CRIMINAL LAW

SANE AUTOMATISM

Basic Understanding, Cases & Articles

This write up is useful for LLB Students of
University of London

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Contents

1. Basic Understanding & Cases.............................................................. 1 - 10
2. Article 1: Sleepingwalking, Automatism & Insanity.................................. 11
3. Article 2: Post-traumatic Stress Disorder and Dissociative State........... 15
5. Article 3: Diabetes & Criminal Responsibility ........................................ 19
SANE AUTOMATISM

Automatism is any physical movement of muscles without any control by the mind. It, therefore, pertains both:

- Voluntariness of the D's conduct (if conduct is not controlled by the mind, it is involuntary)
- Requisite mens rea of the D (no state of mind for his action i.e. D did not intend the conduct or was reckless about it)

Court decisions have regarded automatism as pertaining to the voluntariness of the D's conduct. The basis for automatism is that some mental malfunction destroys the D's capacity to control his actions so that the act is not voluntary. Where this mental malfunction takes the form of a disease of the mind, the defence is governed by M’Naghten Rule (Defence of Insanity) and the burden of proof rest on the D. Otherwise, D is availed with the Defence of Sane Automatism.

Exam Focus

For exams (University of London External Programme), you should know:
1. The meaning of disease of mind so that you are able to determine whether the mental malfunction will give rise the Defence of Insanity or Sane Automatism.
2. The various mental malfunctions such as epilepsy, concussion, sleepwalking, stress, Diabetes etc
3. If the mental malfunction is not disease of mind, you should consider if there are any reasons for not giving the D defence of Sane Automatism.
4. The tests for Sane Automatism and Insanity.
5. The distinction between Sane Automatism, Insanity and Diminish Responsibility and other defences.

<table>
<thead>
<tr>
<th>Sane Automatism</th>
<th>Insanity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosecution disproves</td>
<td>D proves the defence because of the Sanity Presumption</td>
</tr>
<tr>
<td>Complete acquittal if the defence is successful</td>
<td>- On murder charge, the judge give mandatory hospitalisation order;</td>
</tr>
<tr>
<td></td>
<td>- If D is charged with other offences (within UOL syllabus), judge has discretion to either give hospitalisation order or acquit the D</td>
</tr>
<tr>
<td></td>
<td>See: S24 of Domestic Violence Crime &amp; Victim Act 2004 &amp;</td>
</tr>
<tr>
<td></td>
<td>S3 of Criminal Procedures (Insanity &amp; Fitness to Plead) Act 1991</td>
</tr>
<tr>
<td></td>
<td>See S37 &amp; S41 of Mental Health Act</td>
</tr>
</tbody>
</table>

The "M'Naghten Rule"

In 1843, Daniel M'Naghten, an Englishman who was apparently a paranoid schizophrenic under the delusion that he was being persecuted, shot and killed Edward Drummond, Secretary to British Prime minister Sir Robert Peel. M'Naghten believed that Drummond was Peel. To the surprise of the nation, M'Naghten was found not guilty on the grounds that he was insane at the time of his act. The subsequent public outrage convinced the English House of Lords to establish standards for the defence of insanity, the result subsequently referred to as the M'Naghten Rule.
The M’Naghten Rule provides as follows: "Every man is to be presumed to be sane, and ... that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of mind, and 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."

The Meaning of Disease of Mind

The scientific definition of disease of mind is irrelevant in law. It has a legal meaning according to Devlin J in Kemp, R v (1957). D an elderly man suffered with arteriosclerosis caused unconsciousness, attacked wife with hammer during the night. It was held that physical state of the brain may be of importance medically, but it is of no importance to the law, which merely has to consider the state of the mind in which the accused is, not how he got there. It is also irrelevant whether the condition is transient or permanent or whether it is curable or incurable. “...mind in the M’Naghten Rules is used in the ordinary sense of the mental faculties of reason, memory and understanding”

Martin J.A. in Rabey v. The Queen (Ontario Court of Appeal) held that, “In general, the distinction to be drawn is between a malfunctioning of the mind arising from some cause that is primarily internal to the accused, having its source in his psychological or emotional make-up, or in some organic pathology, as opposed to a malfunctioning of the mind which is the transient effect produced by some external factor such as, for example, concussion.” This distinction of internal and external is also used in UK to determine disease of mind.

In conclusion, disease of mind means: 1. Malfunctioning of mind arising from a cause that is internal to the D; & 2. Mental faculties of reason, memory and understanding are impaired or absent. Sane Automatism is not available if malfunctioning of mind arise from a cause that is internal to the D.

Mental Malfunctions

1. Epilepsy – Sane Automatism is not available
In Sullivan (1983) HL, D kicked an 86 yr old neighbour – for whom he customarily did acts of kindness - in the head and body while having epileptic fit. It was held that Epilepsy is insanity, (not automatism) it affects the mind, not an external cause such as drugs or alcohol. A defence of non-insane automatism, for which the proper verdict would be a verdict of not guilty, might be available in cases where temporary impairment of the mental faculties, not being self-induced by drink or drugs, results from some external factor such as a blow to the head causing concussion.

