

## Epilepsy and the law

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### Epilepsy and the criminal law

Everyone who has reached the age of discretion is, unless the contrary is proved, presumed by law to be sane and to be accountable for his actions. This is the doctrine of *mens rea*. 'Actus non facit reum nisi mens sit rea' – the deed does not make a man guilty unless his mind is guilty. This is the fundamental basis of the English law. For to make a man liable to imprisonment for an offence that he does not know he is committing, and is unable to prevent, goes against the spirit of English justice and brings the law into contempt.

Unless the offence is a statutory one which carries an absolute liability (e.g. driving with a raised blood alcohol level), the doctrine of *mens rea*, or the presence of a guilty mind, can only be negated by six major considerations: the person is defending themselves; the person was under duress; the person was provoked; that the mind is not guilty because it is innocent; because the mind is diseased; and because at the time of the act there was an absence of mind. Duress and provocation are not relevant.

The defence of innocence is seldom used and is sometimes applied to mental subnormality, but is of little relevance to epilepsy. Disease of the mind rests on the McNaghten Rule which arose as a consequence of the case of Daniel McNaghten who was tried in 1843. The answers of the judges to the House of Lords following the trial established that for a defence on the grounds of insanity to be successful 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*. This defence can only be used by patients with epilepsy who, at the time they commit an offence, have an associated mental illness. It might thus be used in persons with epilepsy who have, for example, either a post-ictal or an inter-ictal paranoid psychosis and who at the time they commit their crime are suffering from an insane delusion. In these circumstances, epilepsy is very little different from any other functional psychotic illness and the rules applying to persons with epilepsy are no different from those applying to the mentally ill population as a whole.

The law relating to epilepsy is, however, distinct when we consider the sixth category of defect – that no mind was present at the time of the act – for it can be claimed that during an epileptic seizure the mind is absent and so any action carried out is automatic. In law, this defence is the defence of automatism. An act carried out in the absence of mind is known legally as an automatic act, and the defendant may wish to establish the defence of automatism. The legal and medical definitions of automatism are quite different. This may be more clearly understood if it is recognised that the law has to deal with the protection of the public as well as the rights of the individual, and is not overly concerned with the brain and its mechanisms. Medicine, on the other hand, is concerned primarily with brain mechanisms, their disorder and cure, and is not unduly concerned with the rights of society and the

protection of one individual from another. Thus although both the law and medicine use the same word they mean different things.

### **Automatism**

An epileptic automatism is defined medically as:

‘A state of clouding of consciousness which occurs during or immediately after a seizure, during which the individual retains control of posture and muscle tone, but performs simple or complex movements without being aware of what is happening. The impairment of awareness varies. A variety of initial phenomena before the interruption of consciousness and the onset of automatic behaviour may occur’<sup>1</sup>.

By this definition, automatisms are really very common, and can be divided into two groups: ictal automatisms, which occur during a seizure, and post-ictal automatisms, which occur after a seizure.

The accepted legal definition of automatism, as given by Viscount Kilmuir LC<sup>2</sup> in the House of Lords Appeal in the case of *Bratty v Attorney General for Northern Ireland*, is as follows:

‘The state of a person who, though capable of action, is not conscious of what he is doing ... it means unconscious, involuntary action and it is a defence because the mind does not go with what is being done.’ Viscount Kilmuir continued: ‘This is very like the words of the learned President of the Court of Appeal of New Zealand (Gresson, P.) in *Regina v Cottle*, where he said: “With respect, I would myself prefer to explain automatism simply as action without any knowledge of acting, or action with no consciousness of doing what was being done.”’

This definition is very close to the medical definition, and it would thus seem that doctors and lawyers are in agreement about what constitutes an automatism. This is not so, however, because the law, unlike medicine, defines two types of automatisms: sane (*automatism simpliciter*), e.g. after a head injury, and insane (*automatism due to disease of the mind*), e.g. resulting from arteriosclerosis in the brain. Either kind of automatism can be put forward as a defence and if accepted by the court will enable the defendant to plead not guilty. However, the consequences of a successful defence are quite different in the two cases. In the case of sane automatism, the defendant will walk free from the court. But in the case of an insane automatism the defendant will be sentenced under the Fitness to Plead and Insanity Act 1991. This Act allows the judge to decide on disposal, which can range from allowing the defendant to go free to the detention of the defendant in a secure mental hospital for an indefinite period at the discretion of the Home Secretary.

### **Sane and insane automatism**

The distinction between sane and insane automatism is arbitrary and makes little medical sense. A brief look at the case of *Sullivan*, which attempted to clarify the law, may be helpful.

#### *Appeal – Epileptic automatism as disease of the mind: Regina v Sullivan*

*Sullivan*, a man of previous good character, had complex partial seizures with occasional secondary generalisation from the age of eight. He had had two severe head injuries which resulted in widespread brain damage and some degree of personality change. His major attacks ceased in 1979, and only the complex partial seizures remained. These seizures

spread rapidly and bilaterally into both amygdala and hippocampal structures, so that Sullivan had no memory of the seizure or events immediately thereafter<sup>3</sup>.

