flat for stolen goods. The trial judge in what appears to have been open defiance of the House of Lords’ ruling in Sullivan directed the jury to acquit if it considered that the defendant committed the offence during an epileptic seizure, having accepted medical evidence that psychiatrists no longer regarded epilepsy as a disease of the mind. This last point is of course unconvincing, as the appellate courts have frequently emphasised that the question of “disease of the mind” is a question of law, which is not to be determined solely by psychiatric testimony. However, what the McFarlane case does unquestionably demonstrate is the dissatisfaction with Sullivan felt by at least one member of the judiciary.

Naturally, the fact that a member of the judiciary feels compelled to refuse to follow a House of Lords’ ruling which was applicable in the case in question is hardly a cause for satisfaction. Clearly the problem faced by individuals with epilepsy when pleading automatism stems from the external factor doctrine, which on the face of it seems to have been applied more leniently to diabetics. Certainly in Quick Lawton LJ was not prepared to send a diabetic to a mental hospital when his hypoglycaemic condition could be rectified by merely pushing a lump of sugar into his mouth. In order to avoid such a result his Lordship concluded that Quick’s “mental condition...was not caused by his diabetes but by his use of insulin...such malfunctioning of mind as there was, was caused by an external factor and not by a

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17 The case is discussed by H. Milne, ‘Epileptic Homicide: Drug Induced.’ A letter to the editor in (1979) British Journal of Psychiatry 543.
18 [1983] 1 All ER 577, 579.
bodily disorder in the nature of a disease which disturbed the working of his mind.”

It is difficult to accept this dictum, if only for the reason that the diabetic surely needs to take insulin because of his internal organic condition, namely the diabetes. The two factors clearly interrelate with one another and cannot be separated in the manner suggested. However, it can be argued that in a case like Quick the insulin could have been the primary cause of the hypoglycaemia, in the sense that the automatism would not have occurred without an overdose of this drug. Indeed, this line of reasoning led the Court of Appeal in *R v Hennessy* to confirm that if the automatism can be traced to the accused's diabetes rather than to a distinct external factor then the condition in question must be classed as a "disease of the mind". A similar result was achieved by the Court of Appeal in relation to sleepwalking, although perhaps much like the judge in McFarlane, some recent sleepwalking decisions have resulted in outright acquittals rather than in special verdicts.

What all this indicates is the need to rid the law of the external factor doctrine, but even more significantly, the need to overhaul the insanity defence itself. However, before the issue of reform is addressed it is important to examine the way in which law impacts on those who successfully plead insanity as a result of epileptic automatism.

The Case Studies

Three empirical studies into the operation of the Criminal Procedure (Insanity) Act 1964 reveal how the defence of insanity operates in English criminal law. The first such study looked at all verdicts of "not guilty by reason if insanity" (NGRI) during the years 1975-1991. The next two empirical studies have examined all verdicts of NGRI during the first five years (1992-1996) and second five years (1997-2001) of the new regime under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 which permits flexibility of disposal, including supervision and treatment orders and absolute discharges.

It is clear from these studies that formal findings of NGRI based on epilepsy continue to be rare. But they do occur. As a result the three empirical studies reveal that there have been 13 such findings between 1975 and 2001 out of a total of 179 special verdicts. This means that epilepsy accounts for 7.3% of such verdicts.

In the following part of this report we will describe the operation of the criminal law in the area of automatisms on the basis of all cases tried between 1975 and 2001.

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22 See *R v Burgess* [1991] 2 All ER 769.
27 The most prevalent diagnosis leading to a verdict of insanity is schizophrenia which accounts for 51.4% of such verdicts.
where the verdict was NGRI as a result of alleged offences committed during an
epileptic automatism. All the cases were identified as part of ongoing research into the
operation of the M’Naghten Rules. The primary source of information used was the
relevant court and post trial files together with files held by the Mental Health Unit of the
Home Office and the Court Service.28

The Data

Introduction

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

All bar one of the cases were male (92.3%, n=12). This is an unusual gender
distribution about which more will be said below. Table 1 below shows the age
distribution of the defendants.

Table 1: Age distribution of defendants.