In Bratty v AG Northern Ireland (1996), D strangled a girl with her stocking. He claimed that at the time he was suffering from psychomotor epilepsy. It was held psychomotor epilepsy is a disease of mind. If the defence of Insanity is rejected, the D is entitled to raise the defence of Automatism. It was also stated that an act is not involuntary simply because the defendant does not remember it or because he was unable to control an impulse to do it.

- “No act is punishable if it is done involuntarily and an involuntary act … means an act which is done by the muscles without any control by the mind such as a spasm, a reflex action or a convulsion; or an act done by a person who is not conscious of what he is doing, such as an act done whilst suffering from concussion or done whilst sleep-walking”.

Lord Denning in Bratty v AG Northern Ireland:

"Any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind (p. 412)."

2. Arteriosclerosis - Sane Automatism is not available: Kemp (1957) above

3. Sleepwalking – Sane Automatism is not available

In Burgess, R v (1991) CA, D wounded a female neighbour friend whilst sleepwalking. They had been watching videos and she fell asleep on the sofa, he hit her with a bottle and a video recorder and grabbed her round the throat. He was sleepwalking at the time. It was held that the condition is an Internal cause and, therefore, a disease of mind. Sleep is
normal (medically) and sleepwalking not regarded as mental disorder, but violence whilst sleepwalking is abnormal. It is a disease of the mind caused by internal factors. This condition was transitory and unlikely to recur, but a functional or organic internal cause.

Jules Lowe, who had a long history of sleepwalking disorder, was not guilty of murdering his father on grounds of Insanity and was sectioned indefinitely under mental health laws by the judge at Manchester Crown Court in 2005 but was released when the Mental Health Tribunal decided that he was not a risk to the public.

4. Diabetes – the distinction between Hyperglycaemia & Hypoglycaemia

In Bingham (1991) CA, D a diabetic was charged with theft of a can of "Coke" and sandwiches, worth £1.16, at a time when he had £90 in his pocket. He had paid for one can of Coke. He made "no comment" to questions. He was suffering from hypoglycaemia and was unaware of his actions. It was held that hyperglycaemia and hypoglycaemia should be distinguished. The former being too much sugar in the blood caused by the diabetic condition (no production of insulin) which is internal. Hypoglycaemia on the other hand is too little sugar caused by the insulin (external) which is taken to avoid hyperglycaemia.

Hypoglycaemia was caused by too much insulin, or by insufficient quality or quantity of food to counter-balance the insulin. That would provide a satisfactory defence to an alleged crime such as theft, due to lack of mens rea. If automatism was caused by an "external factor," the verdict will be simply not guilty, if by an "internal factor," not guilty by reason of insanity. Diabetes is obviously an internal factor; so if the diabetes results in hyperglycaemia which causes automatism the defendant is "insane" within the meaning of the M'Naghten Rules. The administration of insulin is an external factor and, if it results in hypoglycaemia which causes automatism, the defendant is simply not guilty. It is as if the automatism had been caused by an accidental blow on the head. It is obviously absurd to describe a diabetic as "insane" and to subject him to indefinite detention. For proposals for the reform of the law see the Law Commission's draft Criminal Code (Law Com. No. 177).
In Hennessy (1989) CA, D, a diabetic, took a car without consent and drove whilst disqualified. Had not taken insulin because of stress anxiety and depression. It was held that not taking insulin - leading to hyperglycaemia is insanity and not automatism. The Court of Appeal stated: “In our judgment, stress, anxiety and depression can no doubt be the result of the operation of external factors, but they are not, it seems to us, in themselves separately or together external factors of the kind capable in law of causing or contributing to a state of automatism.’ The Court of Appeal pointed out that they were prone to recur and lacked the feature of novelty or accident. The kind of external factors the law required would be something like a blow to the head, or an anaesthetic.’

In Bailey (1983) CA, D seriously injured his ex-girlfriend’s new partner with an iron bar. He said assaulted the partner to teach him a lesson for associating with the girl. D, a diabetic took insulin and drank some sugared water but he had nothing to eat. D claimed he acted in a state of automatism caused by hypoglycaemia. He did not complicate the issue with alcohol or drugs. It was held that Sane Automatism was available.

In Quick (1973) CA, D, a nurse, assaulted a patient. He was a diabetic, had taken insulin and not eaten sufficient food. He drank whisky and rum he could not remember the assault. He pleaded automatism. It was held that D was suffering from automatism, which a mental abnormality is caused by an external factor. He was not suffering from insanity caused by hypoglycaemia (low sugar in the blood) by taking insulin prescribed by his doctor. Lawton LJ: ‘a self-induced incapacity will not excuse ... nor will one which could have been reasonably foreseen as a result of either doing or omitting to do something, for example, taking alcohol against medical advice after using certain prescribed drugs or failing to have regular meals while taking insulin.

In Broome v Perkins (1987) QBD, D in a hypoglycaemic state drove home very erratically from work, hitting another car at one point. Afterwards he could remember nothing about the journey, but seeing the damage to his car, reported himself to the police. Medical evidence suggested that it was possible for someone in his state to complete a familiar journey without being conscious of doing so, and that although his awareness of what was going on around him would be imperfect, he
would be able to react sufficiently to steer and operate the car, even though not very well. It was held that since the accused was able to exercise some voluntary control over his movements, he had not been acting in an entirely involuntary manner, and therefore the defence of automatism was not available.