During a complex partial seizure Sullivan attacked and seriously injured an elderly neighbour. The seizure and the attack were witnessed, so there was no medical doubt that the assault took place during an epileptic automatism, and this was accepted by both the prosecution and the defence. Sullivan wished to establish the defence of sane automatism (automatism simpliciter), and pleaded not guilty. The trial judge, His Honour Judge Lymbery, ruled that this plea was not available to the defence and that if Mr Sullivan carried out the act during an epileptic seizure, then he must plead not guilty with the defence of automatism due to disease of the mind.

The case went to Appeal in the House of Lords and was rejected. Commenting on the verdict of the House of Lords, Mr Lionel Swift who presented the appeal said: 'From the point of view of the administration of the law and justice to epileptics and others, the reasoning of the House of Lords is, with respect, impeccable ... It matters not whether the impairment (of mind) is organic, as in epilepsy, or functional. It matters not whether the impairment is permanent or transient, or capable of control by drugs. Provided that (impairment) is his condition at the material times, he comes within the definition of being temporarily insane. At the time he committed the act, Sullivan was completely unaware of what he was doing and, therefore, he was insane at the time.'<sup>3</sup>

The present standing of the difference between sane and insane automatism is as follows: Automatism simpliciter occurs when the mind is disordered by an external factor such as an injection of insulin, a blow on the head, the injection of an anaesthetic or even a reflex action resulting from a bee sting. An insane automatism occurs when the mind is disordered due to an intrinsic factor which leads to a situation that is prone to recur and may result in violence. Thus any organic condition of the brain or the body resulting in a disorder of the mind, even if temporary, is an insane automatism. Automatic acts carried out during sleep, during dissociated states, and during any psychiatric or medical condition causing a disruption of brain function which is due to an internal condition is now insanity. This clearly leads to differences which appear to be nonsensical, for a violent act committed while the mind is disordered due to an excess of insulin is automatism simpliciter if the insulin is injected, while it is an insane automatism if the insulin comes from an insulinoma of the pancreas. The distinction between sane and insane automatism is a meaningless one medically, and if the legal profession could bring itself to do so, it is probably best abandoned altogether. The drawing of an arbitrary line always leads to confusion.

### **Epilepsy and criminality**

Not infrequently, hospital psychiatrists are called upon to decide whether or not a crime has been committed during an epileptic seizure, and whether or not the defence of automatism is one that can be substantiated by the medical facts of the case. Usually the offence is fairly trivial, for example, shoplifting during either a post-ictal confusional state or during the automatism of a complex partial seizure. Occasionally, however, defendants may claim the defence of epileptic automatism when there is little evidence to support this. The physician should satisfy himself on the following six points before going to court to substantiate the diagnosis of epileptic automatism:

1. The patient should have a previous diagnosis of epilepsy. It is clearly unlikely that a crime will be committed during a first seizure. Thus, unless there is overwhelming evidence, the diagnosis of epilepsy should be rejected if the act is said to have occurred during a first seizure. The case of epilepsy is strengthened if there is evidence that the patient is either

subject to ictal or post-ictal automatisms, and that the behaviour described during the crime is consistent with behaviour that has been previously described during such an automatism.

2. The act should be out of character for the individual and inappropriate for the circumstances. Clearly, if the defendant is habitually aggressive and commits a violent and aggressive crime, it is much more difficult to substantiate the diagnosis of epileptic automatism than if the act occurs in a patient who is mild mannered and tolerant. It is also important that the act should be inappropriate in the circumstances in which it occurred. A violent act of automatism during a fight, although it may occur, is less likely to persuade the court than one which occurs during a Sunday stroll.

3. There must be no evidence of premeditation or concealment. An epileptic automatism must arise *de novo* from ongoing behaviour. If there is any suggestion that there was preplanning for the act, then it is not possible to substantiate the diagnosis of automatism. Concealment is also unlikely after an automatism. On regaining consciousness a patient emerges from a state of confusion or amnesia and is thus unlikely to register the full meaning of the events which have occurred. His natural response to such a situation is immediately to seek help, and not to conceal the evidence of any crime.

4. If a witness is available, they should report a disorder of consciousness at the time of the act. Unfortunately, witnesses are not always available, but when they are, detailed questioning about the defendant's behaviour to establish a disorder of consciousness is essential. Features to seek are those of automatism: staring eyes, a glassy look, stereotyped movements, confusion and evidence that the person was out of touch with his surroundings.

5. Because the act occurs during an automatism or post-ictal confusional state, a disorder of memory is the rule. It is unlikely that an epileptic automatism can occur in the setting of clear consciousness. Thus, memory for the act should be impaired. It is essential that there is no loss of memory antedating the event. During a seizure, loss of memory starts with the onset of the seizure and not before it. Thus any loss of memory which antedates the episode is a point against it being an epileptic automatism.

6. The diagnosis of automatism is a clinical diagnosis. Although weight will clearly be given to abnormal investigations, such as a focal lesion on the MRI scan or evidence of generalised or focal EEG epileptiform discharges, none of these make the diagnosis of epilepsy. Epilepsy is a clinical diagnosis and any physician who enters court unable to substantiate the diagnosis on clinical grounds alone is likely to find himself in trouble<sup>3,4</sup>.

## References

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