<table>
<thead>
<tr>
<th>Age range of accused</th>
<th>sex of accused</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>Age up to 19</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>60-69</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

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

Table 2: Ethnic background of the defendants and country of birth.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>white</td>
<td>black</td>
</tr>
<tr>
<td>UK- born yes</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>born no</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>

28 Grateful thanks go to Epilepsy Action and the Nuffield Foundation whose combined funding made
this research possible. To the Department for Constitutional Affairs for authorising the research.
To Jacqui O’Riordan and Carole Burry of Records Management Service, The Court Service for
their kind and generous help in raising the case files from numerous Crown Courts. To the Mental
Health Unit and Statistics Directorate of the Home Office.
Table 3 below shows the offence and the relevant disposals. In this connection it must be remembered that all cases disposed of before enactment of the Criminal Procedure (Insanity and Unfitness to Plead) act 1991 resulted in mandatory and indefinite hospitalisation. This accounts for five (the sole murder charge, three GBH and one arson charge) of the 13 cases (38.5%) which in turn means that the judge had discretion as to disposal in only the remaining eight cases. Accordingly, Table 3 reveals that only one of those eight cases, a charge of attempted murder resulted in the equivalent of a hospital order without restrictions. The rest of the cases (n=7) all resulted in non-custodial disposals. The significance of this should not be underestimated for what it means is that the majority of those found NGRI as a result of epileptic automatism (87.5%, n= 7) since the passing of the 1991 Act were not sent to hospital but are instead were dealt with in the community. This despite the fact that some of the relevant charges, such as GBH and arson, can scarcely be described as minor.

<table>
<thead>
<tr>
<th>Main Offence Charged</th>
<th>“Insanity” Disposal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Restriction Order</td>
</tr>
<tr>
<td>Murder</td>
<td>1</td>
</tr>
<tr>
<td>Attempted Murder</td>
<td>0</td>
</tr>
<tr>
<td>GBH</td>
<td>2</td>
</tr>
<tr>
<td>ABH</td>
<td>0</td>
</tr>
<tr>
<td>Arson</td>
<td>1</td>
</tr>
<tr>
<td>Burglary</td>
<td>1</td>
</tr>
<tr>
<td>Child Abduction</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

A summary of medical observations from the 13 cases
Methods

The medical findings were based on a median of 2.5 medicolegal reports (range 1-6) provided to the courts by general psychiatrists (21), forensic psychiatrists (8), neurologists (3), neurophysiologists (2), neurosurgeons (1) and learning disabilities

29 Grievous bodily harm assault.
30 Actual bodily harm assault.
psychiatrists (1). One report was written by a Specialist Registrar in forensic psychiatry, the other reports were completed by Consultants. Two reports were provided to advise the courts about the disposal of an offender, the other reports were written before the court considered the insane automatism defence. All reports included information about medication, ten reports included information about electroencephalographic (EEG) findings, nine included some neuropsychological information, seven reports described neuroimaging findings (four based on cranial computed tomography, three on magnetic resonance imaging).

**Results**

**Clinical and epidemiological features**

The method of case identification used in this study was very different from that employed by previous primary or secondary care studies of people with epilepsy 31. Although comparison with the results of other studies is therefore difficult, a number of features stand out and deserve comment.

As mentioned above 12/13 (92.3%) of the defendants were male. The index offence committed by the only female identified was probably unrelated to an epileptic seizure (although she had a diagnosis of epilepsy). This gender distribution differs markedly from that found in the most recent large community study of epilepsy in the UK (n=1655), in which the gender proportion was evenly matched (47.2% male, 48.5% female, 4.4% not stated) 32. Although the median age of the offenders (40 years, range 19-62) was similar to the mean age in this community study (44.2 years), the duration of epilepsy was much shorter in the offenders (median 6 years, range 0-40) than in the community group (19.7 years). Five index offences occurred within one year of the manifestation of epileptic seizures.

At least 11/13 (84.6%) of the offenders had a focal seizure disorder, 2/13 (15.4%) had unclassifiable epilepsy with generalised tonic clonic seizures. Community studies show that the proportion of generalised epilepsies usually approaches 50% of that of focal epilepsies 33. This suggests that generalised epilepsies were underrepresented in the group of defendants. The localisation of the epileptic focus was characterised

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more clearly in six of the offenders, seizures were thought to arise from the temporal lobes in all of these cases. There was evidence of neurological impairments (dyspraxia, incoordination, spasticity) or significant neuropsychological deficits (low IQ, memory deficits) in 10/13 (76.9%) of the offenders. 6/13 (46.2%) had a history of (usually repeated) head injuries. In view of the absence of a similarly recruited and investigated control group of other patients with epilepsy it is difficult to comment on these findings, but the available data suggest that the prevalence of additional neurological dysfunction was high in these offenders.