5. **Stress**

* See Lord Lane CJ in Hennessy above

In *R v. T* (1990), D committed robbery and assault with two others. D was acting as though in a dream. It was held that evidence of a disassociative state resulting from something qualitatively different to the ordinary stresses of life (in this case rape) would indicate an external cause.

In *Rabey* (1997) Ontario Appeal Court, D was rejected by a girlfriend and so he battered her. He argued that this was an external cause. (A Canadian case.) It was held that a "disassociative state"; resulting from '... the ordinary stresses and disappointments of life which are the common lot of mankind" did not amount to an external cause.

6. **Other Conditions/Circumstances**

In *Finegan v Heywood* (2000) HCJ. D drove with excess alcohol. He said he was suffering from non-insane automatism as he had driven the car in a state of parasomnia. It was held that the defence of automatism was not available where alcohol had induced F's condition and where F knew from previous experience that his parasomnia was preceded by the consumption of alcohol.

In *Smith (Sandie)* [1982] CA, D threatened to kill and carried an offensive weapon. She was already on probation for manslaughter by reason of diminished responsibility, and brought evidence to show a history of psychological disturbance and violent behaviour clearly associated with her menstrual cycle. It was held that PMT could not provide a defence of automatism.
In Watmore v Jenkins [1962] QBD, D drove dangerously while suffering progressive hypoglycaemia gradually lost consciousness over the course of a five-mile drive. Winn J said a state of automatism is no more than a modern catchphrase, which the courts have not accepted as connoting any wider or looser concept than involuntary movement of the body or limbs. Only when the driver is not really driving at all is the defence of automatism available to him.

In Hill v Baxter [1958] QBD, D was behind the wheel when his car collided with another; at his trial on a charge of dangerous driving, he claimed he had been overcome by an unknown illness and had been unconscious. It was held that some credible evidence must support a claim of sudden illness or concussion, they said, usually going beyond D's mere assertion, but (Lord Goddard CJ dissenting) the burden of proof thereafter is on the prosecution to show that the act was a voluntary one. Lord Goddard, quoting Humphreys J in Kay v Butterworth 1945 resurrected the now famous and hypothetical ‘Swarm of Bees’.

In Attorney General's Reference No 2 1992 (1993), D drove his lorry for six hours and hit a stationary vehicle on the hard shoulder, killing two people. He claimed automatism because he was 'driving without awareness'. It was held: automatism occurs when there is a total loss of voluntary control. Impaired or reduced control is not sufficient. D had some control of the lorry, he was able to steer and was partially aware of what was going on the road ahead of him.

**Self-Induced Automatism**
The Defence of Sane Automatism is successful if D had loss total control of his actions Broome v Perkins (1987) QBD.

Where D is charged with Basic Intent Crime (crime that can committed recklessly or negligently), the defence of Sane Automatism will FAIL if self-induced i.e. Defendant is convicted of the offence that he charged with. In Bailey, R v (1983) CA, Griffith Lj stated that Automatism is self induced if there is a common knowledge or special knowledge that the D will become aggressive, unpredictable or uncontrollable i.e. risk of losing his ability to control his action. Special Knowledge refers to the knowledge of the Defendant acquired from past experience and shall include foreseeability. It was held that that there was no common
knowledge among diabetics that taking more insulin or insufficient food after taking insulin will cause D to become aggressive, unpredictable or uncontrollable. The case was decided in the year 1983 and it is left open for speculation if the court will reach the same result today in respect of the common knowledge. In Hardie (1984) CA, the court drew a distinction between dangerous drugs like alcohol and controlled drugs in respect of which the society has such common knowledge. The case concerned a substance called Valium and should apply to other substances which are not of the same nature as those falling within the category of dangerous drugs. The court concluded that dangerous drugs should be treated as same as Valium. There is no common knowledge that Valium would cause a person to behave in similar fashion as a person who induced by dangerous drugs.

Article 1: Sleepwalking, Automatism and Insanity

While it is true that the 1991 Act introduced much needed flexibility of disposal (with the exception of murder charges), the Domestic Violence, Crime and Victims Act 2004 now makes it clear that hospitalisation on the grounds of unfitness to plead or insanity must comply with the Mental Health Act 1983. In short, there must be medical evidence that justifies detention in hospital on grounds of the defendant's mental state, namely a mental disorder within the Mental Health Act 1983 which in turn requires specialist treatment. This means that if the conditions for making a hospital order are not met then neither a restriction order nor a hospital order can be made irrespective of the seriousness of the alleged offence.

Might this apply equally to sleepwalking even where the charge is murder? This, however, is premised on accepting that such a condition is to be regarded in law as “a disease of the mind” within the M’Naghten Rules.

It might be thought that any argument seeking to show that sleepwalking is a form of (non-in) sane automatism has been foreclosed by the decision in Burgess. It is unique in that the “defect of reason” which arises from being asleep precedes the episode of automatism, namely the sleepwalking. It is this uniqueness which in part led both the Ontario Court of Appeal and the Supreme Court of Canada in Parks to rule, in
the circumstances of that case, against this form of automatism being regarded in law as of the insane type. The point is succinctly put by Lamer C.J.C. in *Parks* as follows:

“For a defence of insanity to have been put to the jury...there would have to have been in the record evidence tending to show that sleepwalking was the cause of the respondent's state of mind.”

Rather, the cause of the automatism is not the somnambulism but is instead inevitably dependant upon sleep which even Lord Lane in *Burgess* accepts as “a normal condition” If this is so then how can such an episode qualify as “a defect of reason, from disease of the mind” if the effect of the sleepwalking is not itself the cause of the impairment? In answer to this line of reasoning, barely acknowledged in *Burgess*, Simester and Sullivan remark:

“Perhaps, in defence of *Burgess*, the somnambulism may be said to supervene over the condition of normal sleep, producing a discrete, disordered state. Such an argument is not an answer of principle for classifying sleepwalking as a form of insanity, merely an acknowledgment that it is somewhat forced to maintain a separation between somnambulism and sleep when the states are, as they must be, coincident.”

Certainly, the two states “coincide” as is conceded by Galligan J.A. in *Parks* and in that sense it is nowhere suggested that they be regarded as separate. But to argue that sleepwalking can somehow be regarded as distinct from the normal state, namely the sleep which precedes it, seems unrealistic and fails to answer the question posed above. In reality it is the “walking” part rather than the sleep itself which the court in *Burgess* wishes to label as an episode of insane automatism. But unless the requirement of a causal link between “disease of the mind” and “defect of reason” within the M’Naghten rules is to be disregarded in the case of sleepwalkers, it is difficult to see why a sleepwalker, who is otherwise mentally normal, should be classed as legally insane.

Indeed, in some recent cases this difficulty has resulted in the outright acquittal of sleepwalkers rather than the special verdict handed down in *Lowe*. For example, in *Bilton* the accused who had a history of sleepwalking was acquitted of raping a woman after the jury accepted his claim that he had been sleepwalking at the time. The trial judge told
the jury it was “extremely rare” for a sleepwalker to carry out sexual acts and that “if [his] account was truthful, he is one of those exceedingly rare cases”. A similar result was achieved in *Davies* where the accused was found not guilty of sexual assault on the basis of sleepwalking. One can only assume that in both cases the defendants had pleas of sane automatism left to the jury. But how does this square with *Burgess*? Neither case seems to have resulted from episodes of “sudden arousal disorder” which it has been argued “appear to be due to an external factor (the arousing stimulus) and thus fall within the rubric of sane automatism”. Rather both cases appear to be clear somnambulistic episodes and ought therefore to fall within the ambit of *Burgess* and insane automatism. Unless, of course, it can be argued that the “external factor doctrine” has outlived its usefulness.

**Abandoning the “external factor doctrine”**

None of the English cases on automatism has made any attempt to evaluate the “external factor doctrine”. The doctrine was the result of Lawton L.J.’s decision in *Quick* which sought to avoid the “affront to common sense” of declaring a diabetic who suffered a transitory hypoglycaemic episode from being declared legally insane. But by requiring the need for some external factor in order to achieve this goal, it brought into English law a doctrine which creates arbitrary distinctions such as the one under discussion, namely that sleepwalking seems to qualify as insane rather than sane automatism, owing to the lack of any external trigger.

Evidence that the English courts are still wedded to the “external factor doctrine” can be found in *Roach* where the Court of Appeal stated:

“...the legal definition of automatism allows for the fact that, if external factors are operative upon an underlying condition which would not otherwise produce a state of automatism, then a defence of (non-insane) automatism should be left to the jury.”

Again this seems to mean that sleepwalking ought to fall within insane automatism. However, as was mentioned above, it is the lack of any critique of the “external factor doctrine” which is noticeably absent from any of the English cases and it is to Canada to which one can turn to fill this gap. Unlike their English counterparts the Canadian judiciary have shown a repeated willingness to evaluate and criticise the “external
factor doctrine”. First, in *Parks*, the fact that sleepwalking is not well suited to an application of the external factor doctrine was recognised by La Forest J. when he remarked:

“The poor fit arises because certain factors can legitimately be characterised as either internal or external sources of automatistic behaviour. For example the Crown in this case argues that the causes of the respondent's violent sleepwalking were entirely internal, a combination of genetic susceptibility and the ordinary stresses of everyday life…However, the factors that for a waking individual are mere ordinary stresses can be differently characterised for a person who is asleep, unable to counter with his conscious mind the onslaught of the admittedly ordinary strains of life. One could argue that the particular amalgam of stress, excessive exercise, sleep deprivation and sudden noises in the night that causes an incident of somnambulism, is for the sleeping person, analogous to the effect of concussion upon the waking person…In the end, the dichotomy between internal and external causes becomes blurred in this context, and is not helpful in resolving the enquiry.”