Ten offenders were supposed to be taking antiepileptic drugs (AEDs) at the time of the index offence. The court records make reference to suboptimal medication adherence (or non-adherence) in 8/10 (80%). Whilst the spectrum of adherence rates with AED regimens in different patient groups has been found to range between 25 and 75% \(^34\), the proportion failing to adhere to medication plans amongst the group of defendants is beyond the top end of the range found in clinical patient populations.

9/13 (69.2%) of the defendants had a history of alcohol dependence or regular alcohol excess. 5/13 (38.5%) had a history of parasuicide or deliberate self-harm. 2/13 (15.4%) of the offenders with a diagnosis of epilepsy had additional non-epileptic (dissociative) seizures. 6/13 (46.1%) had formal diagnoses of personality disorder (2 impulsive PD, 3 antisocial/psychopathic PD, 1 “introverted” PD). Only 2/13 (15.4%) had no history of psychiatric problems. The nature of the psychiatric problems and the number of cluster B (impulsive/antisocial) personality disorders identified in this group of offenders is very different from clinical populations of patients with epilepsy in whom diagnoses of anxiety, depression and obsessive compulsive personality features predominate\(^35\).

Whereas around 50% of people with epilepsy described in other community-based studies do not work \(^36\), 12/13 (92.3%) offenders with epilepsy were unemployed. What is more, most had never been in longer-term continuous employment.

In keeping with the poor employment histories of the group and the nature of their psychiatric diagnoses, 8/13 (61.5%) had a previous history of criminal offences (including theft, actual bodily harm, indecent assault, car theft, burglary, fire-setting, shop lifting, being drunk and disorderly), which were not likely to have been related to epileptic seizures.

Neuropsychiatric formulation of the period of “automatism”
In eight of the cases (61.5%), a period of “automatism” occurred either ictally, during a complex partial seizure, or as a postictal state (fire-setting with being oblivious to the flames, assault of police officers trying to remove patient from police premises, breaking a shop window and stealing goods, two episodes of child-snatching, assault in confused state, attempted murder after being surprised during burglary, unprovoked attack on neighbour). 12/13 offenders had a history of epileptic seizures before the seizure associated with the offence while one index offence occurred during or after a first seizure. Unfortunately, the available records and the defendants’ statements or witness reports they included did not allow a clear interpretation of the relationship between the seizure and offence in most cases. It therefore remains uncertain whether the offences were committed during the ictal phase (i.e. associated with ongoing epileptic discharges in the brain) or postictal period (immediately after cessation of seizure-associated epileptic discharges in the brain). One episode of automatism occurred in the postictal period after a witnessed tonic-clonic seizure (assault of paramedics who tried to take the patient to an ambulance).

Two periods of offences were probably unrelated to epileptic seizures: In one case, the offence (assault and imprisonment of family members) was committed whilst the offender with a history of epilepsy was in a paranoid state (most likely related to alcohol withdrawal but possibly ictal or postictal). In the second case, the offender had a history of emotional problems, epilepsy and significant cognitive deficits after an attempted self-poisoning with carbon monoxide and was accused of fire-setting (not described as temporally related to a seizure). Epilepsy was mentioned as one of the factors contributing to a lack of insight into the criminal nature of the offence and the continuing dependence of the offender after the act.

In one case, the records raised the possibility that the index offence may not actually have been committed during a period of automatism. A man with a history of temporal lobe epilepsy was arrested after a fight outside a pub and had a seizure in the police station whilst being questioned. The medical reports do not mention a seizure before the fight.

The data available on one of the defendants was insufficient for a neuropsychiatric formulation. 5/13 (38.5%) defendants had a history of seizure related automatism before the offence.

Association of psychotic symptoms and offences
The behavioural observations of witnesses and medical assessor, and the offenders’ reports of their subjective experience suggest that psychotic features were involved in almost all of the cases in which sufficient information was available (one offender set fire to his flat but was oblivious to the flames, one offender was “agitated” after a generalised tonic-clonic seizure and attacked the ambulance men who wanted to take him to hospital, one offender went to New Scotland Yard and asked the duty officer for his parents’ extra directory telephone number before resisting eviction from the building, two offenders grabbed young children from their mothers, one broke the shop window of a tailor’s shop to take a jacket which he thought belonged to him, one
attempted to throttle a neighbour who had been trying to help him). A detailed recent case report provides further insight into the relationship of child-snatching, epilepsy and delusional ideas.\(^{37}\)