This in turn led La Forest J. to conclude that what he termed the “internal cause” theory “is really meant to be used only as an analytical tool, and not as an all-encompassing methodology”, a point which was endorsed by Bastarache J. in delivering the majority opinion of the Supreme Court of Canada in *Stone*. There he favoured “a more holistic approach” where it would be appropriate “to refer to the internal cause factor and the continuing danger factor, rather than the internal cause theory and the continuing danger theory” thus permitting a trial judge to “find one, the other or both of these approaches of assistance”. Further, in cases where “the internal cause theory is not helpful because it is impossible to classify the alleged automatism as internal or external, and the continuing danger factor is inconclusive because there is no continuing danger of violence…a more holistic approach to disease of the mind must also permit trial judges to consider other policy concerns which underlie this inquiry.” In short what is being favoured here is an approach which, unlike that in *Quick*, does not straitjacket a trial judge.

The fact that the approach described above does not necessarily mean that automatism which is primarily attributable to an “internal factor” will be classed as “insane” is well illustrated in the Canadian sleepwalking case of *Ludeauke*. There the accused was found not guilty of sexual
assault after the trial judge ruled that he “was in an automatistic state, being characterized under the category of parasomnia as sexsomnia, or sex sleep”. In his determination as to whether this condition was a disease of the mind, Otter J. applied the holistic approach adopted in *Stone*. In doing so he concluded that “The jurisprudence recognizes that somnambulism, as in the *Parks* case, is not suitable” to the “internal cause” type of analysis. He then proceeded to “analysis on the second branch of the theory, called the ‘continuing danger theory’, which basically posits that any condition that is likely to present a recurring danger to the public should be treated as a disease of the mind”. In doing so he found that “This is the only incident of its kind in Mr. Luedecke's history. The evidence is that Mr. Luedecke has voluntarily embarked upon a plan of sleep hygiene, modest alcohol consumption and the taking of medication--clonazepam. All of these would reduce the risk of recurrence.” As a result he concluded that “sexsomnia is not a disease of the mind or a medical disorder” and that, therefore, the accused “was entitled to an acquittal”.

What the ruling in *Luedecke* does not mean is that all sleepwalking cases will result in outright acquittals. Rather each case must be decided on its merits. But by applying the approach favoured by the Supreme Court of Canada in *Stone* what is achieved is much needed flexibility instead of being hidebound by an “external/internal factor” dichotomy which has outlived its usefulness. Surely, therefore, it is time for the English appellate courts, if given the opportunity, to re-evaluate the decision in *Quick* and to adopt a more flexible approach, not only in sleepwalking cases, but in an overall consideration of the intractable problem of distinguishing between insane and sane automatism.

**Article 2: Post-traumatic Stress Disorder and Dissociative State**

T, a young French woman aged 23 and two others (R and B) were arrested and charged with robbery (two cases) and T was further charged with ABH. The Crown alleged a joint enterprise by all three to rob two females whilst armed with a Stanley knife (not recovered) and a pen knife, of their handbags, as the two victims were returning to a car late at night. When first seen, T was leaning on the victims' car and said “I'm ill, I'm ill.” The three accused then surrounded one of the girls and there was a scuffle. Her bag opened and the contents spilled out,
whereupon the two victims ran away. A few minutes later, they met another young woman, dressed in a dark coloured jogging suit, who offered to accompany them to the local police station. En route to the car, T saw the two victims and (allegedly) misidentified the third person as a male. T then followed the three women to the motor vehicle and she was followed by R and B. Near the car, the contents of the first victim's handbag were recovered and she got behind the wheel of the car. The second victim sat in the rear nearside passenger seat and the third woman was standing by the open front nearside passenger's door when they were approached by the three defendants. R went to the driver's side and held a Stanley-type knife to the face of the first victim and demanded her bag, which he was given. T approached the open passenger's door where the third woman was standing. When asked what she was doing and why, T stabbed the third woman in the stomach causing a small puncture wound (no medical treatment required other than a dressing). T then pushed past the third woman, leant into the car and demanded the second victim's handbag, which was given to her. All three defendants remained in the vicinity for about one minute. The third woman realised she had been stabbed and started to scream, whereupon the three defendants decamped. The three victims drove away and pointed out T, R and B to a police officer whereupon R and B decamped. R was seen to discard a pen knife in a rubbish bin and discard the first victim's handbag, both of which were recovered. After a short chase R was arrested and brought back to where the victims were, and the officer also detained T who was standing at the side of the road. On being arrested, T was described as being passive and indifferent to what was happening. During a subsequent interview, T could only recollect some of the events. B was arrested the following day and all three were charged. Seven days later, T was examined by a doctor at H.M. Prison Holloway when it was found that her hymen was ruptured and was bleeding, and that there were injuries posterior to the hymen. T complained that she had been raped three days prior to her arrest but had not told anyone about it. T was later examined on a number of occasions by a psychiatrist who diagnosed that after the rape she was suffering from Post Traumatic Stress Disorder and at the time of the offence she had entered a Dissociative State and the offences had been committed during a psychogenic fugue and she was not acting with a conscious mind or will.

The Defence submitted that the “defence” of “non-insane automatism” was open to T on the grounds that the categories of non-insane
automatism are not limited to a blow causing concussion, an injection of insulin or anaesthetic or sleep walking (per Lord Diplock in Sullivan [1983] 3 W.L.R. 123); that rape is the application of an “external force” (per Lawton L.J. in Quick [1973] 3 W.L.R. 26 at p.35); that the rape was such an extraordinary external event that might be presumed to affect the average normal person and it contained features of novelty of accident (per Lord Lane C.J. in Hennessy [1989] 1 W.L.R. 287 at p.294 and Martin J. in Rabey, 79 Dominion Law Reports 435 (Ontario Court of Appeal); that a proper foundation had been laid for leaving the defence to the jury (per Lord Denning in Bratty v. Att.-Gen. for Northern Ireland [1963] A.C. 368 at p.413. The Crown argued that the evidence showed the Defendant had some recollection of what happened. Further that the opening of the blade of the pen knife required a controlled and positive action by the Defendant, therefore this was a case where there was “partial control” (per Broom v. Perkins (1987) 85, Crim.App.R. 321 and Issit [1977] R.T.R. 211) and the only “defence” open to T was “insane automatism” under the M‘Naghton Rules.

Held, that there had been no previous case in which an incident of rape had been held to be “an external factor” causing a malfunctioning of the mind within the definition laid down in Quick; that, if what the Defendant says about the rape is true, such an incident could have an appalling effect on any young woman, however well balanced normally, and that could satisfy the requirement; that a condition of Post Traumatic Stress involving a normal person in an act of violence is not itself a disease of the mind, even if there is a delay before a period of dissociation manifests itself; that if the medical evidence is correct this case is distinguishable from Broom and Issit where there was only a partial loss of control whereas in this case T was acting as though in a “dream”; that the categories of automatism are not closed and that, on the evidence before the court, a proper foundation had been laid for the matter to go before the jury.

If T, for whatever reason, was not acting with a conscious mind or will, she would have to be acquitted and the only question would then be whether she should be found simply not guilty, or not guilty by reason of insanity. The accepted test is now whether the condition arises from an external factor, when the verdict will be not guilty, or from an internal factor when it will be not guilty by reason of insanity. There could surely be no clearer example of an “external” rather than an “internal” factor than rape.
In Rabey it was held that the rejection of the defendant by a girl with whom he was infatuated was not an “external factor” for this purpose. In a sense, this rejection was no less “external” to the defendant than the rape. The difference is that the rejection was, in the opinion of the court, one of “the ordinary stresses and disappointments of life which are the common lot of mankind”; so that the true cause of the defendant’s state was the defendant’s “psychological or emotional make-up”—an internal factor. In a society of young people like a university such rejections by the loved one are common and, as all tutors know, frequently result in much unhappiness and depression; but Rabey’s alleged reaction was wholly exceptional. If the defendant is so shocked by the defeat of his local football team that he goes into a state of automatism and batters a policeman he is clearly a public danger. If the team has a bad season, be may decimate the local police force. He cannot be convicted of an offence but he must be liable to restraint. The right verdict is not guilty on the ground of insanity. It is his “internal” condition, not the ineptitude of the team, which renders him a public danger.

Rape is all too prevalent but we have not yet reached, and it is to be hoped we never shall reach, the stage when it has to be regarded as one of “the ordinary stresses of life.” But, even it were so, Rabey is distinguishable because, as the judge in the present case found, “such an incident could have an appalling effect on any young woman, however well-balanced normally …”

Automatism and control. The draft Criminal Code (Law. Com. No. 177) clause 33(1) provides--

“A person is not guilty of an offence if--

(a) he acts in a state of automatism, that is, his act--

(i) …

(ii) occurs while he is in a condition (whether of sleep, unconsciousness, impaired consciousness or otherwise) depriving him of effective control of his act…”

Broome v. Perkins is criticised by the Law Commission in the commentary on the Code, para. 11.4, as inconsistent with other authorities and with principle: “Finding it necessary to choose between
the authorities, we propose a formula under which we expect (and indeed hope) that a person in the condition of the defendant in Broome v. Perkins would be acquitted (subject to the question of prior fault).”

**Article 3: Diabetes and Criminal Responsibility**  
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An overview by Dr John Rumbold

Diabetes is a common chronic condition affecting three million people in the UK (0.5m are undiagnosed), [figures from Diabetes UK web site: http://www.diabetes.org.uk/]. Untreated diabetes is characterized by high blood sugar (hyperglycaemia), but diabetics on drug treatment can suffer low blood sugar (hypoglycaemia) which causes effects superficially similar to alcohol intoxication. Hyperglycaemia can cause similar mental impairment but to a lesser degree and with a much slower onset, so it is of much lesser forensic importance. There have been numerous reported cases of people being arrested for drink driving or public order offences whilst suffering hypoglycaemia, and there have been deaths of people arrested by the police where their condition was not recognized by the arresting officers, [Sue Leonard “‘Violent’ Diabetic to Sue Maker of Wonder Drug”, (2003) The Times, December 7; Linda von Wartburg “Mr Universe Assaulted by Police During Low Blood Sugar Episode”, (2007) Diabetes Health, April].