**Amnesia for period of “automatism”**

One reason why the exact relationship of ictus and index offence is difficult to judge from the court papers of the 13 identified cases is that they contain very little information provided by the defendants themselves. Only one person had no amnesia, and was able to describe the offence and the delusional, persecutory ideas he experienced at the time. None of the others could recall the index offence itself (although some had partial memories, for instance of holding the baby which had been snatched from his mother, or of “going berserk” in a neighbour’s flat). 6/10 (60.0%) of the defendants claimed complete amnesia. Amnesia was reported to have lasted over one hour in 9/10 cases where this information was available (range 1-12 hours, median 8 hours). A complaint of profound and prolonged amnesia as described by more than half of the patients who committed their index offence in the ictal or postictal period would be unusual in an epilepsy clinic. Even patients in non-convulsive status epilepticus typically have a degree of recall for events which occurred during the episode of status.\(^{38}\) In the clinical setting, patients with epilepsy characteristically attempt to fill amnesic memory gaps with information gleaned from incomplete memory traces, witness accounts or assumptions.\(^{39}\) Although the limitations associated with the extraction of this kind of information from court papers has to be freely acknowledged, this otherwise typical interactive behaviour only became apparent in 4/10 of the defendants.

One possible pathophysiological explanation for the unusually prolonged and profound periods of amnesia may be that 8/13 (61.5%) of the offences were committed in a state of acute alcohol intoxication (and a further three in a state of alcohol withdrawal). However, it should also be noted that all of the defendants claiming complete amnesia for the offence had a history of previous criminal convictions. This means that it is possible that their behaviour during police and medical interviews could have been informed by previous experience with law-enforcement agencies.

**Discussion**

The medical reports on the identified cases are either implicitly or explicitly based on a set of informal guidelines which were summarised by Lishman in the 1970s (see table 4 below).\(^{40}\) Not all criteria had to be met, but the likelihood of a criminal act being related to an epileptic seizure was thought to be greater if more criteria were met. It has been suggested that the list should be extended by the point that the criminal act should be very much out of keeping with the usual character of the

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defendant\textsuperscript{41}. However, as this case series demonstrates, most ictal or postictal offences were committed by men with a previous criminal history and a history of alcohol abuse, many of whom had experienced an unusual amount of violence. Many had psychiatric diagnoses associated with an increased risk of violence (especially personality disorders), poor antiepileptic treatment adherence, and chronic employment difficulties. This is in keeping with the results of a review of video-EEG documented aggressive postictal behaviour in people with epilepsy, which identified interictal risk factors for aggressive behaviour in all cases\textsuperscript{42}. It suggests that epileptic seizures are more likely to disinhibit people with latent aggressive tendencies rather than trigger aggressive behaviour directly.

This interpretation fits with the impression that most of the offences described here are likely to have been committed in the postictal period. Although the available records did not allow a definite distinction between ictal and postictal offensive behaviour in most cases, previous studies suggest that aggression is much more likely as a postictal than an ictal phenomenon\textsuperscript{43}. For instance, of 17 prisoners in England and Wales identified in the early 1970s who were thought to have committed offences related to epileptic seizures only two were considered to have committed their crimes during the seizure itself\textsuperscript{44}. A commission of epilepsy experts who reviewed the case descriptions later actually thought it possible that even these two offences may have been committed in the postictal period. This commission found that fairly simple ictal violent acts were possible but very rare\textsuperscript{45}.

In most of the cases described here there was a suggestion that the offences were committed in a delusional, psychotic state. This interpretation is consistent with the observation that postictal aggression is typically associated with psychotic symptoms\textsuperscript{46}. Given that all of the defendants whose epilepsy was classifiable to this extent had focal seizures of temporal lobe origin, the suggested association of criminal behaviour and postictal psychosis also fits with the link between focal (especially temporal lobe) epilepsy and psychosis observed in most previous studies\textsuperscript{47}. It should be pointed out that aggressive behaviour is not a feature of interictal psychosis in epilepsy in general but is a relatively rare feature of postictal states\textsuperscript{48}.