One such dramatic case was a man tasered in Leeds, six days after the July 7, bombings, because it was feared he was a suicide bomber, [Andrew Norfolk “Diabetic in Coma Shot with Taser out of Fear he was Suicide Bomber”, (2007) The Times, November 16] – in light of the Stockwell incident it is perhaps fortunate he is still alive. Nurses are becoming more commonplace in custody suites, although not universal, and a determination of blood glucose is essential in any situation where hypoglycaemia may have contributed to criminal behaviour.

Diabetics are given extensive education about how to manage their condition; typically they have one to five days of education when they start insulin which is the treatment most likely to cause hypoglycaemia. They will be told the importance of eating after administering insulin or concurrently in the case of administration of synthetic short-acting
insulins or oral diabetic treatments, and to avoid alcohol, which are both factors that will increase the likelihood of hypoglycaemia. They will be told about the warning signs of hypoglycaemia – pallor, sweatiness, feeling of anxiety, tremor, hunger – that precede the effects on the brain which include behavioural changes, confusion, fatigue, seizure, and loss of consciousness. Death can result if hypoglycaemia is not recognized and treated, [John Bingham “Diabetic Man Died After Police Mistook him for Drink-driver, Inquest Hears” (2009) The Telegraph, January 19].

Loss of the warning signs, or “hypoglycaemic awareness”, is caused by frequent episodes of hypoglycaemia. Loss of hypoglycaemic awareness is potentially very dangerous [Simon de Bruxelles “Diabetic ‘driving like a joyrider before fatal crash’” (2007) The Times, April 20] and bars the diabetic from driving, DVLA Medical Rules for drivers; [http://www.dvla.gov.uk/medical/ataraglance.aspx] (when known). In any case, diabetics have a duty to test their blood glucose before driving, and periodically during a long journey. All diabetics on treatment should wear a warning bracelet or pendant, eg, MedicAlert™ and have a suitable sugary snack at hand at all times.

Diabetes is not the only cause of hypoglycaemia – those with liver disease and poor nutrition are prone to low blood sugar. This is not an exhaustive list and the consumption of alcohol will exacerbate the tendency to hypoglycaemia in all cases. This makes alcoholics especially prone to hypoglycaemia, and their alcohol intake may make consideration of other causes of strange behaviour less likely. Hypoglycaemia is not necessarily the result of neglect – “tight control” (which means having borderline blood glucose) of diabetes reduces the likelihood of certain long-term complications and so a well-motivated and educated diabetic may suffer episodes of hypoglycaemia despite faultless management of his diabetes. If a diabetic develops an infection, eg, hepatitis in the case of Watmore v. Jenkins [1962] 2 QB 572, or another medical problem, hypoglycaemia may occur as the need for insulin (or other treatment) changes unpredictably.

The forms of incapacity recognized by English criminal law are (sane) automatism and insanity (which includes insane automatism). The distinction depends on whether the cause is internal or external.

According to Herring, “to plead automatism a defendant needs to show: (1) He had suffered a complete loss of voluntary control;
(2) This was caused by an external factor; He was not at fault in losing capacity.” [Criminal Law Text, Cases and Materials (2nd edn) (Oxford, Oxford University Press, 2006) p.706].

Insanity is still defined by the M’Naghten Rules where there must be a “disease of the mind”. This includes purely physical disorders like diabetes as well as psychiatric and neurological conditions, eg, strokes, R. v. Kemp [1956] 3 WLR 724, and epilepsy R. v. Sullivan [1984] AC 156. Lord Denning made what I consider the most practical and logical formulation when in Bratty he stated that, “any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind”. This neatly sums up the essence of the insanity defence – it seeks on philosophical grounds to excuse those who are not responsible for their actions and so are not blameworthy, whilst on policy grounds it seeks to protect wider society from these harmful actions. Diabetes provides a clear illustration of the problems of the internal/external divide doctrine which Lawton LJ established in Quick ironically, [R. v. Quick [1973] QB 910]. A diabetic like Hennessy who neglects his condition by not injecting insulin may be found not guilty by reason of insanity (but faces certain constraints for the protection of the public), whilst a diabetic like Quick who neglects their condition by not eating properly may be acquitted by reason of non-insane automatism.