Although both the (probably) common relationship of epilepsy-related criminal offences with manifestations of psychosis and psychiatric comorbidity in this group of defendants could reduce the enthusiasm of law-makers to change the legal approach to automatism or, more specifically, to drop the concept of “insane” automatism, there is surely no doubt that the word “insane” would now be considered offensive in every other context. With this in mind it is important to re-emphasise that 7/9 of these cases where the judge had flexibility of disposal resulted, not in hospitalisation, but rather in five supervision and treatment orders and two absolute discharges. This in turn means that in none of these seven cases was the condition of the accused sufficiently serious to warrant in-patient treatment. Further, since the enactment of the Domestic Violence, Crime and Victims Act 2004 the law is now clear. Unless the “insane” accused is suffering from a “mental disorder” within the meaning of the Mental Health Act 1983 which warrants treatment in a psychiatric hospital he cannot be given a Hospital Order. In short, any admission to hospital of an “insane” person who has committed a criminal act must now comply with all the requirements of the 1983 Act. This means that if the only reason for the automatism was found to be epilepsy, then only a non-custodial disposal would be available in such a case. No longer then would Mr. Sullivan be threatened with inappropriate hospitalisation and be “forced” to change his plea to one of guilty in consequence. Although this represents a major step forward it must not be forgotten that in such cases the accused still faces the prospect of being labelled “insane” which of its own accord remains a massive disincentive to using such a plea. Accordingly, it is now time to turn to the fundamental question of how best to reform the M’Naghten Rules.

Table 4 Guidelines for the medico-legal assessment of offenders who may have committed criminal acts during a period of epilepsy-related automatism (based on 17)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Typical features</th>
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| Epilepsy                      | • History of definite epileptic seizures prior to the offence.  
• History of epilepsy-related automatism prior to offence.  
• EEG abnormalities supportive of diagnosis.                                                                                                     |
| Offence                       | • No obvious motives.  
• No planning or premeditation.  
• Apparently senseless.  
• No attempted concealment.                                                                                                                      |
| Seizure associated with offence | • Abnormal behaviour should last minutes rather than hours.  
• Observation of typical seizure manifestations (impaired awareness, inappropriate gestures, stereotyped movements, irrelevant replies, aimless wandering, vacant expression)  
• Amnesia for the offence.  
• No anterograde amnesia after resumption of conscious awareness.                                                                                      |

Reform

The M’Naghten Rules have long been criticised as being out of step with psychiatric thinking. For this reason the report of the Committee on Mentally Abnormal Offenders
(commonly known as Butler Report) recommended a radical alternative which would have introduced a new special verdict of “not guilty on evidence of mental disorder”, one basis for which was a “mens rea” element. A second specific exemption was suggested which would also have included defendants who were shown to have been suffering from severe mental illness or severe subnormality at the time of the alleged offence, but in this exemption, no proof of a causal link between the mental illness/subnormality and the act or omission charged would have been required. However, this suggestion was felt to be so radical that it was never enacted. Since then there has been no further full consideration in England of reform of the insanity defence, although the Law Commission as part of its work on a criminal code did concede the need for a causal link by revising the Butler Report’s proposal in order to allow the prosecution to ensure that a mental disorder verdict should not be returned "if the jury is satisfied beyond reasonable doubt that the offence was not attributable to severe mental illness or severe mental handicap." Further, it is clear that even under the Butler Report revised “mental disorder” plea epileptic automatism would continue to qualify for a special verdict, a point fully endorsed by the Law Commission as follows:

There is not, so far as we can see, a satisfactory basis for distinguishing between (say) a brain tumour and cerebral arteriosclerosis on the one hand and diabetes or epilepsy on the other. If any of these conditions causes a state of automatism in which the sufferer commits what would otherwise be an offence of violence, his acquittal should be "on evidence of mental disorder"…. What is objectionable in the present law is the offensive label of "insanity" and the fact that the court is obliged to order the hospitalisation of the acquitted person, in effect as a restricted patient.

At the same time, however, the Commission stated that some might consider its definition of “what is now termed ‘insane automatism’” to include “too much”. In short, if what is “objectionable” in the current law is the “insanity” label alone then its replacement with a more acceptable term would be all that is needed. But surely this alone would not suffice? First, the M’Naghten Rules themselves are in need of reform and secondly the replacement of the outdated and offensive terms “insanity” and “disease of the mind” with the more recent term “mental disorder” does not constitute an adequate improvement. In most areas of usage (including the current international diagnostic manuals) the term “mental disorder” is used for psychiatric disorders alone and is an inappropriate label for individuals with conditions such as epilepsy and diabetes. Not only that, there is now the impact of the Human Rights Act 1998 to be considered which has already led a court in one small jurisdiction, namely the Island of Jersey, to rule that the M’Naghten Rules are in breach of the Human Rights Act, as the ‘disease of the mind’ component is wide enough to include those who are