When hypoglycaemia occurs without prior warning and prior fault, there is no liability for crimes of specific intent. However, if the person has been reckless about their diabetes, they may still be convicted due to self-induced incapacity [R. v. Bailey[1983] 1 WLR 760] – just as a person who drinks alcohol knowing that it may induce sleepwalking may not rely on the defence of automatism [Finegan v. Heywood (2000) JC 444; [2000] SLT 905]. As stated by Lawton LJ in Quick, “A self-induced incapacity will not excuse, nor will one which could have been reasonably foreseen.” So someone who, like Quick, is reckless in managing their diabetes whilst knowing the possible consequences will have the requisite mens rea for a crime of basic intent just like a person who is voluntarily intoxicated [R. v. Majewski [1977] AC 443]. Lawton LJ’s reasonable foresight implies an objective test, although his words, “taking alcohol against medical advice after using certain prescribed drugs” imply a subjective test. Certainly in the case of Hardie, where the defendant was given diazepam but was unaware of the disinhibiting nature of the drug, the test indicated by the Court of Appeal suggests a
subjective test of recklessness. In the case of Quick, (an assault on a patient on a psychiatric ward), it was held that a diabetic male nurse who became hypoglycaemic was entitled to have the question of whether or not he was suffering from automatism left to the jury. Quick had eaten little and had drunk alcohol. The Court of Appeal held that since the hypoglycaemia was caused by administration of a drug and therefore an external factor, the defence of automatism should be left to the jury. However, they expressed doubt that a jury would absolve him of responsibility given his reckless failure to manage his condition and previous history of violence during hypoglycaemic attacks. The previous episodes of hypoglycaemia accompanied by violence did not render Quick legally insane; it simply made his culpability for his incapacity higher. Insulin administration by a diabetic cannot reasonably be compared to “one-off” external events like concussion, and so labelling this as sane automatism (without any possibility of supervision) is problematic.

The changes in the methods of disposal following the special verdict of not guilty by reason of insanity under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 have made the insanity defence a more attractive option, given the possibility of outpatient supervision to prevent a recurrence. There is little point in detaining a diabetic or epileptic in hospital. However the label is problematic – “insanity” conjures up images of Victorian asylums in the mind of the public. Epileptics and diabetics as a whole are understandably disturbed at stigmatization by acquittals by reason of insanity, [Fenwick P., Fenwick E., eds, Epilepsy and the Law] (Royal Society of Medicine: London, 1984).

By contrast, in R. v. Hennessy [1989] 1 WLR 287, a diabetic who had hyperglycaemia was considered not to fall within non-insane automatism because his disease was an internal factor (it was in any event thought unlikely that hyperglycaemia alone accounted for his state of mind). The important difference between hypo- and hyperglycaemia was apparently not appreciated by the trial Judge [Case Comment, “Importance of Distinguishing Between High (hyper) and low (hypo) Blood Sugar Level in Case of Diabetics Relying Upon Defence of Automatism” Crim LR [1991] June 433-434] in R. v. Bingham [1991] Crim. LR 433, where he refused to leave the defence of automatism to the jury.

In motoring offences, the diabetic will be found liable if he decides to
drive (or continue to drive) whilst exhibiting symptoms of hypoglycaemia, [Moses v. Winder [1981] RTR 37;] and will not be allowed to argue automatism if hypoglycaemia develops whilst driving [Watmore v. Jenkins [1962] 2 QB 572; Broome v. Perkins (1987) Cr App R 321, on the grounds that in the early stages his actions were not entirely involuntary. This applies even in cases of lack of hypoglycaemic awareness, as the recent case of R. v. Clarke [2009] EWCA Crim 921, convicted of causing death by dangerous driving, demonstrates. It was a mitigating factor in sentencing, but as the defendant drove for over two miles whilst hypoglycaemic it was held that there was a time when he could have and should have pulled over. It should be noted that the defendant was very rigorous in checking his blood sugar, in contrast to Mr Davies, a lorry driver who killed three people in an accident due to hypoglycaemia who had not been managing his diabetes properly, [R. v. Davies (John Watkin)[2001] EWCA Crim 2319].

Most worryingly, he had been involved in an accident six years before which had been caused by hypoglycaemia. This decision follows the reasoning in Attorney-General’s Reference (No.2 of 1992) where it was deemed that the lorry driver “mesmerized” by the monotony of the motorway had not suffered total loss of control initially (additionally it was not considered an “external factor”). Similarities can be seen in the Scottish case of Cardle v. Mulrainey [1992] SLT 1152, where a man committed various motoring offences and attempted theft having had his drink “spiked” with amphetamines, and the High Court held that there was no “total alienation of reason” and therefore automatism could not be a defence. As Lord Goddard CJ commented in Thomson v. Knights [1947] KB 336, “[when] a man driving or attempting to drive, or being in charge of a motor car is in a self-induced state of incapacity, whether that incapacity was due to drink or drugs, the man commits an offence”. For policy reasons, there is a greater responsibility on diabetics to ensure their fitness to drive, and for most motoring offences the lack of mens rea caused by incapacity is irrelevant according to DPP v. Harper [1998] RTR 200, although many commentators disagree with the decision and Hennessy suggests that insanity may be a defence.

**Conclusion**

In summary, arrests of diabetics suffering hypoglycaemia occur regularly. Police officers should be aware of MedicAlert or similar bracelets so as to ensure speedy diagnosis of diabetic problems.
Testing of blood glucose and assessment of medical records will determine whether the person was hypoglycaemic. The level of education and history of compliance of the diabetic, in combination with expert evidence, will indicate how foreseeable the hypoglycaemic episode was. The type of offence together with the foreseeability of hypoglycaemia will determine how culpable the diabetic is for their incapacity. As a matter of policy, even those with loss of hypoglycaemic awareness will still be convicted of strict liability or negligence-based motoring offences, but sentences will be reduced where the defendant does not know he has loss of hypoglycaemic awareness, has done everything possible to reduce the possibility of hypoglycaemia and most importantly pulls over as soon as he feels unwell.