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49 Cmnd 6244 (1975) para 18.18.
50 Ibid. paras 1820-25.
51 Ibid. paras 18.26-36.
53 Ibid. Volume 1 at para 11.28.
54 Ibid.
not mentally disordered. As a result the law of Jersey has accepted a completely new and wider insanity defence. The ruling was as follows:

I prefer, and I respectfully adopt, a definition suggested by Professor R. D. Mackay. I therefore hold that a person is insane within the meaning of Article 2 of the Criminal Justice (Insane Persons)(Jersey) Law 1964 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. This test will permit objective medical evidence of a defendant’s unsoundness of mind to be given in the sense required by Convention jurisprudence while retaining a clear causal link between the offence and the mental disorder. It will also cater for defects of volition.

Neither epilepsy nor diabetes alone would fall within “unsoundness of mind” as interpreted by the European Court of Human Rights. However, English Law has already taken steps to deal with this problem by ensuring that only those who are suffering from a “mental disorder” within the Mental Health Act 1983 and in need of inpatient treatment can be the subject of a Hospital Order. All others can only be given a Supervision Order or an Absolute Discharge. As mentioned above, this ensures that a repeat of the Sullivan case would be likely to result, not in hospitalisation, but rather in one of the other two modes of disposal. In that sense some degree of public protection is ensured by giving the court the power to impose a supervision order where this is considered necessary but at the same time permitting an absolute discharge in cases where no element of supervision is required.

It is this tension between the need for public protection while at the same time continuing to permit the acquittal of some through a “sane” automatism plea which is difficult to resolve. Many would argue that to permit all forms of automatism to fall within a revised “insanity” plea would be inappropriate. Clearly it would satisfy the public protection lobby but at the same time it would mean that even the concussed automaton could never achieve a simple acquittal. Conditions such as epilepsy and diabetes pose a real dilemma in this connection which is why in Quick the Court of Appeal created the distinction between “external factors” and “internal factors” criticised above. One of us (RDM) has suggested elsewhere that it is surely time for the law to rid itself of this unsatisfactory distinction and for the English appellate courts, if given the opportunity, to re-evaluate the decision in Quick and to adopt a more “holistic” approach towards distinguishing “insane” and sane automatism. This in turn would enable the judge to consider all relevant factors in deciding what category of automatism the particular defendant’s condition should fall within. Accordingly, epilepsy, much like diabetes and sleepwalking, might or might not qualify as “sane” automatism depending on the individual facts and circumstances of each case. With that in mind it must be conceded that if one again considers the case

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57 [2001] JLR 146, emphasis added.
58 See Mackay and Gearty, op.cit.
studies discussed above it is clear that pathologies other than epilepsy were relevant in each of the 13 cases so it is possible that all would properly continue to qualify for the special verdict which, we can only hope will be destigmatised in the not too distant future as part of fundamental reform of the “insanity” defence.

The way forward

The fact that there has been no review of the insanity defence since the Butler Report in 1975 can be viewed in both a negative and a positive light. On the negative side this lack of interest could be a reflection of the fact that policy makers do not view the insanity defence as a problem; a point exemplified by the small number of successful cases each year.61 Further, the additional mental disorders and violent tendencies discovered in our cases seem to support the fact that findings of “sane” automatism would have been inappropriate. On the positive side, however, it can be argued that after a period of over 30 years it is surely time for a fundamental review of reform options. While the insanity defence may only play a minimal role within the criminal justice process insofar as the number of cases is concerned, its symbolic significance greatly outweighs its practical importance. In many respects as one of the most fundamental doctrines within criminal jurisprudence it is nothing short of a disgrace that in the 21st century we continue to label all those who use the defence successfully as “insane”.

What is encouraging is that the Law Commission, which is about to embark on its 10th programme of reform consultation, wishes to identify new projects for inclusion in its next programme of work and has set up a forum for this purpose which will remain open until 30 March.62 As part of this exercise the above report will be submitted to the Commission in the hope that it will decide that the insanity defence should be included in its new reform programme. If such a decision is made this will mean that the Commission will engage in a public consultation of any reform measures it proposes. This will enable all interested parties to actively engage in the reform process. However, the most vital first step will be the Commission’s decision as to whether the defence of insanity should form part of its 10th reform programme. In that sense we stand at a crossroads which it can only be hoped will soon signal a renewed interest in ridding the law of an outmoded and outdated insanity defence.

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61 In the three studies referred to above at page 8 the biggest number of successful insanity defences in any one year was 17 in 1989.
62 At http://forum.lawcom.gov.uk/